

Breast cancer best practice Faster Diagnosis Standard implementation handbook

Developed with SWAG and Kent and Medway Cancer Alliances

April 2026



**Somerset, Wiltshire,
Avon and Gloucestershire**
Cancer Alliance



**Kent and Medway
Cancer Alliance**

Foreword and contents: breast cancer best practice FDS implementation handbook

Foreword

The Getting It Right First Time (GIRFT) programme has produced this handbook to help cancer alliances and organisations delivering breast cancer care to effectively implement the best practice timed pathways, drawing on effective approaches used across all alliances. [Best practice timed pathways](#) underpin ongoing efforts to shorten diagnosis times, reduce unwarranted variation, improve patient experience of care and meet the [Faster Diagnosis Standard \(FDS\)](#).

This handbook summarises the national context for breast cancer care and outlines the potential for improvement in delivery of the FDS, if we all adopt best practice. It includes practical checklists to help trusts and cancer alliances improve on their baseline performance, supported by examples of good practice nationally highlighted and shared by Somerset, Wiltshire, Avon and Gloucestershire (SWAG), Kent and Medway Cancer Alliance and GIRFT's national breast surgery clinical lead, Tracey Irvine, to enable improved performance. Performance against the FDS for breast cancer pathways improved year on year up to 2024/25, but has declined in 2025/26, with performance now below the level achieved four years ago. Urgent action is required to reverse this deterioration.

This handbook aims to support clinicians and operational managers to improve outcomes and experiences for people referred into the breast cancer diagnostic pathway, through standardising clinical pathways and optimising the use of diagnostic capacity and resources. We want alliances and trusts to adopt these best practice examples to improve care and reduce FDS waiting times.

Professor Tim Briggs, GIRFT programme lead and National Director for Clinical Improvement, Elective Recovery and UEC for NHS England

Contents

- [Overview: Working with Cancer Alliances](#)
- [National context](#)
- [Improvement opportunity](#)
- [The 28-day best practice timed pathway](#)
- [How to implement the best practice timed pathway:](#)
 - ✓ [Demand & capacity planning](#)
 - ✓ [Cancer pathway tracking](#)
 - ✓ [Triage](#)
 - ✓ [Pathways for low-risk patients](#)
 - ✓ [One-stop clinics](#)
 - ✓ [Enhancing patient flow and stopping the clock](#)
 - ✓ [Workforce optimisation](#)
- [Case studies](#)

NHS England Best practice timed pathways



Cancer Alliances Futures workspace



Working with cancer alliances

Overview

In the autumn of 2025, the Somerset, Wiltshire, Avon and Gloucestershire (SWAG), Cheshire and Merseyside and Kent and Medway cancer alliances collaborated with GIRFT and the national cancer team to respond to the 100-day challenge, initially developed by SWAG. This challenge set out to identify and collate best practice in the management of lower GI, bladder and prostate, gynaecology, skin and breast cancers which could be adopted across all cancer alliances.

Conversations were held with several trusts, cancer alliances and colleagues working on these pathways nationally, focusing on the start of the pathway to get patients to the point where they either receive a cancer diagnosis or have cancer ruled out within 28-days of referral. Furthermore, the GIRFT breast surgery clinical lead undertook a series of gateway reviews in 2025 which identified best practice around the country. Following completion of these reviews, GIRFT and the national cancer team hosted a [webinar focused on achieving best practice in breast cancer waiting times](#).

The result of this is a checklist of best practice elements, based on a culmination of findings across various cancer networks and acute trusts. The checklist is supported by case studies, detailing the individual approaches taken by trusts and cancer alliances.

We extend our thanks to the SWAG, Cheshire and Merseyside and Kent and Medway cancer alliances for their efforts in undertaking this work, and to the respective trusts and cancer alliances in engaging with the programme.

Case studies

We would like to acknowledge the contribution of case studies and resources from the following organisations:

- Airedale General Hospital NHS Foundation Trust
- Bolton NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- East Midlands Cancer Alliance
- Greater Manchester Cancer Alliance
- James Paget University Hospitals NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Manchester University NHS Foundation Trust
- Mersey & West Lancashire Hospitals NHS Trust
- Northern Care Alliance
- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Royal Surrey NHS Foundation Trust
- Somerset NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Warrington & Halton Teaching Hospitals NHS Foundation Trust
- West Midlands Cancer Alliance
- York & Scarborough Teaching Hospitals

The national context for breast cancer pathways – referral rates

Referral rates for suspected breast cancer

Nationally, referral volumes into breast services have remained broadly stable at approximately 2,500 referrals per day.

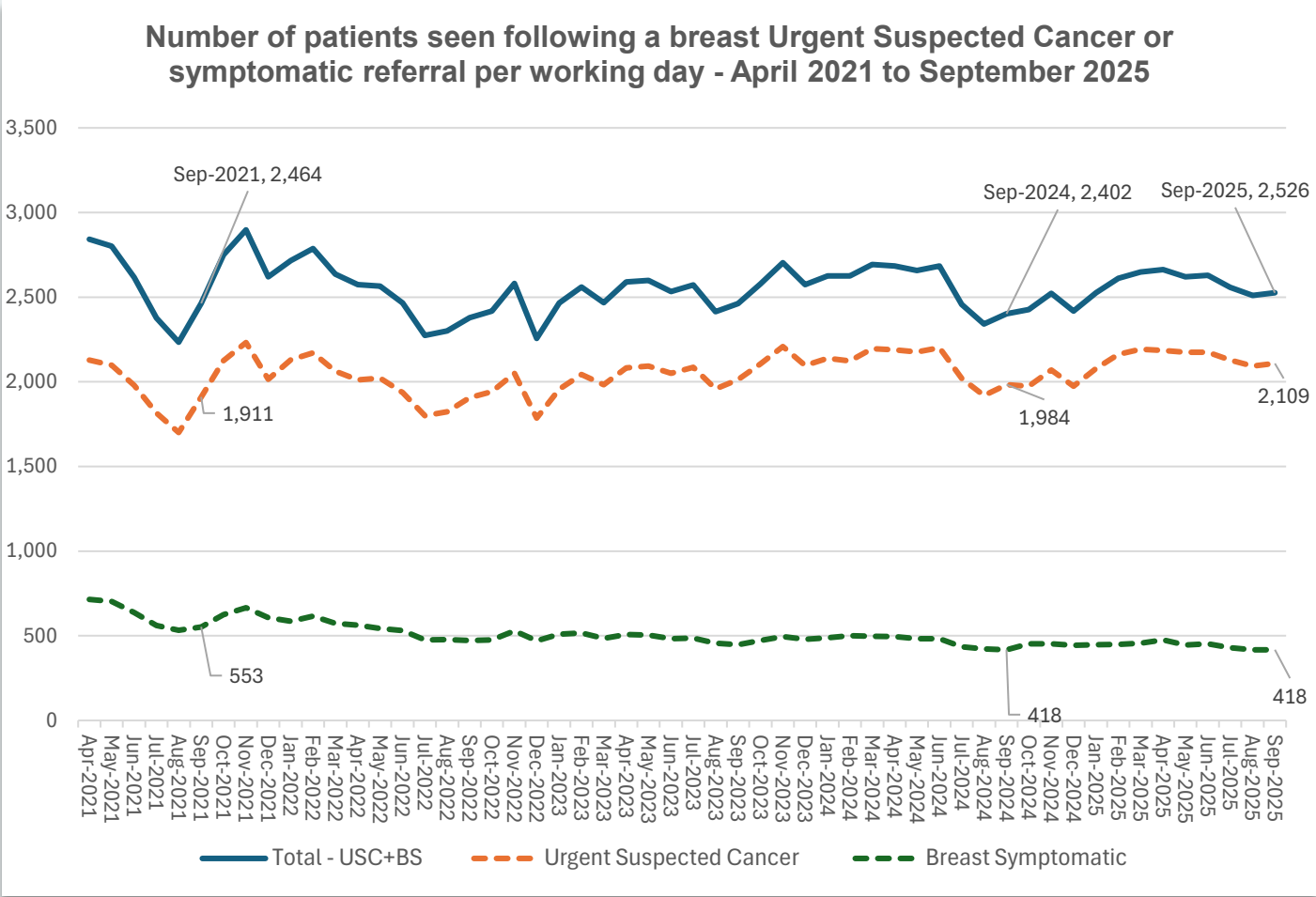
While overall volumes have remained static, there has been a significant shift in the type of referrals being made. Urgent Suspected Cancer (USC) referrals have increased by 11%, while breast symptomatic referrals have decreased by 28%.

As a result, although the total number of referrals has remained largely unchanged, the case mix has shifted significantly. The proportion of USC referrals has risen from approximately 76% in 2021 to 83% in 2025.

Cancer conversion rates are low across both pathways:

- 5.3% for USC referrals
- 1.2% for breast symptomatic referrals

New breast cancer diagnoses have also remained stable, with a small shift towards diagnosis via USC routes when comparing 2024 with 2019.



Data source: National cancer waiting times dataset

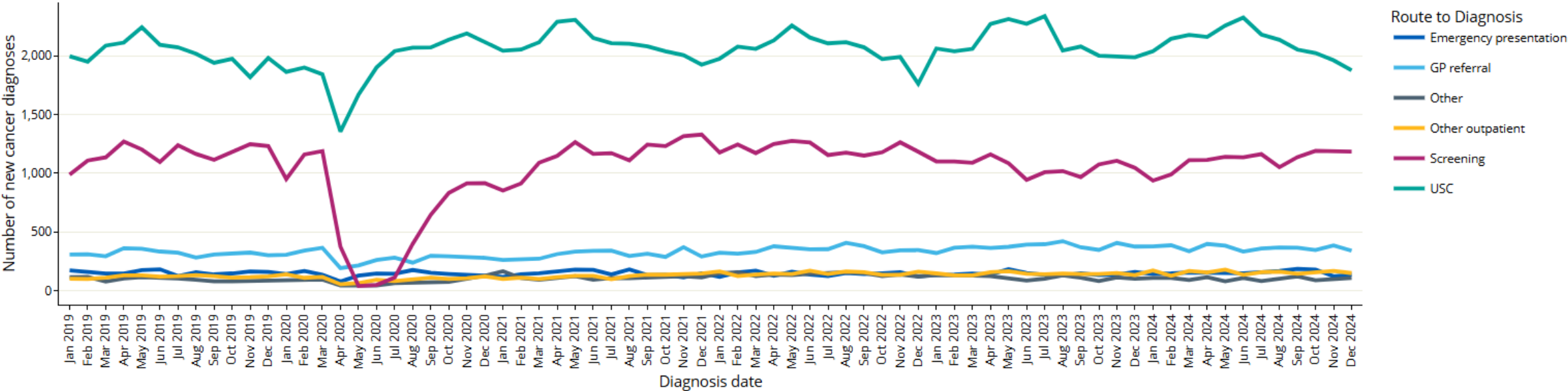


The national context for breast cancer pathways – diagnosis route

Breast cancer diagnosis

New breast cancer diagnoses are broadly in line with pre-pandemic levels, with a small shift towards diagnosis via USC routes when comparing 2024 with 2019. Diagnoses made following USC referral (including breast symptomatic) increased from 24,264 in 2019 to 25,312 in 2024, a rise of 4.3%. In contrast, diagnoses arising from screening fell slightly over the same period, from 13,974 to 13,337 (-4.6%). Emergency presentations also reduced marginally, from 1,896 to 1,855 (-2.2%).

