Best Practice Timed Diagnostic Cancer pathways

Practical guidance for clinicians to maximise use of NHS Cancer pathways for the benefit of patients

October 2023

Produced in partnership by NHS England's GIRFT and Cancer programmes
Getting It Right First Time (GIRFT) and the NHS England Cancer Programme have co-produced this guide, outlining how cancer alliances and constituent organisations can implement NHSE’s best practice timed pathways for cancer, with insights from the relevant GIRFT national clinical leads.

The guide summarises the key guidance documents available to NHS colleagues, with links provided. We recommend that these are read in full alongside this guide.

Teams have worked incredibly hard over the past few years to maintain and drive services, and for that we thank you for your continued dedication. However, we now have a greater challenge than ever before – to shorten diagnosis times, reduce variation, improve the patient experience of care, and to meet the Faster Diagnosis Standard (FDS). Morale and motivation are crucial to delivering meaningful change, so teams should be engaged with at every step of the way.

We hope that clinicians and operational managers across the country will use this guide as a template to support the standardisation of clinical pathways, and to optimise diagnostic capacity and resources to improve patient pathways and experience in cancer care.

Professor Peter Johnson, National Clinical Director for cancer, NHS England

Professor Tim Briggs CBE, Chair of GIRFT and National Director for Clinical Improvement and Elective Recovery, NHS England
Faster Diagnosis Standard

The 28 Day Faster Diagnosis Standard (FDS) was introduced to replace the Two Week Wait (2WW) standard, setting a maximum 28-day wait for communication of a cancer diagnosis or ruling out of cancer for patients referred.

Since Spring 2021, Faster Diagnosis Standard (FDS) performance by provider and commissioner has been published on a monthly basis, with the threshold introduced initially at 75%.

The NHS Long Term Plan committed to providing a faster diagnosis for people through the introduction of the Faster Diagnosis Standard (FDS) to ensure people are told they have cancer, or that cancer is excluded, within 28 days from referral. The new standard is intended to allow:

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 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 coordination 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

Since the introduction of the Faster Diagnostic Standard, performance has been 71.3% (April 2023) across England. We now need to go further to reach 75% performance by March 2024.
Building on the most recent evidence, the Best Practice Timed Diagnostic pathways were developed by multidisciplinary consensus groups with clinical leaders from local and specialist services across England, expert advice from cancer alliances, professional bodies, NHS England teams including Getting It Right First Time (GIRFT), charities, and patient and public partners, to support cancer alliances and constituent organisations to adopt consistent, system-wide approaches to managing diagnosis pathways.

Efficient, patient-centred, pathways that allow clinicians to focus on the rapid investigation of the highest priority patients, whilst allowing fast and effective rule out and management of those without cancer will become ever more important. Enabling systems to meet this standard through this aligned strategic approach to Faster Diagnosis, is a priority for the NHS cancer programme and will support patients care and service capacity.

Timed Pathways Available:
- Head & Neck
- Gynaecology
- Colorectal
- Lung cancer
- Prostate
- Oesophago-gastric
- Skin

In development:
- Breast
- Urology (non-prostate)
- Hepatobiliary
The constitutional standards for cancer have not been met for a number of years, and pre-existing challenges exacerbated during the pandemic.

Urgent referrals for suspected cancer almost doubled between 2012-2019, meaning more cancers being detected and reduced emergency presentations.

An estimated one in six patients diagnosed with cancer saw their GP three or more times before being referred, and many patients had multiple referrals before being diagnosed.

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

Many operational performance challenges lie at the diagnostic end of the pathway.

The number of people investigated for suspected cancer will continue to rise, both as a result of demographic change and as a result of actions taken to target the Early Diagnosis ambition.

Since the Covid-19 pandemic, patients seen following a 2WW referral has consistently been higher than pre-pandemic levels – see graph – and therefore we need to change the way services are delivered to meet this challenge.
Learning resources

Share and Learn webinars

FutureNHS Cancer Alliances Forum

Case Studies

SOPs and templates

Watch webinars sharing learning to support Cancer Alliances

Ask a question to the Cancer Alliance community

Read about the experiences of others

Explore SOPs and other documents from trusts

All resources can be accessed on the Cancer Alliances Workspace on FutureNHS

Click here to sign up

Produced in partnership by NHS England’s GIRFT and Cancer programmes
Colorectal cancer diagnostic pathway