New cancer diagnoses, England, January 2019 to December 2024
Cancer group: Breast



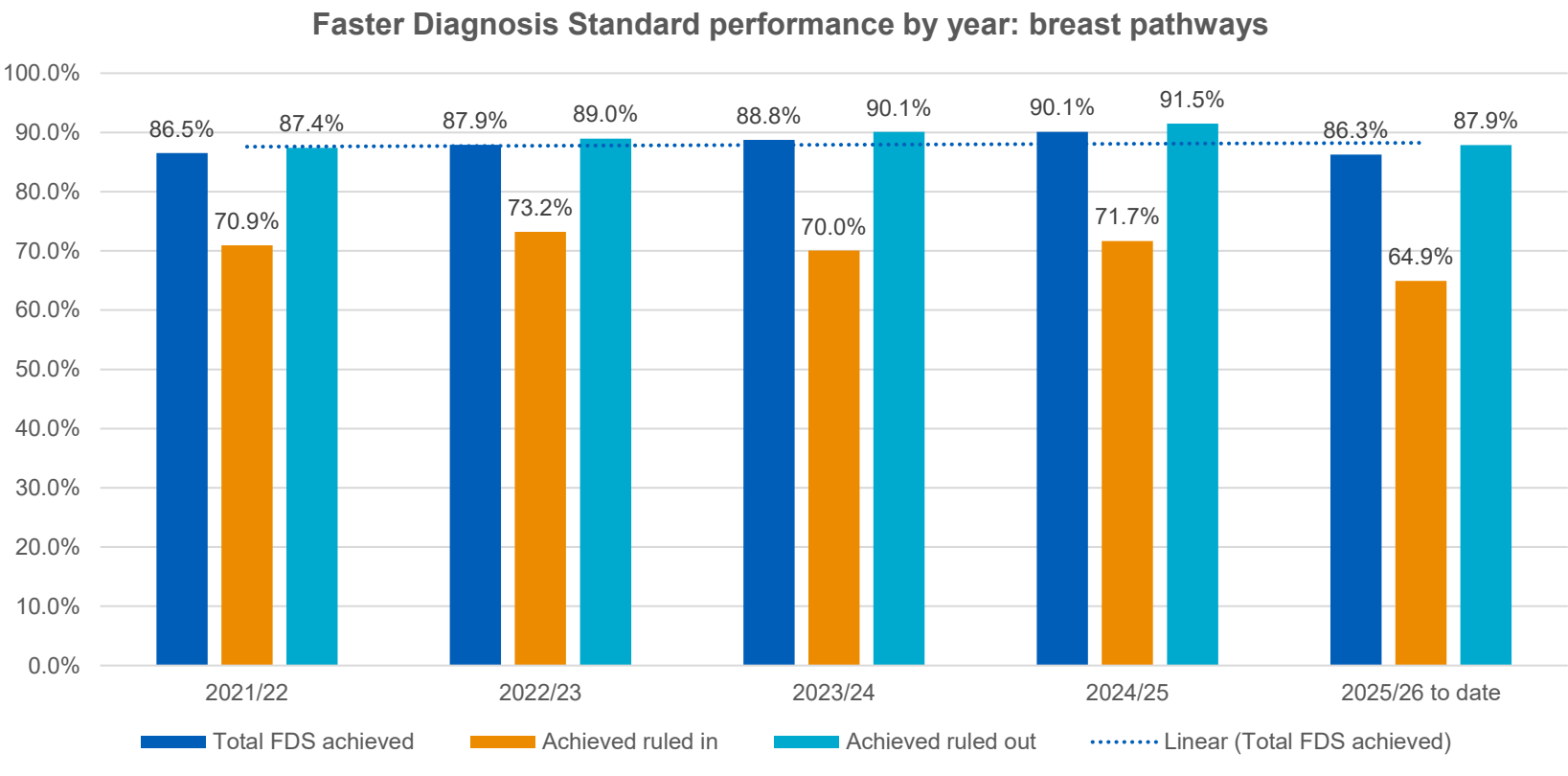
Source: National Disease Registration Service, NHS England (CAS2510).

The national context for breast cancer pathways – FDS performance in England

Breast cancer pathways - Faster Diagnosis Standard (FDS) performance

Performance against the FDS for breast cancer pathways showed steady year-on-year improvement up to 2024/25. However, this progress has not been sustained. In 2025/26, performance has declined and is now below the levels recorded in previous years.

There is also notable variation in FDS performance between different patient groups. **Among patients who have cancer ruled out, 88% meet the standard. In contrast, only 65% of patients who are diagnosed with cancer meet the standard.** This variation, combined with the overall decline in performance, disproportionately affects people who go on to receive a cancer diagnosis.



Data source: National cancer waiting times dataset



Regional context for breast cancer pathways

28-day FDS by region – suspected breast cancer

Regional FDS performance for the latest reported month of January 2026 ranged from 88.5% to 63.1%, showing significant variation between regions.

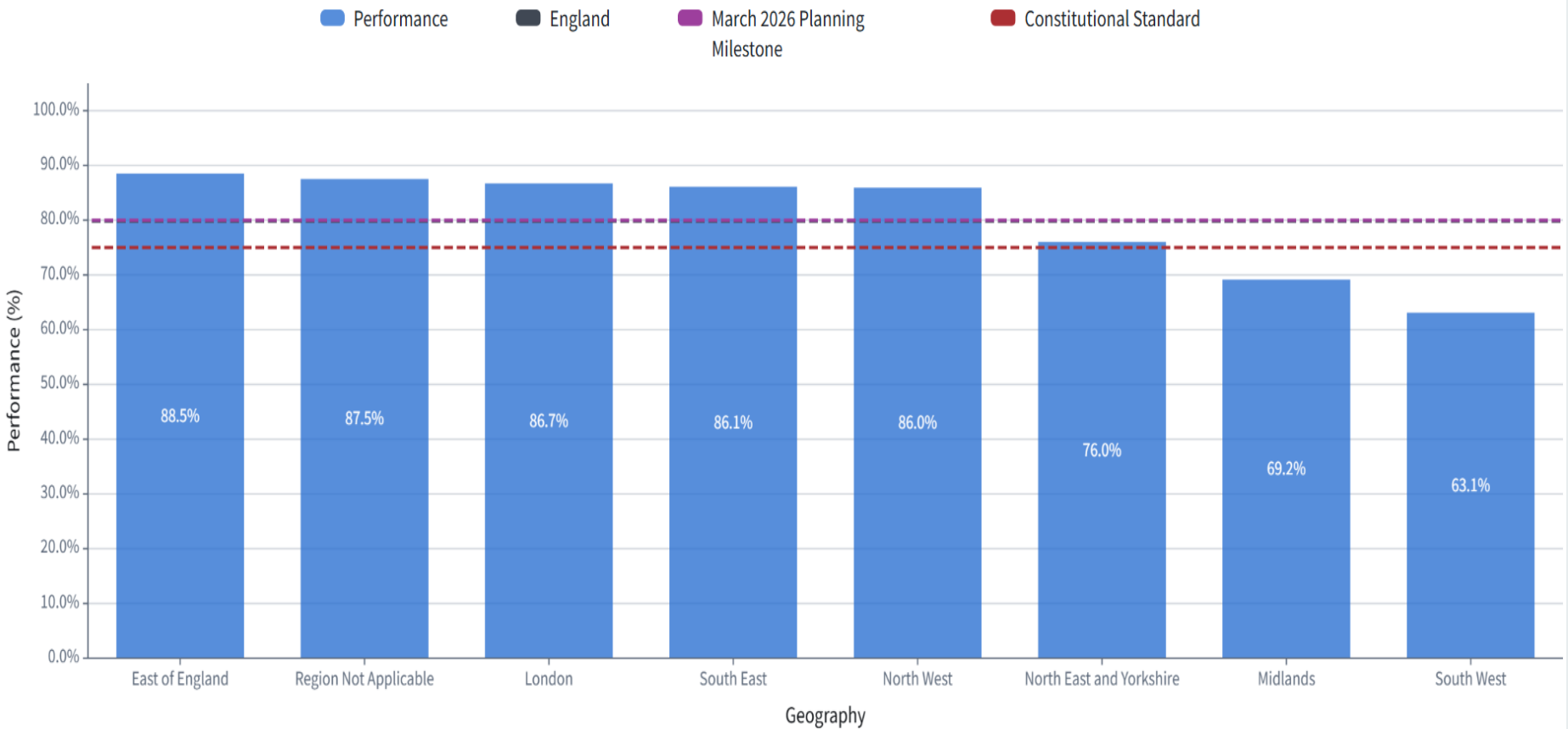
Please note there are eight regions reported because Commissioning Hubs and Health and Justice Hubs are allocated to a national ‘region not applicable’ category.



Cancer performance insights dashboard



28-day FDS performance by geography

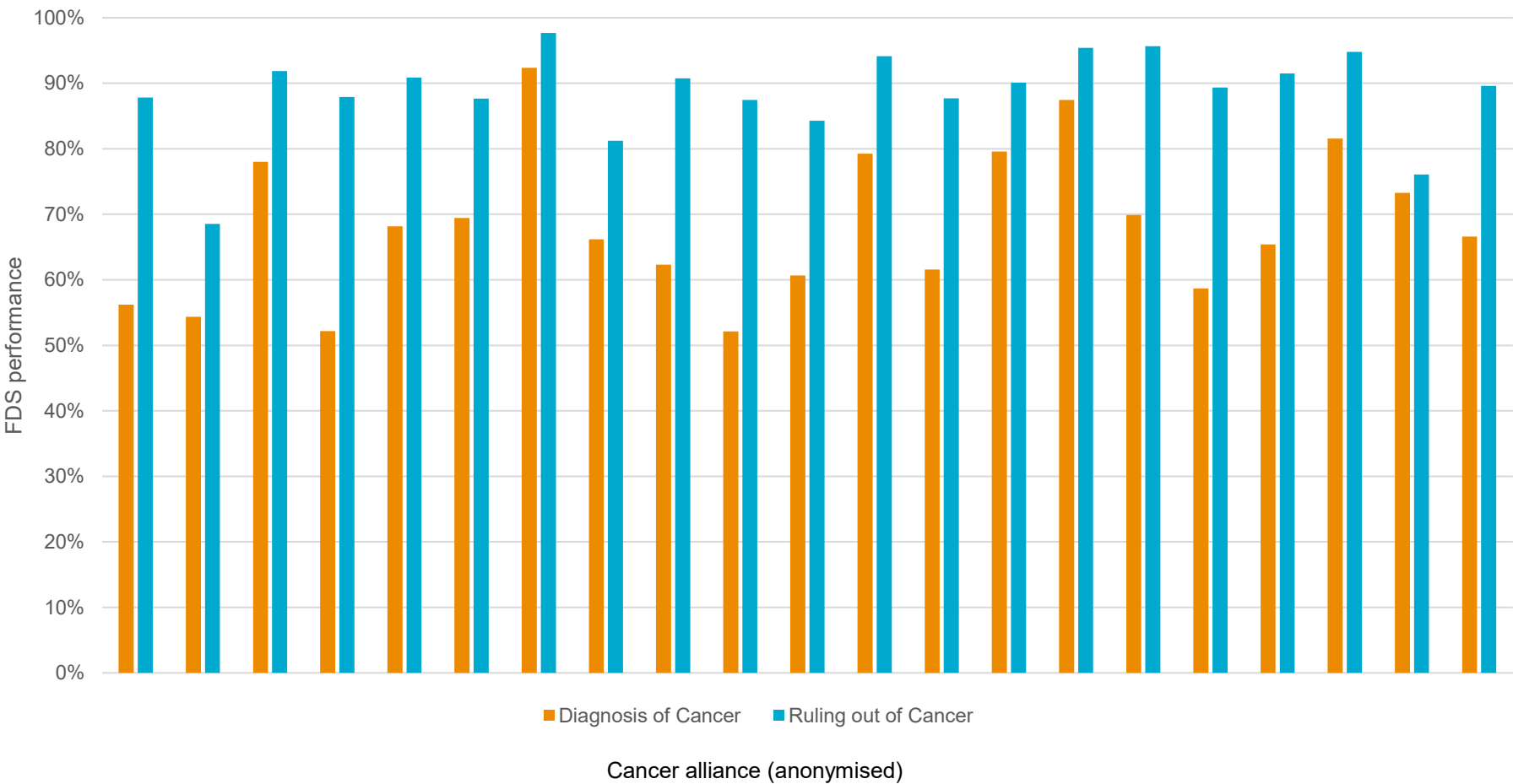


The national context for breast cancer pathways – FDS performance by cancer alliance

Variation in (FDS) performance in England by cancer alliance

FDS performance shows consistently high results for patients who have cancer ruled out. In contrast, performance for patients diagnosed with cancer is lower and more variable. This pattern suggests targeted improvement is needed on the cancer diagnosed pathway to reduce delays and narrow unwarranted variation between alliances. It should be noted that reviewing performance by cancer alliance can hide the variation between providers, which is demonstrated on the next page.