Lower GI actions for systems and providers

- Review FIT uptake data by PCN and GP surgery, and provide directed support to those <80% uptake
- There should be clear protocols in place at clinical triage to ensure those with a FIT <10ug Hb/g, normal examination and normal full blood count who are at very low risk of colorectal cancer are not referred for a lower GI endoscopy on the lower GI urgent cancer pathway
- Understand the performance within the system at each point of the FDS pathway, and use this understanding to investigate the root causes
- For patients with FIT <10ug Hb/g and ongoing symptoms, systems and providers to ensure referral pathways are in place for appropriate symptomatic services
- ICBs should put processes in place to monitor and drive improvement of referral quality
- Providers should report their endoscopy list utilisation, in-sourcing and waiting-list initiative data monthly and review the job plan balance of endoscopy trained staff

Maximising 62-day reductions

On 1st February 2023, systems and providers received a letter from NHS England to thank them for efforts in reducing the COVID backlog while continuing to see newly referred patients. In the letter, priorities were set for work to continue on this, via:

- Prioritising Community Diagnostic Centre (CDC) capacity
- Implementing FIT triage for 2ww patients on endoscopy waiting lists
- Making maximum use of wider local capacity
- Continued focus on data validation and accuracy

Collectively, these actions impact certain tumour sites above others, but all 4 actions have the potential to make a strong impact for patients with suspected Lower GI cancer.

NHS Long term plan

The NHS Long term plan committed to faster diagnosis provision through the Faster Diagnosis Standard (FDS). In lower GI cancers, early diagnosis is critical; patients with cancer diagnosed at stage 4 have a 10% five-year survival rate, compared to 90% for stage 1 and 80% for stage 2 – in 2019 only 37% of colon cancers were diagnosed at an early stage (1 or 2).

NHS England – Maximising 62 day backlog reductions
Day 0: FIT Testing

In a symptomatic patient, Faecal Immunochemical Testing (FIT) may identify whether colorectal investigation is a high priority. It is recommended that all GP surgeries in England take the following steps:

1. Patients who meet NG12 criteria for suspected cancer pathway referral (excepting those with anal rectal mass or anal ulceration) should be offered FIT.

2. Patients with fHb <10ug Hb/g, normal examination and full blood count are at very low risk of colorectal cancer and should not be referred on the lower GI urgent cancer pathway, they should be safety netted or referred on an alternative pathway. Examples of safety netting include a repeat FIT test - patients with two negative FIT results have a colorectal cancer risk of <0.04%, review at 4-6 weeks or some areas have developed FIT negative pathways managed by either primary or secondary care.

3. Patients with fHb >10ug Hb/g should be referred on an urgent cancer pathway, with the FIT results documented alongside full blood count results on the referral form. Patients should be informed that they are being referred for an urgent suspected cancer pathway, but also that the vast majority of referrals result in a non-cancer diagnosis.

Day 0: Referral minimum dataset

- Patient demographics
- Patient symptoms (in line with NG12)
- Past medical history (including previous colorectal investigations and co-morbidity)
- Family history
- Anticoagulant status
- WHO performance status
- Smoking status alcohol intake
- Prescribed medication
- Need for interpreter
- Mental capacity to consent
- FBC, ferritin, CRP, MCV, U&E / eGFR, FIT
- Digital rectal examination findings

Patient Safety Netting for <10ug Hb/g

- GP surgeries should provide clear information about who to contact if the patient develops new symptoms, or existing symptoms worsen.
- GP surgeries should use Specialist Advice and Guidance via eRS to guide management of patients with persistent or troublesome symptoms.
- Acute providers should ensure Specialist Advice and Guidance provision is timely.

FIT uptake by region in March 2023

- North East & Yorkshire 66.4%
- North West 69.8%
- Midlands 59.2%
- East of England 76%
- South West 64.6%
- South East 72.2%

Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a FIT result, with the result recorded either in the twenty-one days leading up to the referral, or in the fourteen days after the referral.
Colorectal cancer diagnostic pathway

Day 7: Clinical Triage

Clinical triage in the acute setting should take place within 7 days of referral. In many organisations, this is safely and effectively delivered over the telephone by a Clinical Nurse Specialist (CNS) team with oversight from the consultant team.

Outcomes from CNS triage

- **Diagnostic test** – following a review of the referral and tests with a telephone conversation with the patient, the CNS can safely signpost to the most appropriate diagnostic test for patients (e.g. flexible sigmoidoscopy, colonoscopy, CT colonogram).