FDS performance by end reason broken down by cancer alliance (anonymised) of FDS provider (ranking is by combined performance of cancer ruled in & ruled out) - September 2025 – November 2025



The national context for breast cancer pathways – patients diagnosed with breast cancer

Variation in breast cancer Faster Diagnosis Standard (FDS) performance in England

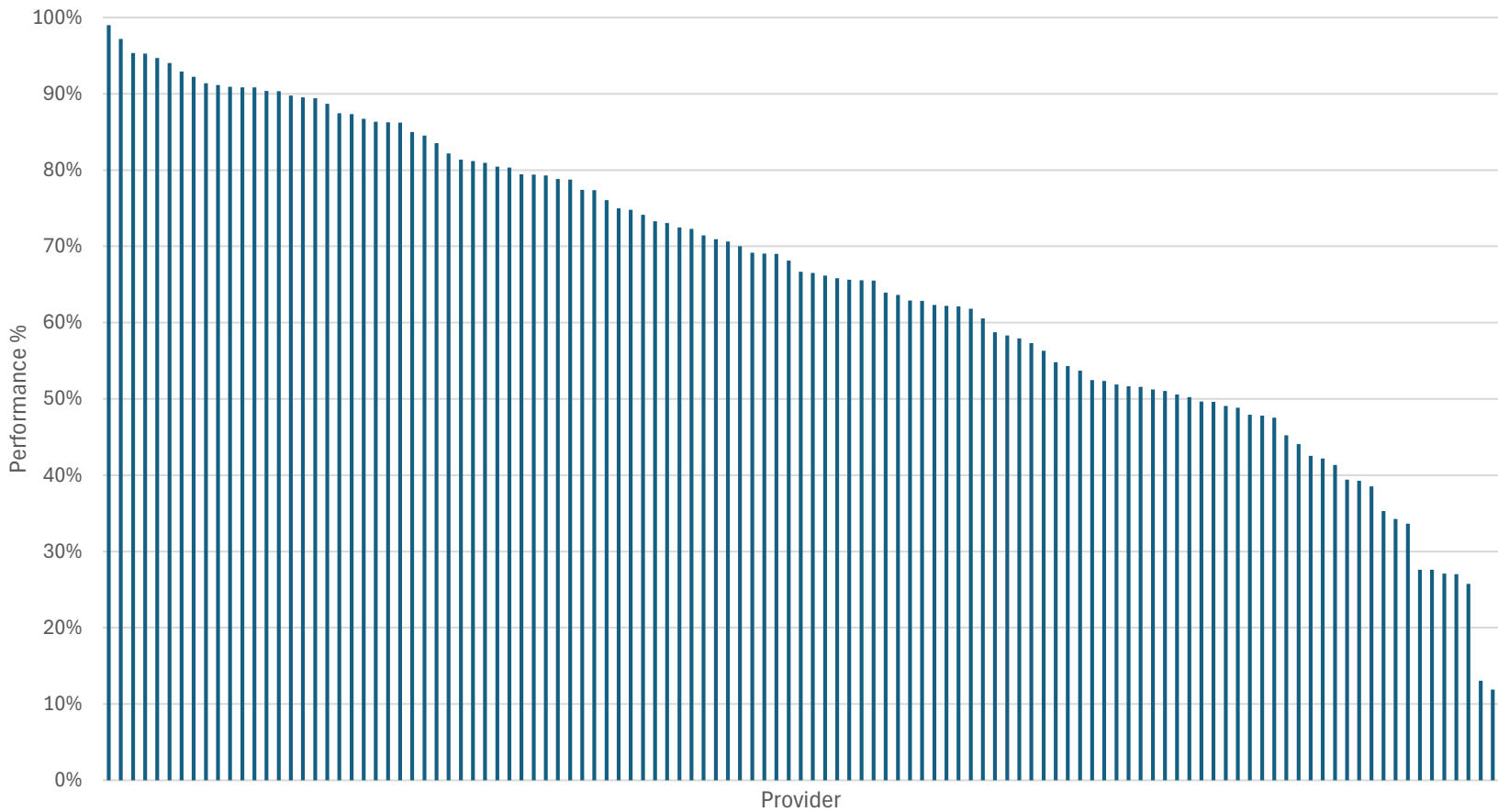
There is significant variation in FDS performance across providers **for those diagnosed with cancer** on breast pathways. Providers in the top quartile achieved performance over 82% (including 15 providers exceeding 90%). In contrast, those in the bottom quartile reported performance below 51%.

Reducing this variation is essential to ensuring that all patients receive timely diagnosis and treatment, thereby maximising the likelihood of achieving the best possible clinical outcomes.

Data source: National cancer waiting times dataset



Faster Diagnosis Standard performance for those with cancer by provider
- April to September 2025



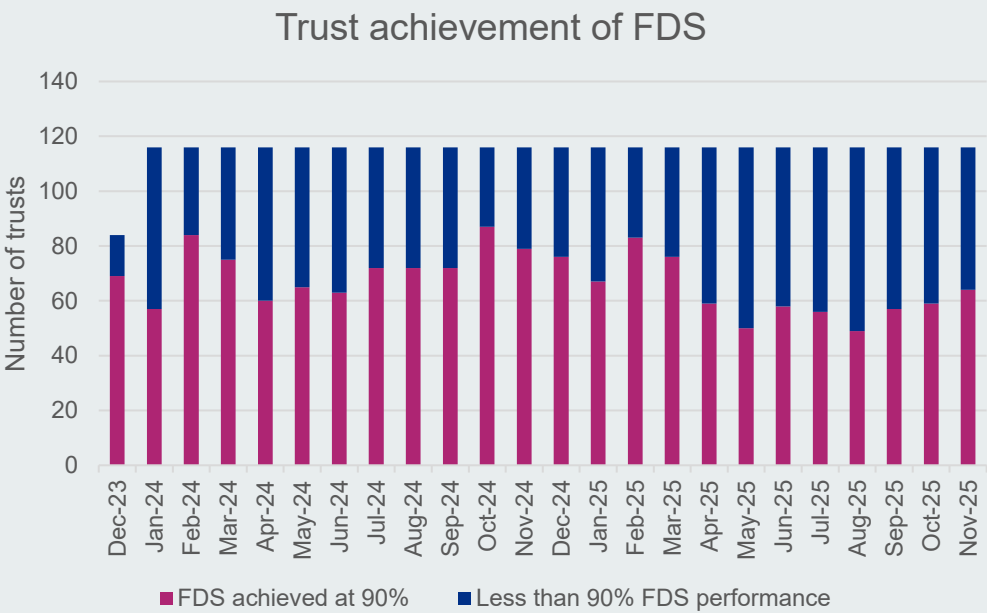
Improvement opportunity

Breast cancer services currently meet the national FDS of 75% (rising to 80% from March 2026) across all tumour sites, but performance varies significantly between providers. However, there is an expectation that breast achieves 90% FDS. The data shows that many providers still have substantial room for improvement. Although some trusts have achieved the 90% aim for the standard over the last two years, there remain realistic opportunities to both improve and sustain FDS performance.

A key opportunity lies in providing more patients with a faster ruled-in diagnosis, reducing delays and anxiety for those who ultimately have cancer. Improving this part of the pathway helps move patients more quickly towards treatment. If services **achieved 90% performance overall nationally**, it would mean:

- **15,758 additional patients per year** receiving a diagnosis or having cancer ruled out within 28 days.
- Of these, **10,779 would be patients receiving a cancer diagnosis (ruled in).**

These numbers are based on annual breast surgery activity of 695,302 referrals and performance from Dec 2024 – Nov 2025.



64 out of 116 trusts achieved 90% FDS performance (cancer diagnosed & ruled out) in November 2025

Overall FDS performance (cancer diagnosed & ruled out) by provider ranges from 15% to 99% achievement

The top 20 performing trusts in the country are achieving over 89% FDS performance for patients diagnosed with cancer

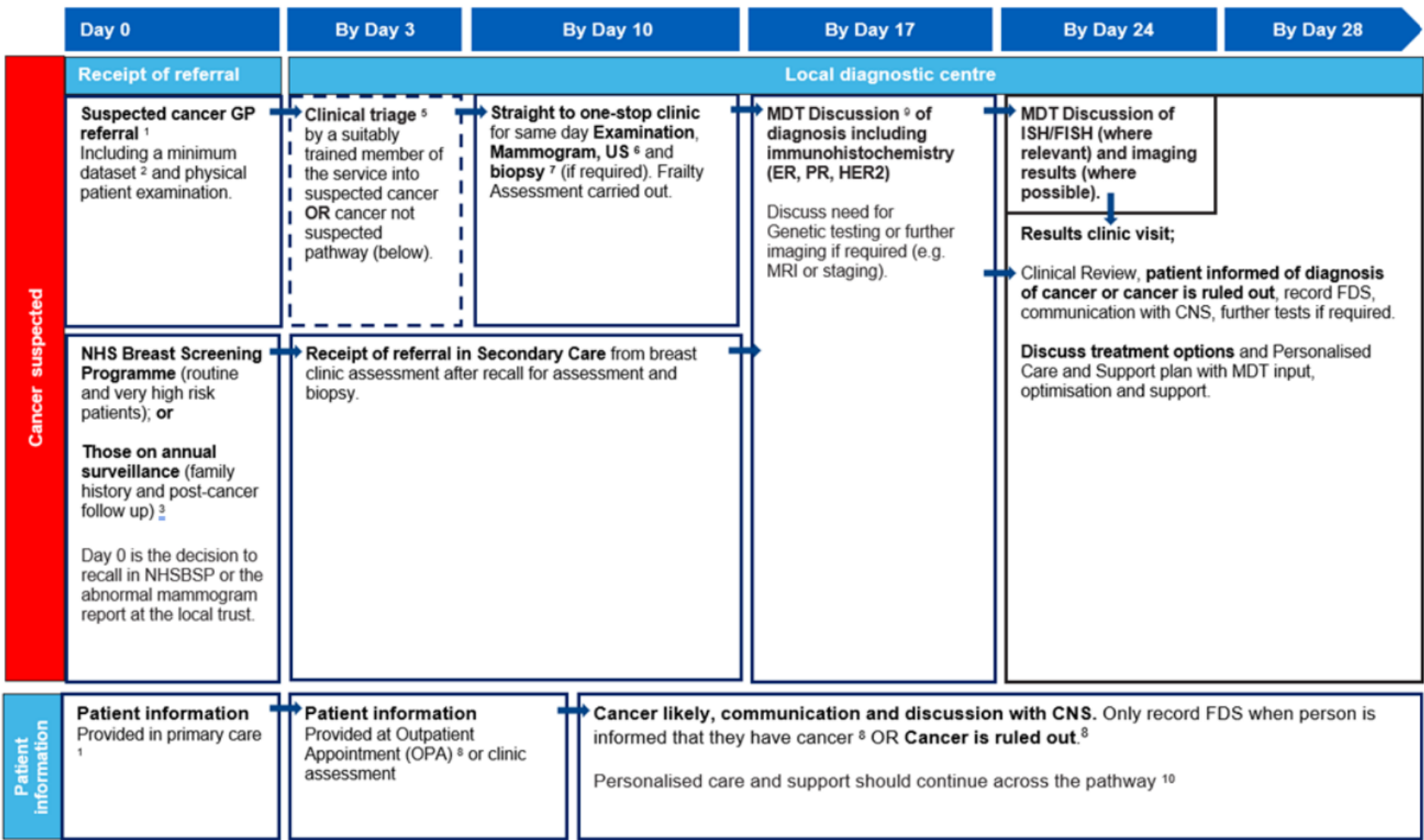
Three trusts sustained 95%+ overall FDS performance for the period Dec 2024 – Nov 2025



The best practice timed pathway (BPTP) – breast cancer

28-day BPTP

The 28-day breast cancer pathway, published in March 2024, aims to reduce the time between referral and diagnosis of cancer. The timed pathway sets the expectation that a breast cancer diagnosis includes the tumour receptor status, including HER2. Communicating the cancer or non-cancer diagnosis to the patient stops the 28-day clock. It should be noted the numbers on the pathway link to the [Breast Cancer Best Practice Timed Pathway Guidance document](#) which should be read in conjunction with this handbook.

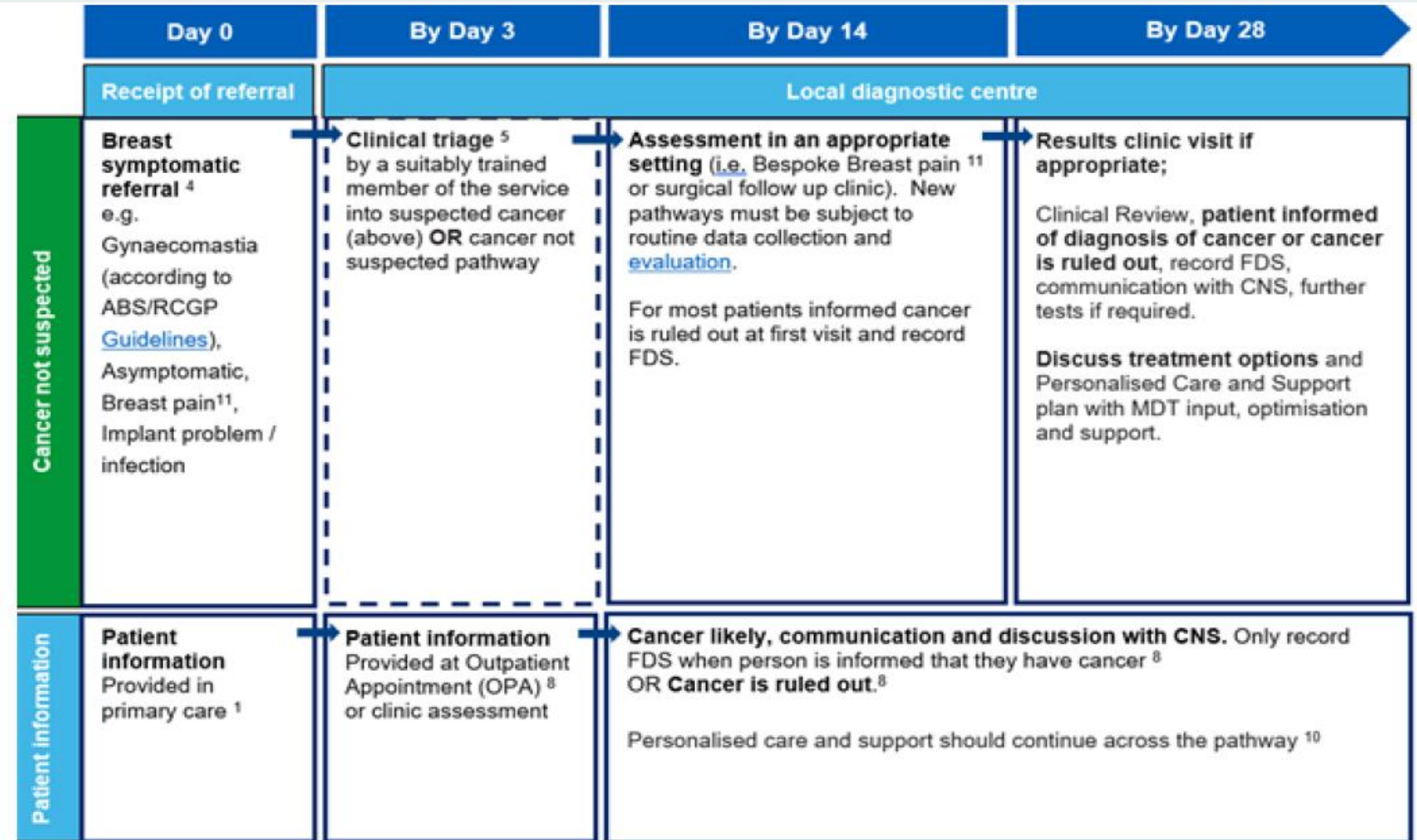


The best practice timed pathway (BPTP) – cancer not suspected

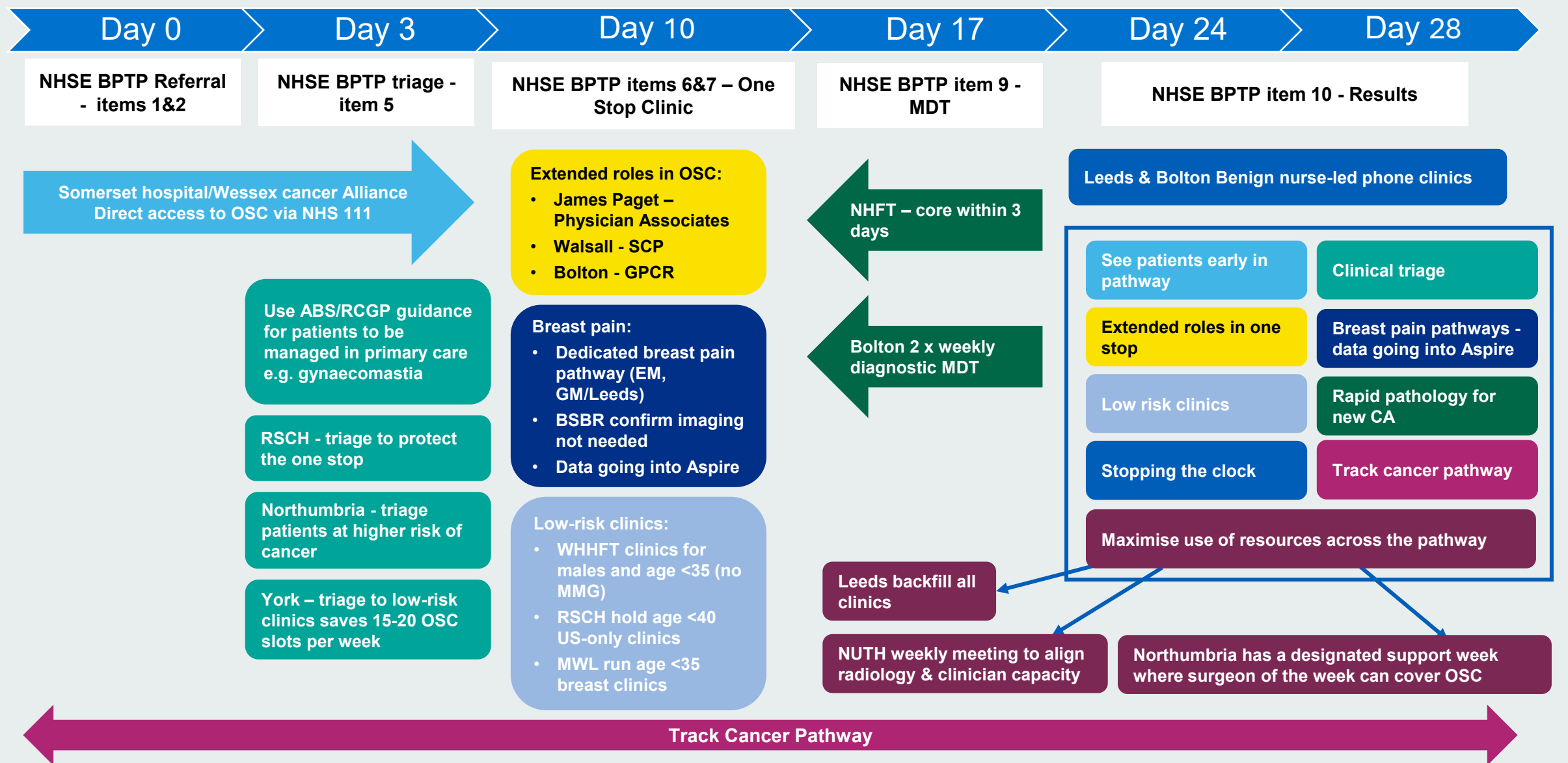
28-day BPTP – cancer not suspected

The purpose of the ‘cancer not suspected’ pathway is to reduce unnecessary and inappropriate imaging and to make most effective use of limited resources, while providing the appropriate management and support for those in whom breast cancer is not suspected within the same 28-day timeframe.

For those referred urgently with breast symptoms where cancer is not initially suspected, such as breast pain in the absence of any other symptoms or gynaecomastia, each unit, working with their cancer alliance, should review their current practice and ensure it aligns with the national guidance.



Breast cancer pathway – how the BPTP model can work in practice



How to implement the best practice timed pathway: demand and capacity planning

Demand and capacity (D&C) planning

High referral rates for breast cancer, combined with limited diagnostic capacity, make robust demand and capacity modelling essential for meeting the FDS. Services should use D&C models to identify bottlenecks and pinpoint where improvements are needed. Modelling helps ensure there is sufficient capacity for managing breast symptomatic and USC referrals within existing resources, avoiding the need for ad hoc or Waiting List Initiative (WLI) clinics. It also supports effective resource planning for services caring for women at high risk of breast cancer, ensuring those teams have the necessary resources to provide treatment. Additionally, demand and capacity modelling can help services to manage and reduce any backlogs that may have been caused by a mismatch between demand and available capacity.