- **Discharge or Re-route** – if patients have a FIT <10ug Hb/g, normal examination, full blood count and no ongoing symptoms of concern, after a telephone discussion they can be discharged back to their GP or re-routed to an alternative pathway for definitive diagnosis.

- **Outpatient appointment** – where there are clinical concerns but the patient is not appropriate for a straight-to-test referral, they should be offered a face-to-face outpatient appointment.

Cancer navigator role

These roles may have different titles across the country, but the purpose of the role should be:

- Maintain a single electronic patient tracking list for all suspected and confirmed cancer cases referred into the acute provider.
- Ensure the list is current, and update all changes such as confirmation of diagnosis or non-diagnosis and the date it was communicated to the patient.
- Liaise with patients, clinical teams and managers across the provider and system to ensure that slots are allocated equitably.

Endoscopy List Utilisation

Despite high demand, some providers routinely under-utilise their planned diagnostic testing capacity. NHS England asks providers to report their planned and actual session data monthly via e.endoprogramme@nhs.net. The response rate currently varies as shown in the second column, but the data set does allow for providers to benchmark themselves against peers. Providers should report their endoscopy list utilisation, in-sourcing and waiting-list initiative data monthly and use this information to review the job plan balance of endoscopy trained staff.

<table>
<thead>
<tr>
<th>Month of 2023</th>
<th>Provider response rate</th>
<th>Planned sessions</th>
<th>Actual sessions</th>
<th>Utilisation</th>
<th>Cancelled lists</th>
<th>Waiting list initiative</th>
<th>Insourcing</th>
<th>Outsourcing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No endoscopist</td>
<td>No nurse</td>
<td>Other factors</td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>53.7%</td>
<td>14,563</td>
<td>12,736</td>
<td>87.5%</td>
<td>47%</td>
<td>17%</td>
<td>35%</td>
<td>1,438</td>
</tr>
<tr>
<td>Feb</td>
<td>59.3%</td>
<td>14,303</td>
<td>12,315</td>
<td>86.1%</td>
<td>61%</td>
<td>14%</td>
<td>25%</td>
<td>1,660</td>
</tr>
<tr>
<td>Mar</td>
<td>61%</td>
<td>15,612</td>
<td>13,035</td>
<td>83.5%</td>
<td>69%</td>
<td>4%</td>
<td>27%</td>
<td>1,851</td>
</tr>
<tr>
<td>Apr</td>
<td>61.8%</td>
<td>13,947</td>
<td>11,124</td>
<td>79.8%</td>
<td>58%</td>
<td>3%</td>
<td>38%</td>
<td>1,376</td>
</tr>
</tbody>
</table>

Key

- **Other factors**
  - lack of other staff, equipment failure, or other example

- **Waiting list initiative**
  - additional activity above usual core service

- **Insourcing**
  - sub-contract of activity using the provider estate and equipment

- **Outsourcing**
  - providers contracts the delivery of endoscopy procedures to another provider. It is believed this number is under-reported, as the person completing the return may not know the full amount of outsourcing arrangements in place within their provider.
## Audit Tool

Shared from the [Faster Diagnosis Pathway guidance document](#), this tool can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measurements for improvement, and conduct re-audits as part of continuous improvement.

<table>
<thead>
<tr>
<th>Day</th>
<th>Pathway step</th>
<th>Service in place?</th>
<th>Capacity in place?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>GP referral – local agreements made ensure minimum dataset (as detailed in pre-referral information) can facilitate straight to test provision. Primary care provision of FIT testing prior to referral for all patients with NG12 symptoms except those with anal/rectal mass or anal ulceration.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Patient information resources developed for primary care – ensure patient engagement and empowerment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Clinically led triage – should be consultant supervised and delivered by appropriately trained clinician (e.g. CNS) using FIT result for risk assessment – ensure local protocols in place &amp; bowel prep arrangements agreed. Consider early opportunities for pre-habilitation or symptom control if necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Straight to test provision for all eligible patients – develop local protocols for appropriate first test ideally matched to resource provision between radiology (CTC) and endoscopy (colonoscopy). Consider parallel booking of other relevant tests, e.g. OGD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>OPA – Ensure provision for outpatient consultation, no more than 14 days from GP referral, for patients unsuitable for straight to test for clinical assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Staging investigations – Develop local arrangements for staging investigations (such as a standardised diagnostic bundle), ideally should be straight to staging booked at time the initial definitive investigation is completed. Can include same-day/one-stop model (see OSCARS example). MDT with some patients on clear and agreed cancer protocol pathways that may not need formal discussion. These patients need to be recorded on the MDT agenda with their treatment plan. Regular audits of patients on protocol pathways should be conducted to ensure the plan was delivered. <strong>Addition</strong> - Following tissue sampling results, confirmed cancer tumours for all colorectal diagnosis should be tested for all molecular markers required to determine onward management, including Lynch syndrome as per NICE Guidance (DG27). For metastatic patients, molecular testing should be delivered by the Genomic Laboratory Hub, preferably by gene panel analysis to include all relevant gene markers as directed by the <a href="#">National Genomic Test Directory</a>. Results from initial tumour tests should be discussed as MDT as diagnosis may impact treatment options.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Clinic review – Ideally a consultant surgeon or oncologist supported by a CNS leads a discussion regarding diagnosis and treatment options in person with the patient supported by next of kin. Consideration of fitness for treatment, prehabilitation and symptom control should be included. Appropriate communication and contact with CNS should be encouraged throughout the pathway (e.g. at endoscopy, telephone consultation, etc)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Prostate cancer diagnostic pathway