Check	Action	Resources
✓	Collect data on service demand (e.g., the number of referrals) and available capacity (e.g., available clinic sessions, staff, and equipment).	- NHS England - Demand and capacity core model - NHS England - FDS Audit Tool - West Midlands Cancer Alliance – see a summary here and Rapid Review of Breast Services across the West Midlands - Northumbria Healthcare NHS Foundation Trust - Surgeon of the Week Standard Operating Procedure (SOP)
✓	Use modelling tools to calculate the necessary capacity required to meet the current and projected demand.	
✓	Model the flow of patients, to pinpoint areas of constraint and reduced capacity within the service.	
✓	Analyse the data to identify how and where you can make improvements and measure the impact of changes.	
✓	Audit against timed pathway milestones (Day 0, 3, 10, 14, 17, 24, 28).	
✓	Ensure that the service runs for 52 weeks per year, backfill clinics and theatre lists that are lost to annual and study leave e.g., by using colleagues’ flexible sessions or support week surgeon (see resources).	

How to implement the best practice timed pathway: cancer pathway tracking

Cancer pathway tracking

Effective pathway tracking is essential in breast surgery, where high referral volumes and limited imaging capacity create potential for delays. A clear, real-time Patient Tracking List (PTL) helps teams identify patients at risk of breaching and ensures urgent cases move quickly through one-stop clinics, imaging, pathology and MDT review. Regular tracking and capacity meetings allow services to match radiology and clinic availability, backfill cancelled sessions and maintain flow through core diagnostic steps. Strong co-ordination between breast surgeons, radiologists, Clinical Nurse Specialist (CNS) teams and operational leads ensures timely decisions, rapid result reporting and consistent delivery of the 28-day standard. [The National Cancer Plan for England: delivering world class cancer care](#) supports the use of tools such as Cancer 360 to support services to understand and mitigate bottlenecks and delays in pathways. Cancer 360 consolidates near-live data from multiple source systems into a single, automated Cancer PTL. Staff can instantly see whether appointments have happened or been cancelled, scans are booked, reports are back and milestones are complete - without manually checking multiple systems.

Check	Action	Resources
✓	Use dashboards for real-time PTL monitoring and escalation where possible. This should include automated flags for patients at risk of breaching the 28 or 62-day standards.	- Chelsea and Westminster NHS Trust - Cancer 360 Platform - Gov.UK Press release Government's tech reform to transform cancer diagnosis
✓	Undertake weekly capacity planning meetings to respond to capacity fluctuations as they happen. This should include ensuring clinicians are available to utilise all radiology OSC capacity.	
✓	Undertake weekly cancer tracking meetings to streamline patient pathways.	
✓	Ensure that co-ordinators, clinicians and operational managers attend cancer tracking meetings. For clinicians time for attending these meetings should be included in job-plans.	
✓	Contact england.fdp@nhs.net if you are interested in rollout of Cancer 360.	

How to implement the best practice timed pathway: triage

Triage

As a specialty breast surgery has very high referral rates for suspected cancer making it challenging to manage all patients referred with breast symptoms in a timely manner. One of the benefits of the FDS is optimised referral triage to ensure effective use of limited resources in the OSC and support delivery of the FDS. The lower conversion rate for referrals for breast symptoms shows that triage is effective. Triage can be undertaken by a suitably trained member of the service and should be supported by clear processes. Clinical triage keeps limited imaging and biopsy capacity focused on the highest risk patients and diverts low risk presentations to more appropriate pathways (breast pain, gynaecomastia, family history, incidentaloma). **Patients diverted to these pathways must still be managed via the FDS.**

Check	Action	Resources
✓	Consider piloting a self-referral model to give patients faster access to care.	- NHS England - Best practice solutions A&G - Northumbria Healthcare NHS Foundation Trust - Breast cancer non-clinical triage flow chart - Royal Surrey NHS Foundation Trust - Sample ERS triage response - ABS/RCGP - Gynaecomastia Guidance <i>*In accordance with the National cancer waiting times monitoring dataset guidance [2.3.5 NHS E-RS A&G for cancer pathways.] - "The A&G function should not be used in place of an Urgent Suspected Cancer referral. For example, where a patient clearly meets NG12 criteria for Urgent Suspected Cancer, A&G should not be used, a direct referral should be made at this stage."</i>
✓	Use Advice & Guidance* (A&G) and minimum dataset referral forms to reduce inappropriate USC referrals.	
✓	Implement consultant-led triage of referrals to prioritise high-risk patients. This should be undertaken regularly in response to demand e.g. triage undertaken daily with one hour per day included in job plans for this work.	
✓	Consider developing a process for non-clinical staff to carry out triage for selected cases. The process must be developed, approved and overseen by clinicians and be accompanied by clear guidance and criteria.	
✓	Local protocols are in place to support triage and reduce delays.	
✓	Consider setting up a dedicated breast team email for triage queries.	
✓	Stream low-risk cases into alternative pathways (e.g. breast pain, gynaecomastia and family history). See the resources section for guidance on managing patients in primary care.	

How to implement the best practice timed pathway: pathways for low-risk patients

Pathways for low-risk patients

Low-risk pathways are designed to ensure that patients with a low risk of cancer receive appropriate assessment and management without undergoing unnecessary or inappropriate imaging. These pathways help reduce avoidable demand on diagnostic services and support the most effective use of clinical resources. Breast pain alone is not a symptom of cancer and the risk of finding cancer in a patient with breast pain is lower than the screened population incidence. A range of models have already been successfully implemented to manage this patient cohort (see resources and case studies below). For example, many providers are implementing dedicated breast pain pathways and exploring approaches such as remote delivery and imaging-only pathways to manage these low-risk referrals. While local flexibility is important, any new or adapted model must be supported by robust evaluation to confirm that it is safe and clinically effective.

Check	Action	Resources
✓	Identify named clinical leaders and establish clear lines of accountability to ensure that pathways for low-risk patients are implemented safely.	- Northern Care Alliance - Information for GPs on Breast Pain - ABS ASPIRE breast pain pathway service evaluation - RCR/BSBR - Guidance on screening and symptomatic breast imaging Fifth edition - Royal Surrey Breast Unit - Gynaecomastia management - ABS/RCGP - Gynaecomastia infographic - York & Scarborough Teaching Hospitals - Low risk clinic criteria
✓	All trusts need to implement a dedicated breast pain pathway that includes allocated clinics (telephone or community-based) to divert benign cases by the end of 2026. ¹	
✓	Establish SOP-driven pathways for gynaecomastia and incidentaloma referrals.	
✓	Establish safety-netting processes for patients triaged to low-risk clinics to expedite imaging if needed.	
✓	Monitor outcomes following implementation of pathways for low-risk patients, including patient experience and impact on diagnostic capacity.	

¹ Department of Health & Social Care - [The National Cancer Plan for England: delivering world class cancer care](#)

How to implement the best practice timed pathway: one-stop clinics

One-stop clinics

The Best Practice Timed Pathway expects one-stop access to clinical examination, mammography, ultrasound and biopsy (if required) in a single visit for suspected cancer. Delivery of this shortens time to diagnosis and reduces unwarranted variation against the 28-day FDS. For those in whom cancer is suspected, access to the one-stop clinic with triple diagnostic assessment in a single hospital visit may reduce the anxiety and uncertainty of a possible cancer diagnosis, with less time between urgent referral and receiving the outcome of diagnostic tests. It is important to regularly review one-stop clinics to ensure they are being used efficiently and to identify opportunities to introduce and adopt new and innovative practices and models.

Check	Action	Resources
✓	Undertake review of one-stop clinics to assess opportunities for efficiency.	- James Paget University Hospitals - Physician associate (PA) role: Business Case, Role Profile, Person Specification and Job Description - Walsall Healthcare NHS Trust - Specialist Surgical Care Practitioner Job Description - Northumbria Healthcare NHS Foundation Trust - Surgeon of the Week Standard Operating Procedure (SOP)
✓	Utilise extended roles, e.g. physician associates or specialist surgical care practitioners, in one-stop clinics as appropriate.	
✓	Ensure consultant presence for complex cases and immediate FDS clock stop when cancer is suspected.	
✓	Consider implementing a system whereby a designated support week surgeon provides cover for the one-stop clinics – see Northumbria summary here and in the resources section.	
✓	Incorporate frailty assessment early to inform treatment planning.	

How to implement the best practice timed pathway: enhancing patient flow and stopping the clock

Enhancing patient flow and stopping the clock

Stopping the clock on the FDS requires fast, co-ordinated movement through the pathway, with patients being seen as early as possible. One-stop clinics play a central role by enabling same-day assessment and biopsy, allowing pathology processes to begin immediately. Rapid pathology is often the critical rate-limiting step. Data shows that delays in pathology reporting are a key driver of slower FDS performance for patients ultimately diagnosed with cancer, in contrast to faster pathways for benign outcomes. Timely communication of results is also key to ensuring achievement of the 28-day standard. By implementing the following actions breast services can make the process of moving the patient through the pathway more efficient and therefore stop the clock as early as possible.

Check	Action	Resources
✓	Complete clinically led triage by day 3 to direct patients to appropriate pathways and avoid unnecessary delays.	- ABS - Improving the Efficiency of Breast Multidisciplinary Team Meetings: A toolkit for breast services - Bolton NHS Foundation Trust – Diagnostic MDT Model - Leeds Teaching Hospitals NHS Trust – Nurse-led telephone results clinic - Airedale General Hospital NHS Foundation Trust – Pathology quick wins - Newcastle upon Tyne Hospitals NHS Foundation Trust – Breast Pathology Service - NHS England Breast Cancer Best Practice Timed Pathway Guidance document
✓	Implement workflows to deliver core biopsy histopathology within seven days of referral.	
✓	Use structured benign results pathways (e.g., CNS-led telephone clinics) to accelerate communication and pathway closure.	
✓	Schedule MDT review by day 17, including radiology, pathology and immunohistochemistry.	
✓	Ensure HER2 FISH/ISH results are available by day 24, enabling MDT discussion and diagnosis by day 28.	
✓	Implement FDS result letters that automatically close the diagnostic pathway using Robotic Process Automation (RPA).	

How to implement the best practice timed pathway: workforce optimisation

Workforce optimisation

Optimising the breast cancer workforce strengthens pathway resilience, improves diagnostic flow, and enhances patient experience across screening, symptomatic and suspected cancer routes. By maximising skill-mix - through models such as the four-tier framework of mammography associates, radiographers, advanced practitioners and consultant clinicians - services can significantly expand diagnostic capacity and reduce bottlenecks, particularly in one-stop and triple assessment clinics. Training, career development and protected learning time improve staff capability, morale and retention, while MDT integration ensures co-ordinated decision-making and consistent, high-quality care. Combined with digital tools, automation and demand-and-capacity modelling, workforce optimisation enables earlier diagnosis, more efficient use of finite resources, and a more sustainable, patient-centred breast cancer service.

Check	Action	Resources
✓	Plan recruitment collaboratively across trusts to address shortages, particularly in radiology and breast imaging roles.	- National Breast Imaging Academy: - Mammography Associate Training Programme Breast Clinician Credential Breast Radiology Fellowship - James Paget University Hospitals - Physician associate (PA) role: Business Case, Role Profile, Person Specification and Job Description - Walsall Healthcare NHS Trust - Specialist Surgical Care Practitioner Job Description - Greater Manchester Cancer Alliance – GPCR role
✓	Utilise extended roles, e.g. physician associates or specialist surgical care practitioners, in one-stop clinics and other parts of the pathway as appropriate.	
✓	Utilise mammography associates within breast screening programmes to support pipeline growth and free radiographer time.	
✓	Engage with training programmes such as the Breast Clinician Credential and Radiology Fellowship.	
✓	Strengthen the MDT co-ordinator role by giving them responsibility for: collating information on patients who have abnormal clinic results; proactively managing patient pathways; and acting as the central communication point.	
✓	Upskill staff on digital tools, AI-enabled imaging and risk stratification to enhance productivity.	

In 2021, the West Midlands Cancer Alliance completed D&C modelling of its breast 2WW services across two trusts (Wye Valley NHS Trust and Worcestershire Acute Hospitals NHS Trust).

Key aims:

- Develop a standardised and replicable model for assessing D&C.
- Identify the variation in core and ad-hoc capacity.
- Establish the sustainable wait list size, compared to current list.
- Identify resource needs, support opportunities such as mutual aid and inform future planning.

Method

The National D&C Core Model was used to analyse referral-to-first-appointment activity across the ICS, ensuring consistent comparison. The model quantifies required versus available capacity and compares the current waiting list with a sustainable waiting list size. It is built on key demand and capacity principles, including use of the 85th percentile to reflect urgency profiles, calculation of sustainable waiting lists, and the use of Statistical Process Control (SPC) charts.

[illegible]

Case study: West Midlands Cancer Alliance demand and capacity modelling cont.

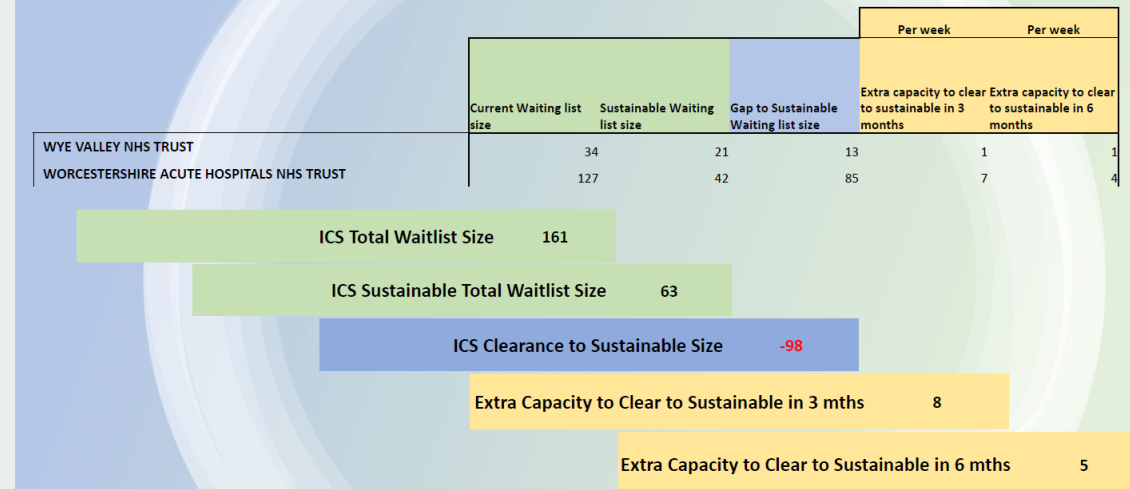
Findings

- Both trusts showed deficits in capacity of approximately 4.5 clinics per week based on average 11 slots per clinic.
- Clinic profiles varied significantly.
- 7.2% of total capacity was ad hoc and potentially unsustainable. If this ad hoc capacity was lost the shortfall would increase by approximately one clinic per week.
- The ICS waiting list was 161 patients; the sustainable size is 63. This is a gap of 98 between current and the sustainable waitlist size.
- Clearing this gap required an additional five slots per week for 24 weeks or eight slots per week for 12 weeks over and above the capacity shortfall to get the waiting list down to a sustainable size.

Recommendations following the review

- Consider redesigning the **whole** breast pathway.
- Explore co-location and/or co-management of screening and symptomatic services to improve efficiency.
- Undertake a workforce review, including wellbeing and gap analysis.
- Map the pathway mapping with analytical support to identify the workforce required across pathway.
- Review primary care access.
- Review short-term funding constraints and associated risks.
- Funding review to support training and development.
- Identify ways to enable and incentivise training to develop the workforce.

2ww Breast Waiting List Overview by Trust & ICS *



* Waiting list size is a snapshot at time that models were completed

Analyse

Compare

Redesign

Case study: Chelsea & Westminster NHS Trust Cancer 360 Platform

Chelsea and Westminster NHS Trust: Cancer 360 Platform

The Cancer 360 Platform is a real-time live data dashboard which acts as a central point of reference for all patients on a cancer pathway.

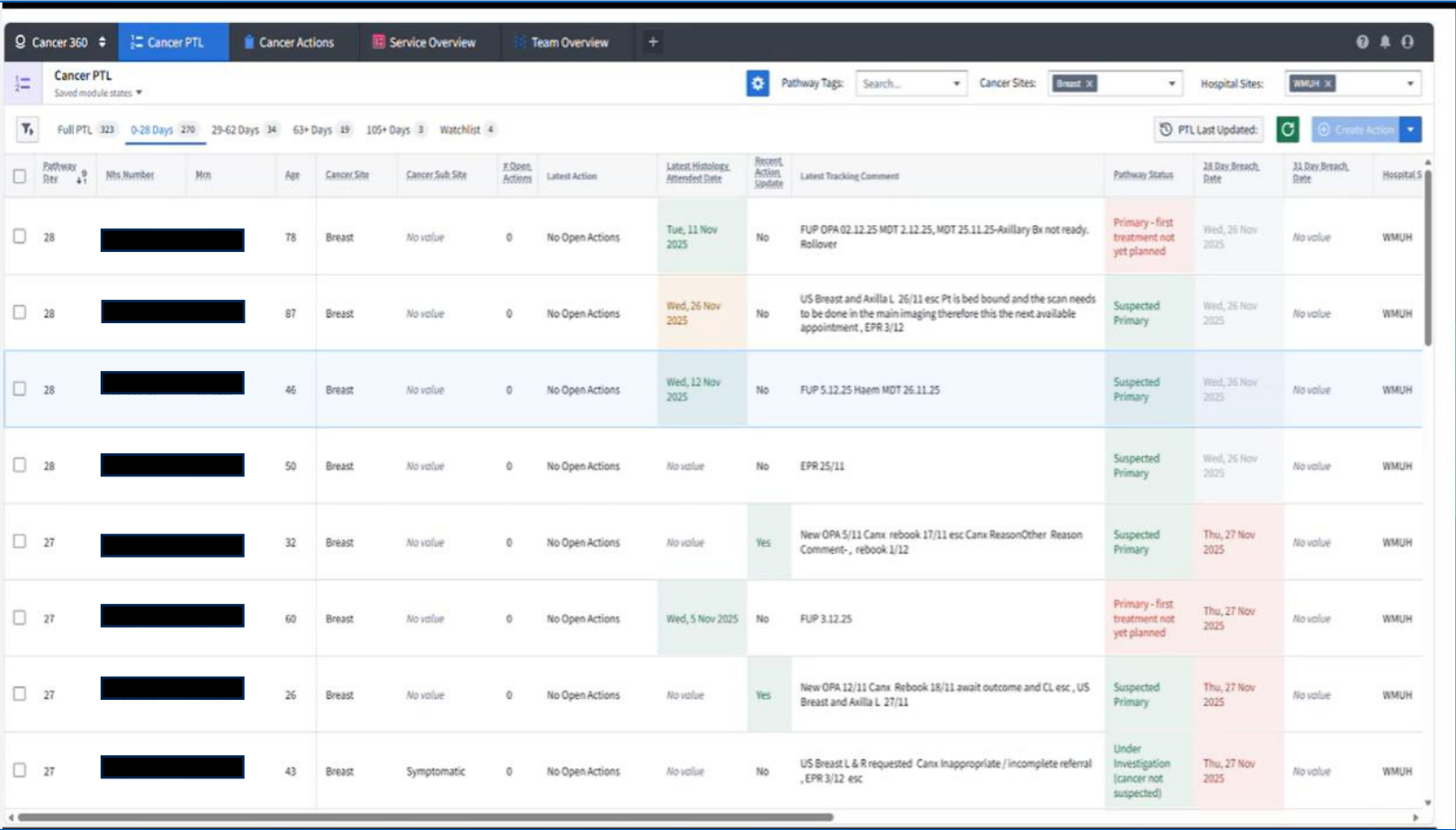
The functionality of the platform makes it integral for the PTL meetings, as the colour coding enables staff to clearly see which patients are at risk of breaching the 62-day target.

The platform allows the creation of actions, tasks and comments, which removes the need for emails or spreadsheets. This ensures that information remains up to date.

The introduction of the platform has enabled the trust to improve its FDS performance from 70% to over 80% and has enabled it to maintain capacity, despite an increase in demand.

The platform has given staff a clearer oversight of performance and individual patient needs.

It has also been beneficial in identifying pinch points within the system and has provided data for D&C modelling and business planning.



Pathway Ref	NHS Number	Mm	Age	Cancer Site	Cancer Sub Site	F. Open Actions	Latest Action	Latest Histology	Recent Action Update	Latest Tracking Comment	Pathway Status	28 Day Breach Date	31 Day Breach Date	Hospital Site
28	[REDACTED]		78	Breast	No value	0	No Open Actions	Tue, 11 Nov 2025	No	FUP OPA 02.12.25 MDT 2.12.25, MDT 25.11.25-Axillary Bx not ready. Rollover	Primary - first treatment not yet planned	Wed, 26 Nov 2025	No value	WMUH
28	[REDACTED]		87	Breast	No value	0	No Open Actions	Wed, 26 Nov 2025	No	US Breast and Axilla L 26/11 esc Pt is bed bound and the scan needs to be done in the main imaging therefore this the next available appointment, EPR 3/12	Suspected Primary	Wed, 26 Nov 2025	No value	WMUH
28	[REDACTED]		46	Breast	No value	0	No Open Actions	Wed, 12 Nov 2025	No	FUP 5.12.25 Haem MDT 26.11.25	Suspected Primary	Wed, 26 Nov 2025	No value	WMUH
28	[REDACTED]		50	Breast	No value	0	No Open Actions	No value	No	EPR 25/11	Suspected Primary	Wed, 26 Nov 2025	No value	WMUH
27	[REDACTED]		32	Breast	No value	0	No Open Actions	No value	Yes	New OPA 5/11 Canx rebook 17/11 esc Canx ReasonOther Reason Comment-, rebook 1/12	Suspected Primary	Thu, 27 Nov 2025	No value	WMUH
27	[REDACTED]		60	Breast	No value	0	No Open Actions	Wed, 5 Nov 2025	No	FUP 3.12.25	Primary - first treatment not yet planned	Thu, 27 Nov 2025	No value	WMUH
27	[REDACTED]		26	Breast	No value	0	No Open Actions	No value	Yes	New OPA 12/11 Canx Rebook 18/11 await outcome and CL esc, US Breast and Axilla L 27/11	Suspected Primary	Thu, 27 Nov 2025	No value	WMUH
27	[REDACTED]		43	Breast	Symptomatic	0	No Open Actions	No value	No	US Breast L & R requested Canx Inappropriate / incomplete referral, EPR 3/12 esc	Under Investigation (cancer not suspected)	Thu, 27 Nov 2025	No value	WMUH

Cancer 360 streamlines patient pathways across NHS trusts



GIRFT webinar: best practice in achieving breast cancer waiting time targets (webinar archive)



Case studies: Somerset NHS Foundation Trust and Wessex Cancer Alliance self-referral

Somerset: Breast symptomatic self-referral via NHS 111

Somerset's new breast cancer self-referral pathway gives patients faster access to specialist care, while reducing pressure on GP services.