About the NHS England best practice timed pathway
This guide provides a concise summary of the rapid prostate cancer diagnostic and assessment pathway published by NHS England in October 2022. The pathway aims to ensure that people are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. This pathway from NHS England is based on the National Cancer Vanguard.

GIRFT guidance on prostate cancer is planned to take place in Autumn 2023.

About prostate cancer
Prostate cancer is the second most common diagnosed cancer in England and the most common cancer diagnosed in men. In 2019 only 42% of all prostate cancers were diagnosed at an early stage, ranging from 23% to 66% between CCGs. With relatively high survival of prostate cancer, the impact of late diagnosis is less severe than for other cancers (almost 100% one-year survival for stage 3 diagnoses and over 80% for stage 4); identifying high and intermediate risk cases is important.

Primary care
- Local agreement with GPs on minimum dataset to accompany referrals
- Primary care inform patient of their referral and responsibilities to be available for testing

Triage
- Clinical triage can be done by suitably experienced urologist physician or cancer CNS
- Same day investigations and remote consultations used to reduce repeat visits

Patient / carer information
- Continuity of caseworker/navigator is ideal
- Personalise communication to patient preferences where possible
- Inform if cancer ruled out or confirmed at earliest face-to-face, unless other method preferred

Key points of best practice:

Resources
- NHSE Implementing a timed prostate cancer diagnostic pathway
- GIRFT National Report and guides on urology
- Prostate Cancer UK best practice pathway
- Cancer waiting times data
- Cancer Alliance FutureNHS workspace

Produced in partnership by NHS England’s GIRFT and Cancer programmes
Prostate cancer diagnostic pathway

Increasing use of pre-biopsy multi-parametric MRI (mpMRI)

Trials have shown that pre-biopsy mpMRI is able to triage patients towards a biopsy so at least 25% can avoid it, with recent data showing 45% can avoid a biopsy in the RAPID programme; diagnose over 90% of significant cancers; and diagnose fewer insignificant cancers.

No suspicious lesions reported

- Downgrade following cases from urgent cancer pathway: Likert or PIRADS 1/2, Likert or PIRADS 3 with PSA density <0.12 or <0.15 (both reported in literature). Also consider risk factors
- Consider shared decision making for biopsy or PSA observation in equivocal scans with patient risk factors.

Biopsy

Prostate biopsy: this could be transrectal, transperineal targeted (visual-estimation or image-fusion) depending on local expertise, protocols and availability of equipment. Transperineal template sectoral or mapping biopsies should only be used in select cases.

Where cancer is ruled out

- In some cases (specific symptoms), provide an MRI or CT before referring on to non-cancer routine pathway
- When other non-prostate cancer not ruled out, may refer to alternative tumour site pathway
- FDS Clock Stop when cancer exclusion or confirmation communicated to patient

Core roles at full MDT

- Lead clinician, radiologist with established urology interest, pathologist, oncologist with interest in urological cancer, CNS and relevant AHP with pathway navigator
- Reflect capacity to deliver core roles in job plans
- Follow national guidance on effective MDTs
- Locally agreed clear criteria for referral to sMDT
- Some patients may require additional mini-MDT between radiologist, oncologist and referring surgeon by day 21
- Consider direct referral from pathologists and radiologists.

Where negative biopsy

Arrange imaging review meeting (with radiology and urology), and consider re-biopsy, surveillance or discharge depending on mpMRI and histology findings. Likert or PIRADS 4/5 with no atrophy or inflammation might be a ‘miss’ so should consider re-biopsy/surveillance. Likert or PIRADS 1-3 can be discharged to GP with personalised PSA threshold for re-referral.

Audit tool

Units should complete the pathway audit tool to identify services in place and capacity
## Prostate cancer diagnostic pathway

### Prostate cancer - 28-day best practice timed pathway for prostate cancer diagnosis

<table>
<thead>
<tr>
<th>Day -3 to 0</th>
<th>By Day 3</th>
<th>By Day 14</th>
<th>By Day 21</th>
<th>By Day 28</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care</strong></td>
<td><strong>Clinical triage</strong> Based on local protocol Men with UTI/positive MSU to be informed and referred to non-cancer routine pathway</td>
<td><strong>Straight to mpMRI before biopsy</strong></td>
<td><strong>Prostate biopsy</strong> (by day 9)</td>
<td><strong>Further investigations</strong> (if required for staging)</td>
</tr>
<tr>
<td><strong>Local diagnostic centre</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MDT</strong></td>
<td><strong>Outpatient clinic; Discuss treatment options and Personalise care and support plan with MDT input; assess fitness +/- pre-op assessment; patient optimisation and support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Urgent GP referral**
  - Including locally mandated information

- **Patient information**
  - Provided in primary care
  - Provided in consultation or OPA/clinic

- **Cancer likely/diagnosed**
  - Clinic review;
  - Communication with patient and discussion with CNS. Record FDS when patient is informed that they have cancer.
  - OR
  - No suspicious lesions reported or negative biopsy.

- **Cancer ruled out and communication with patient**
  - Patient informed; referred to other secondary care service if possible.
  - Record FDS when patient informed that cancer has been excluded.

*This is a straight to test pathway using MpMRI. The 21-day pathway should be used when an immediate MRI is not required or is contraindicated.*
# Prostate cancer diagnostic pathway

## Prostate cancer - 21-day best practice timed pathway for prostate cancer diagnosis

<table>
<thead>
<tr>
<th>Day -3 to 0</th>
<th>By Day 3</th>
<th>By Day 14</th>
<th>By Day 21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care</strong></td>
<td><strong>Local diagnostic centre</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent GP referral</td>
<td>Clinical triage</td>
<td>Outpatient clinic</td>
<td>sMDT</td>
</tr>
<tr>
<td>Including locally mandated information</td>
<td>Based on local protocol</td>
<td>Stratify risk (incl. PSAD)</td>
<td>Discuss treatment options and Personalised Care and Support Plan</td>
</tr>
<tr>
<td>with UTI/positive MSU to be informed and referred to non-cancer routine pathway</td>
<td>and plan investigations</td>
<td>followed by Prostate biopsy (if indicated)</td>
<td>with MDT input; assess fitness +/- pre-op assessment; patient optimisation and support</td>
</tr>
<tr>
<td>Patient information</td>
<td>Patient information</td>
<td>Cancer likely/diagnosed</td>
<td>Outpatient clinic</td>
</tr>
<tr>
<td>Provided in primary care</td>
<td>Provided in consultation or OPA/clinic</td>
<td>Clinic review; Communication with patient and discussion with CNS. Record FDS when patient is informed that they have cancer OR Cancer ruled out and communication with patient</td>
<td></td>
</tr>
<tr>
<td>Provided in consultation or OPA/clinic</td>
<td>Cancer likely/diagnosed</td>
<td>Patient informed; referred to other secondary care service if possible, Record FDS when patient informed that cancer has been excluded</td>
<td></td>
</tr>
</tbody>
</table>

This is a straight to test pathway using MpMRI. This pathway ensures diagnosis is reached by day 14 for the subset of patients where MRI may not be required or is contraindicated (this should be the exception). Exceptions include: Unsuitable for active treatment options in which local staging with same; Upper limit threshold for PSA may be agreed locally to indicate likely metastatic disease at presentation; Contraindications to MRI (dependent on local protocols).
Prostate cancer diagnostic pathway

Prostate cancer - 14-day best practice timed pathway for prostate cancer diagnosis