Patients living in Somerset aged over 30 with breast lump symptoms can self-refer via NHS 111 Online and the NHS App, in line with the recently published [NHS 10 Year Plan](#), which includes shifting from sickness to prevention and from analogue to digital.

The service has clear referral criteria and is not intended to replace routine screening for asymptomatic patients.

The self-referral pilot is currently only available online.

Somerset was the first area in England to introduce this pathway, which since its launch nine months ago, has seen more than 930 people self-refer directly to our breast diagnostic clinic without the need for a GP appointment.

The service will be evaluated before a nationwide rollout.

[Somerset NHS Foundation Trust self-referral process map](#)

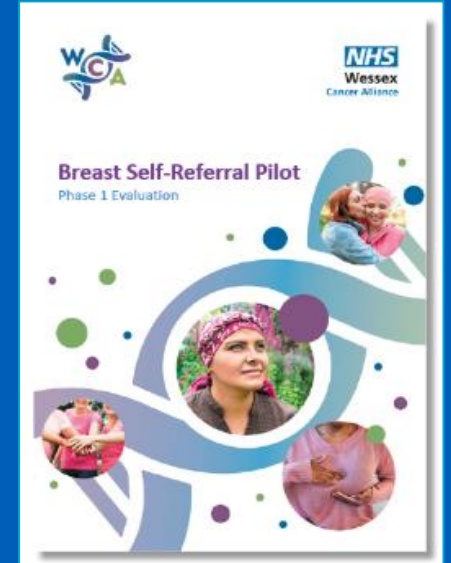


Wessex Cancer Alliance (WCA): Breast self-referral pilot

The breast self-referral pilot service forms part of the WCA response to the national Rapid Diagnostic Centre (RDC) programme, which aims to speed up cancer diagnosis and improve patient experience.

The RDC programme also forms part of the response to deliver the Faster Diagnosis Standard (FDS). The RDC specification cites self-referral as part of work that could be undertaken to open access to referrers other than primary care and forms part of their recommended approach to implementation.

This pilot service has been developed in partnership between the Rapid Investigation Service team working together with clinical colleagues from Hampshire Hospitals NHS Foundation Trust and the Winchester Rural North and East Primary Care Network and The Camrose, Gillies, and Hackwood Partnership.



[Wessex Cancer Alliance Breast Self-Referral Pilot](#)



Case studies: Royal Surrey NHS Foundation Trust and Northumbria Healthcare NHS Trust triage models

Royal Surrey NHS Foundation Trust: consultant-led triage

While Faster Diagnosis Standard (FDS) performance was strong, significant pressure on OSC capacity was identified.

In response, a consultant-led triage process was introduced to ensure that only patients requiring the full range of investigations provided at the OSC were booked into these clinics. All other patients were redirected to appropriate alternative pathways.

Triage process

- **Daily consultant review of all new referrals**
- **Job planning includes one hour per day dedicated to triage**
- **Utilises the electronic referral system**
- **Operates alongside the daily Advice and Guidance offer**

Patients not suitable for OSC are referred to one of several dedicated pathways: breast pain, family history, gynaecomastia or incidentaloma.

During a four-month period in 2024, a total of 1,336 referrals were made to the OSC. Of these, following triage 214 (16%) were diverted to alternative pathways. The data shows that 7% of suspected cancer referrals and 63% of breast symptomatic referrals (excluding patients GPs refer directly to the pain pathway) can be triaged out of the OSC. This frees up at least one OSC per week for the trust.

Northumbria Healthcare NHS Trust: non-clinical triage

Northumbria Healthcare NHS Trust identified limited radiology capacity as an issue impacting the effectiveness of their one-stop clinics (OSC).

To address this, two options were introduced to maximise the radiologist's capacity:

1. **OSC for patients meeting the urgent suspected cancer (USC) criteria and those presenting with an abscess.**
2. **Low risk clinic for all other patients, with access to imaging if required.**

Clinicians developed a process and criteria enabling non-clinical staff to complete triage. The contact centre team completes triage using tick boxes on the referral form (red or blue side). If they identify any discrepancies within the referral form - for example, the tick box choices do not align with the free text responses given - guidance is requested from a clinician. A dedicated breast team email was set up to support with triage queries.

Safety netting is in place to ensure that imaging can be expedited for patients triaged outside of the USC pathway, for example, young women presenting with a lump.

A challenge that has been identified is variation in how different teams approach triage.

Royal Surrey Sample ERS triage responses



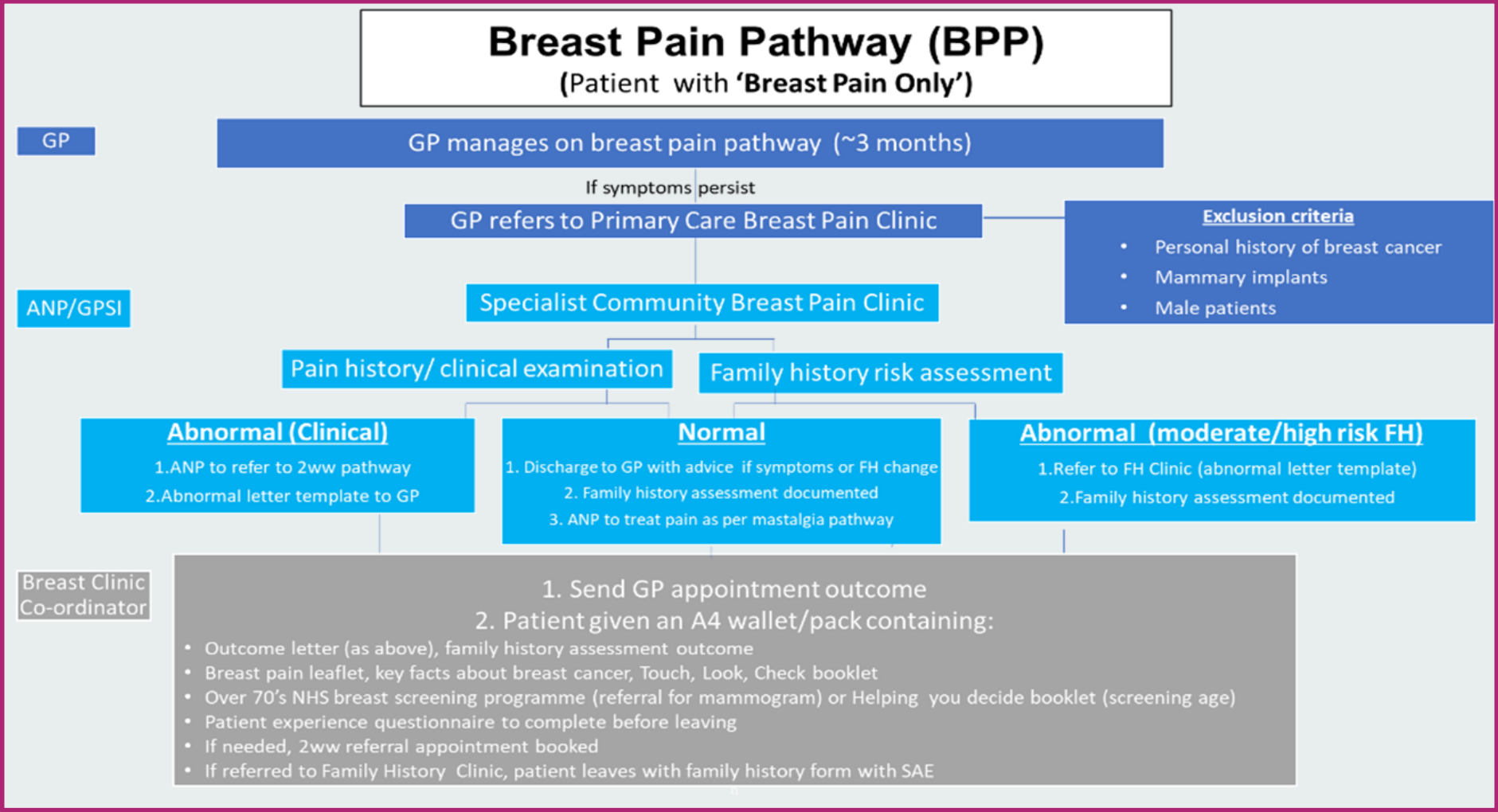
GIRFT webinar: best practice in achieving breast cancer waiting time targets (webinar archive)



Northumbria breast cancer non-clinical triage flow chart



Case study: East Midlands (EM) Cancer Alliance breast pain pathway



Case study: Greater Manchester Cancer Alliance breast pain pathway

The primary principle of the Greater Manchester mastalgia (breast pain) pathway is that referral from primary care is not required.

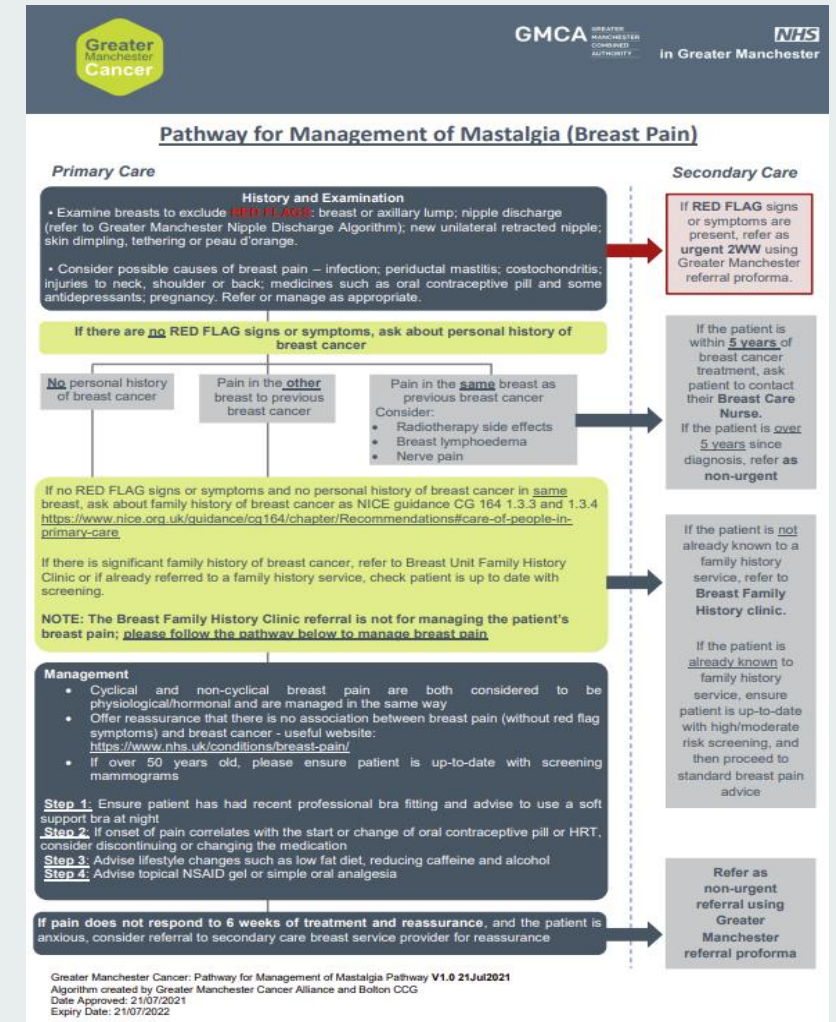
This is supported by an 'always on' primary care engagement programme including: mastalgia management algorithm (as shown) available on the primary care electronic system; mastalgia information on standard referral forms; live and recorded webinars; GatewayC infographics; patient information leaflets; public-facing animation for waiting rooms and social media; regular updates in Primary Care Network bulletins

A mastalgia telephone clinic provides an appropriate low risk pathway for the small volume of patients with mastalgia who cannot be managed in primary care

- Referrals are triaged by secondary care clinicians or trained Band 4 HCPs using a triage protocol.
- Clinics are delivered to the remotely by Advanced Nurse Practitioners (ANPs) or GPs with Cancer Role (GPCR).
- Patients aged over 40 years are currently offered a mammogram, while awaiting ASPIRE results.
- Standardised documentation, letters and patient information has supported system-wide implementation.