<table>
<thead>
<tr>
<th>Day -3 to 0</th>
<th>By Day 3</th>
<th>By Day 7</th>
<th>By Day 14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary care</strong></td>
<td><strong>Local diagnostic centre</strong></td>
<td><strong>Local diagnostic centre</strong></td>
<td><strong>Local diagnostic centre</strong></td>
</tr>
<tr>
<td>Urgent GP referral&lt;sup&gt;1&lt;/sup&gt; Including locally mandated information&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Clinical triage&lt;sup&gt;3&lt;/sup&gt; Based on local protocol Men with UTI / positive MSU to be informed and referred to non-cancer routine</td>
<td>One-stop diagnostics clinic (consultant led) MpMRI before biopsy, followed by Targeted biopsy&lt;sup&gt;8&lt;/sup&gt; +/- systematic biopsies if MRI clinically suspicious</td>
<td>sMDT&lt;sup&gt;10&lt;/sup&gt;; Outpatient Clinic; Discuss treatment options and Personalised Care and Support Plan with MDT input; assess fitness +/- pre-op assessment; Patient optimisation and support&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Patient information

- Provided in primary care<sup>1</sup>
- Provided in consultation or OPA / clinic<sup>4</sup>
- Cancer likely / diagnosed
- Communication with patient and discussion with CNS: Record FDS when patient is informed that they have cancer<sup>6</sup>
- OR
- No suspicious lesions reported<sup>7</sup> or negative biopsy<sup>9</sup>
- Cancer ruled out and communication with patient
- Patient informed; referred to other secondary care service if possible. Record FDS when patient informed that cancer has been excluded<sup>6</sup>

Produced in partnership by NHS England’s GIRFT and Cancer programmes
## Actions for Cancer Alliances

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

1. **Complete any outstanding work on the cancer recovery objectives**
2. **Ensure there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, including increasing diagnostic activity to a minimum of 120% of pre-pandemic levels**
3. **Improve performance against all cancer standards**
4. **Make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower**
5. **Ensure at least 65% of urgent cancer referrals for suspected prostate meet timed pathway milestones**
6. **Increase the recruitment and retention of clinical nurse specialists (CNSs), cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce**
Skin cancer diagnostic pathway

An overview of the Skin Cancer Best Practice Timed Diagnosis Pathway

The full Best Practice Timed Diagnosis Pathway guidance can be read at “Faster diagnostic pathways Implementing a timed skin cancer diagnostic pathway guidance for local health and care systems” available via the link below.

In particular, footnotes for the figure here are provided on pages 20-24.

Produced in partnership by NHS England's GIRFT, Cancer and Outpatient Recovery and Transformation programmes
Key opportunities to streamline skin lesion pathways and achieve faster diagnosis

Meeting the Skin Cancer 28 day Faster Diagnostic Standard (FDS)

- Over 80% of people referred for suspected skin cancer received a confirmed communication of diagnosis within 28 days of referral, all systems should be enabled to meet this target to reduce anxiety for people referred with suspected skin cancer.
- Removing the emphasis on meeting the 2 week wait target allows more flexibility to concentrate on developing treatment pathways.
- The FDS provides the opportunity to review and streamline pathways using new and innovative approaches to optimise referrals and ensure timely diagnosis and management, examples are as follows:
  - Rapid turnaround skin lesion diagnostic services using images sent using specialist advice (advice and guidance) for lesions where there is diagnostic uncertainty.
  - Implement the two-week wait (2WW) virtual/teledermatology pathway. This requires macroscopic and dermoscopic images which can replace some face-to-face interactions.
  - Develop referral pathways for BCC; particularly high-risk lesions where delays in treatment can increase morbidity.

Skin cancer diagnostic pathway

Skin Cancer and the Faster Diagnosis Standard

Skin cancer types covered by the faster diagnosis standard

In-scope:
- Melanoma
- Invasive squamous cell carcinoma
- Rare skin cancers:
  - Cutaneous adnexal/appendageal carcinomas
  - Merkel cell carcinoma
  - Extramammary Paget's disease (EMPD)
- Angiosarcoma
- Pleomorphic dermal sarcoma
- Dermatofibrosarcoma protuberans (DFSP)
- Cutaneous metastasis of solid tumours

Out of scope:
- Basal cell carcinoma
- Soft tissue sarcoma
- Lymphoma

Basal Cell Carcinoma (BCC)

- The most common skin cancer, basal cell carcinoma (BCC) is usually locally malignant and treatment of people with BCC sits outside the cancer waiting times guidance even though NICE guidelines suggest urgent referral for some of these patients.
- The large numbers will impact on the ability to implement the best practice diagnostic pathway so this is an essential consideration when redesigning skin cancer pathways.

Skin Cancer and the Faster Diagnosis Standard

NHSE has already provided actions for cancer alliances in the timed skin cancer diagnostic pathway. The remainder of this guide highlights key opportunities covered by those actions:

- Locally agreed referral threshold policies/low priority frameworks
- Teledermatology/teletriage skin lesion pathways
- Community based ‘Spot clinics’
- Skin cancer Superclinics or Rapid clinics

Skin cancer types covered by the faster diagnosis standard

In-scope:
- Melanoma
- Invasive squamous cell carcinoma
- Rare skin cancers:
  - Cutaneous adnexal/appendageal carcinomas
  - Merkel cell carcinoma
  - Extramammary Paget's disease (EMPD)
- Angiosarcoma
- Pleomorphic dermal sarcoma
- Dermatofibrosarcoma protuberans (DFSP)
- Cutaneous metastasis of solid tumours

Out of scope:
- Basal cell carcinoma
- Soft tissue sarcoma
- Lymphoma

Basal Cell Carcinoma (BCC)

- The most common skin cancer, basal cell carcinoma (BCC) is usually locally malignant and treatment of people with BCC sits outside the cancer waiting times guidance even though NICE guidelines suggest urgent referral for some of these patients.
- The large numbers will impact on the ability to implement the best practice diagnostic pathway so this is an essential consideration when redesigning skin cancer pathways.
## Skin cancer diagnostic pathway

### Develop and implement locally agreed referral threshold policies/low priority frameworks

#### What are these and why are they important?
- These policies identify and state the type of skin lesions which can be managed in primary care or are of a more cosmetic nature.
- They give clear guidance to primary care health professionals about situations when people should or should not be referred for specialist opinion.
- They guide specialists who should receive hospital treatment.
- This allows services to prioritise appropriately and ensure that people are only referred and treated when there is a medical need.

#### Developing these policies/frameworks

##### Engagement
- All stakeholders (patient groups, primary care, secondary care) must be involved in setting threshold policies/low priority frameworks to maximise buy-in and empower services to focus on those who will benefit most from specialist care.
- Communication of these policies/frameworks is essential to manage patient expectations particularly with regards to asymptomatic benign lesions and cosmetic lesion removal.

##### Flexibility
- There should be a process for practitioners to make exceptions to the frameworks/policies and this needs to be agreed locally.
- Threshold policies exceptions should be explained and audited to ensure that this is not abused and if regular audit shows that examples of exceptions are acceptable then this such exceptions can be agreed independently without approval, otherwise 'prior approval' processes need to be agreed.

##### Complaints
- ICBs and hospitals must support staff who are subject to patient complaints when correctly upholding threshold policies.
- Explain to those who are not offered treatment that these policies allow them and their relatives to be treated promptly in the future if they have cancer or other serious problems.

[See here for relevant NICE Guidance](#)

**GIRFT Dermatology National Report on benign conditions management**

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Produced in partnership by NHS England's GIRFT, Cancer and Outpatient Recovery and Transformation programmes
Consider developing teledermatology/teletriage pathways for both before and after urgent referral

Summary

- Teletriage for suspected skin cancer has been shown in some NHS departments to be highly effective but others have had less success; sometimes it can increase referrals.
- A good teledermatology referral requires relevant clinical history and high-quality images.
- In addition to normal photographs, dermoscopic images are recommended for skin lesions referred using Specialist Advice and Guidance (A&G) and they are essential for the virtual 2 week wait pathway.

Developing a teledermatology service: things to consider

- You will need someone to take and send the images, a system to send them and someone to review them.
- Macroscopic and dermoscopic images are needed for the virtual two week wait pathway; patient-taken images may be suitable for specialist advice and guidance.
- The NHS ERS system is available for everyone to use; solutions from private providers can work well but may be expensive.

How to measure efficiency of teletriage

- Clinical time must be allocated for teletriage. The time saved by not seeing patients face-to-face or booking direct to surgery, should outweigh the reduction in face-to-face clinic time needed to perform teletriage.
- The time to triage a patient divided by the time to see a patient face to face must be smaller than the proportion of patients discharged or directed straight to surgery.

Use of Artificial Intelligence (AI) to support teledermatology

- AI has potential to improve teledermatology and is expected to be of future benefit by excluding benign lesions.
- Pilot studies to date suggest that the tools currently being used may be helpful and the results of an external independent meta-evaluation are expected in 2023.
- Trusts already using AI should gather high quality data on cost benefit and report this learning in peer reviewed journals so that the methodology can be validated and benefit other NHS users.

Teledermatology and skin lesion referral pathways: two pathways

- Virtual two week wait: teledermatology pathway replaces face-to-face interaction requires dermoscopic images.
- Back to GP with advice.

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Further guidance on innovations in the pathway inc. teletriage

- OPRT Dermatology FutureNHS pages for case studies and discussion
- Teledermatology/teletriage pathways for both before and after urgent referral

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Skin cancer diagnostic pathway

Consider developing community based ‘Spot clinics’ to undertake triage prior to urgent referral or community based urgent referral skin cancer clinics

‘Spot clinics’ - principle

Piloted as part of the Elective care Collaborative 100 day project in Lincolnshire:

- Face-to-face skin lesion triage service (pre-2 week wait) in community setting
- Experienced specialist dermatologist (usually consultant) reviews patient in a community setting
- Rapid triage of large numbers of patients
- Range of outcomes including direct booking for surgery
- Reduces the need to attend hospital.

The model has proved successful, and clinics have continued and expanded to other sites since the initial pilot. This type of clinic can also be used to provide community based single lesion suspected skin cancer clinics.

‘Spot clinics’ - process

- 24 patients with a single suspicious skin lesion seen in a two-hour clinic in a community setting
- Three clinic rooms staffed by a practice nurse and two health care assistants
- Staff complete a skin lesion questionnaire with patient and prepare them for examination
- Dermatologist performs a clinical and dermoscopic examination of the relevant lesion
- Proforma with a diagnosis and treatment plan completed for the patient and sent to the GP.

‘Spot’ clinics for pre-2 week wait triage: potential pathway and outcomes*

<table>
<thead>
<tr>
<th>Patient presents in primary care with skin lesion</th>
<th>Obvious melanoma (MM) or squamous cell carcinoma (SCC)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer on 2 week wait pathway</td>
<td></td>
</tr>
<tr>
<td>Suspicious lesion, not obvious MM or SCC, meets Spot clinic criteria, seen in Spot clinic</td>
<td>Requires referral to specialist dermatology service</td>
</tr>
</tbody>
</table>

*The ‘Spot’ clinic model can also be used to provide single lesion community based urgent referral clinics
Skin cancer diagnostic pathway

Consider developing hospital based (a) Skin cancer Super-clinics or (b) Rapid 2 week wait clinics

(a) Skin cancer Super-clinics

Super-clinics offer one stop diagnosis, biopsy or curative surgery. They can reduce follow ups and ensure all patients get consultant opinions. They include same day biopsies and some excision surgery to shorten pathways. Whilst usually dermatology led, they can include plastics, maxillo-facial surgeons and other surgeons according to local skill mix. The lead consultant does not usually have their own list so they can see all patients seen by others who are being supervised.

Derby Super-clinic

- 30 patients in 2 hours. 3 patients every 12 minutes.
- One consultant. 3 junior doctors or specialist nurses, 3 HCA navigators and one clinic nurse to orchestrate.
- Patients pre-fill a proforma before clinic assisted by health care assistants.
- One junior doctor in theatre operating alongside doing some same day surgery.
- Only index lesion assessed unless clearly more - then patient undressed.
- 92% FDS achievement in 2023.

Staffing tips

- Include appropriately trained and banded nurses, Physician Associates, and junior doctors supervised by a consultant to diagnose and operate on suitable patients.

Facilities tips

- Sufficient clinic space for all staff in one area, close enough for consultant to supervise all.
- Should include staffed procedure rooms sufficient to deal with all biopsies and most excisions (consider pre-book surgical slots to avoid wasted capacity for first slots of day).
- Demand will fluctuate so is not feasible to have adequate capacity for 100% of cases.

(b) Rapid 2 week wait clinics: a ‘Spot clinic’ but in a specialist setting

- An experienced dermatologist sees 24 patients in a 4-hour session supported by one-stop surgery services.
- Two clinic rooms are staffed by two health care assistants, the staff complete a skin lesion questionnaire with the patient and prepare the patient for examination.
- The dermatologist performs a clinical and dermoscopic examination of the relevant lesion and arranges appropriate surgery; documentation in electronic proformas.

See here for further Guidance on innovations in the skin cancer pathway