Evaluation of the pathway has identified the following learning and outcomes:

- Ongoing engagement with primary care is essential to embedding a new best practice pathway.
- Mastalgia referrals have reduced from 20% of total breast referrals to an average of 5.5% (local multicentre audit), while maintaining a year-on-year increase in the number of cancers diagnosed.
- Triage of referrals needs to be undertaken in secondary care. A trial of primary care triage resulted in inappropriate referrals and an increase in overall referrals.
- Mastalgia telephone clinics must be delivered by experienced HCPs to avoid high re-booking rates.



Case study: Leeds Teaching Hospitals NHS Trust breast pain pathway

Leeds breast pain pathway

The Leeds breast pain pathway was established to reduce unnecessary face-to-face (F2F) appointments and redirect patients away from the OSC where appropriate. A pilot was undertaken before the breast pain pathway was embedded as business as usual. During the pilot period, 2,200 referrals were received, with 867 (39%) triaged as appropriate for the breast pain pathway. Only 172 patients (19.8%) needed F2F review, meaning 80.2% were successfully managed without clinic attendance. Re-presentation rates were low: 15% of patients seen in clinic re-attended within 12 months, with only 8.1% returning specifically with breast pain. Imaging was used selectively across age groups, consistent with a low-risk pathway. Cancer incidence was extremely low (two cases in 867 triaged referrals), and neither presented initially with classic red-flag symptoms.

Overall, the service shows that a triage-led, supported self-management pathway for breast pain is safe, efficient and significantly reduces unnecessary OSC activity.



Case studies: triage to low-risk clinics

York & Scarborough Teaching Hospitals

The trust triages all breast referrals. Low risk patients are seen by a Surgical Care Practitioner (SCP) in clinic. If imaging is required, it is undertaken within one week.

Criteria for the SCP low risk clinic:

- Aged under 30 years and no concerning symptoms
- Gynaecomastia
- Obvious skin condition
- Bilateral nipple symptoms
- Other symptoms considered to be of low clinical concern

This approach releases up to 20 slots per week (with 665 patients seen in the low-risk clinic in one year), enabling the trust to free up at least one OSC per week.



Mersey & West Lancashire Teaching Hospitals runs breast clinics for patients aged under 35 years.

Royal Surrey County Hospital (RSCH) holds ultrasound-only clinics for patients aged under 40.

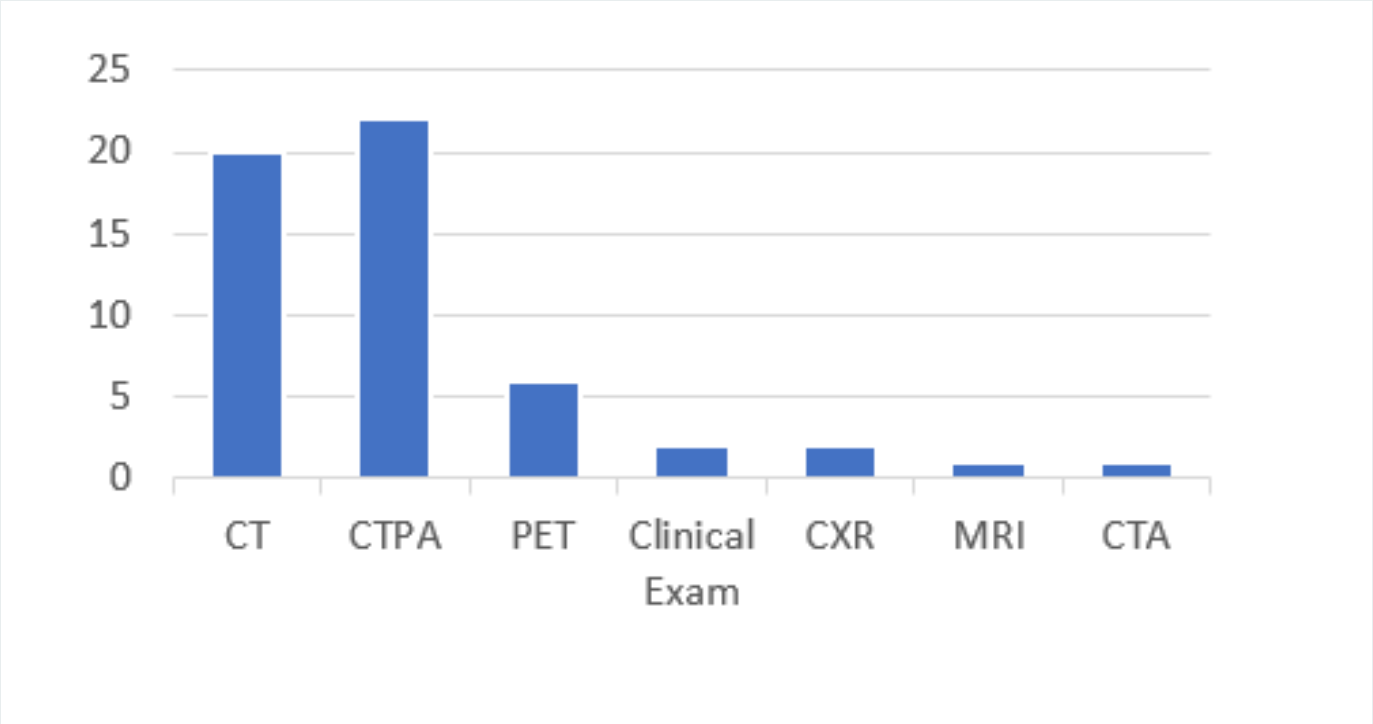
Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHHFT) offers evening clinics that are tailored for males and people aged under-35. Mammograms are not required in this cohort.

Case study: Royal Surrey County Hospital incidentaloma pathway

Royal Surrey County Hospital – incidentaloma pathway

- The trust has a dedicated pathway for all incidentaloma referrals.
- Proforma to include previous breast history and clinical findings.
- Previous breast imaging requested prior to MDT.
- Section on weekly MDT to discuss the referrals before any further investigations/appointments. This ensures better use of the time in the one-stop clinic (OSC).
- Patient outcomes:
 - Nil needed = standard letter to referrer
 - (OSC) appointment booked.
- Audit at six months – 89 patients reviewed with 56% avoiding the OSC.

Type of imaging undertaken prior to referral to the breast service for patients on the incidentaloma pathway



RSCH MDT incidentaloma referral form



Case study: Northumbria Healthcare NHS Foundation Trust support week model

Northumbria breast team support week model

Northumbria has established a model that involves having a structured five-week rota for surgeons, with one of those weeks being the support week and the four others being the standard job plan. Five surgeons rotate across the five-week cycle, creating dedicated Surgeon of the Week (SOTW) cover. This helps to ensure consistent availability for one-stop clinics (OSC) and urgent clinical demands. It means a named clinician is accessible for joint operating if needed, even though theatre is not routinely built into SOTW job plans.

Protected capacity

Core one-stop and results clinics remain in job plans, but theatre and routine direct clinical care (DCC) is stepped down temporarily to create flexible capacity.

The SOTW provides cover for:

- OSC sessions impacted by leave
- Short-notice clinic pressures
- Acute clinics linked to cancer pathways

This structure is a key factor in sustaining strong CWT performance.

Acute clinic

The model includes a dedicated acute clinic (0.5 PA) with 20-minute slots for patients who don't fit standard pathways. It is used for abscesses, urgent benign issues, post-op concerns, endocrine-related problems, and other rapid-response needs. Requests are routed via a single acute clinic inbox and having clear criteria ensures efficient booking and reduces delays.

Operational support and governance

- One PA per week allocated for admin including: triage, MDT alerts, A&G responses and support-week email management.
- Clear process for short-notice cover requests, flexibility on scheduling, and structured liaison with Operational Service Manager (OSM) to ensure DCC alignment.
- Power BI-enabled oversight and consistent documentation support continuity across rotating surgeons.

Breast Team Support Week – Standard Operating Procedure



Case study: Leeds Teaching Hospitals NHS Trust nurse-led telephone clinic for benign results

Background

The breast service introduced a nurse-led telephone clinic to deliver results and follow-up after imaging or biopsy, reducing unnecessary face-to-face (F2F) appointments while maintaining safety and patient experience.

Model overview

Band 5 - 7 breast clinic/ward nurses run daily scheduled telephone clinics, supported by consultants and ANPs on site. Nurses have access to initial consultation notes, imaging and pathology results and MDT outcomes. Scripts ensure consistent communication. Calls are booked into timed clinic slots, so patients know when to expect contact.

Clinical scope

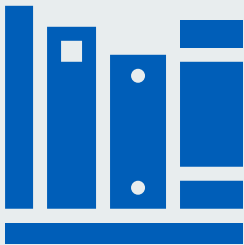
The clinic is used only for expected benign or normal results. Patients with suspected malignancy and/or likely need for surgery receive F2F appointments. Patients with significant language/access barriers may also be given a F2F appointment. If results are not ready, a brief update call is made, and a new date is provided. Nurses arrange F2F consultant OPAs when patients have questions they are unable to answer.

MDT integration

MDT outcomes include instructions on whether follow-up should be via telephone or F2F. MDT co-ordinators book appointments in real time as plans are dictated. Incorrect bookings (e.g., inappropriate F2F OPA) are amended. If an unexpected cancer is identified in someone booked for telephone follow-up, the telephone slot is retained for continuity, but an urgent F2F appointment is added, and the nurse informs the patient.

Impact

The model reduces F2F follow-up, eases outpatient waiting room pressure, and provides patients with timely communication of their results. Nurses enjoy the extended role and are supported by clear processes and prompt access to senior clinical advice.



Clinic Process



Clinic Checklist



Clinic Letter



Case study: Bolton NHS Foundation Trust

One-stop clinic (OSC)

The OSC is generally led by ANPs and GPs with Cancer Roles (GPCRs). At the OSC all patients who have undergone a biopsy are automatically booked into diagnostic MDT, leaving histopathology 3-5 working days for biopsy turnaround. Patients with suspected cancer (M4/U4 or above) are allocated to a surgeon-led F2F clinic on the same day as the diagnostic MDT.

Patients with low suspicion of malignancy (U3/M3 or below) are allocated to a nurse-led telephone clinic on the same day as the diagnostic MDM.

Diagnostic MDT model

Bolton runs two diagnostic MDTs per week, giving frequent opportunities to progress patients through the FDS pathway.

Biopsy results are turned around within 3 - 5 working days and histopathologists present their own cases at the MDT.

Two or three surgeons are present at each MDT, reviewing the cases they will see in diagnostic clinic on the same day. All MDTs and clinics have at least one oncoplastic consultant present.

An ANP attends MDT to present U3/M3 cases that are booked into nurse-led telephone clinic on the same day.

What makes the Bolton model effective?



Benign telephone clinic

Bolton runs a benign telephone results clinic to manage indeterminate/likely benign cases (typically U3/M3 or below). The clinic is run by an Advanced Nurse Practitioner (ANP).

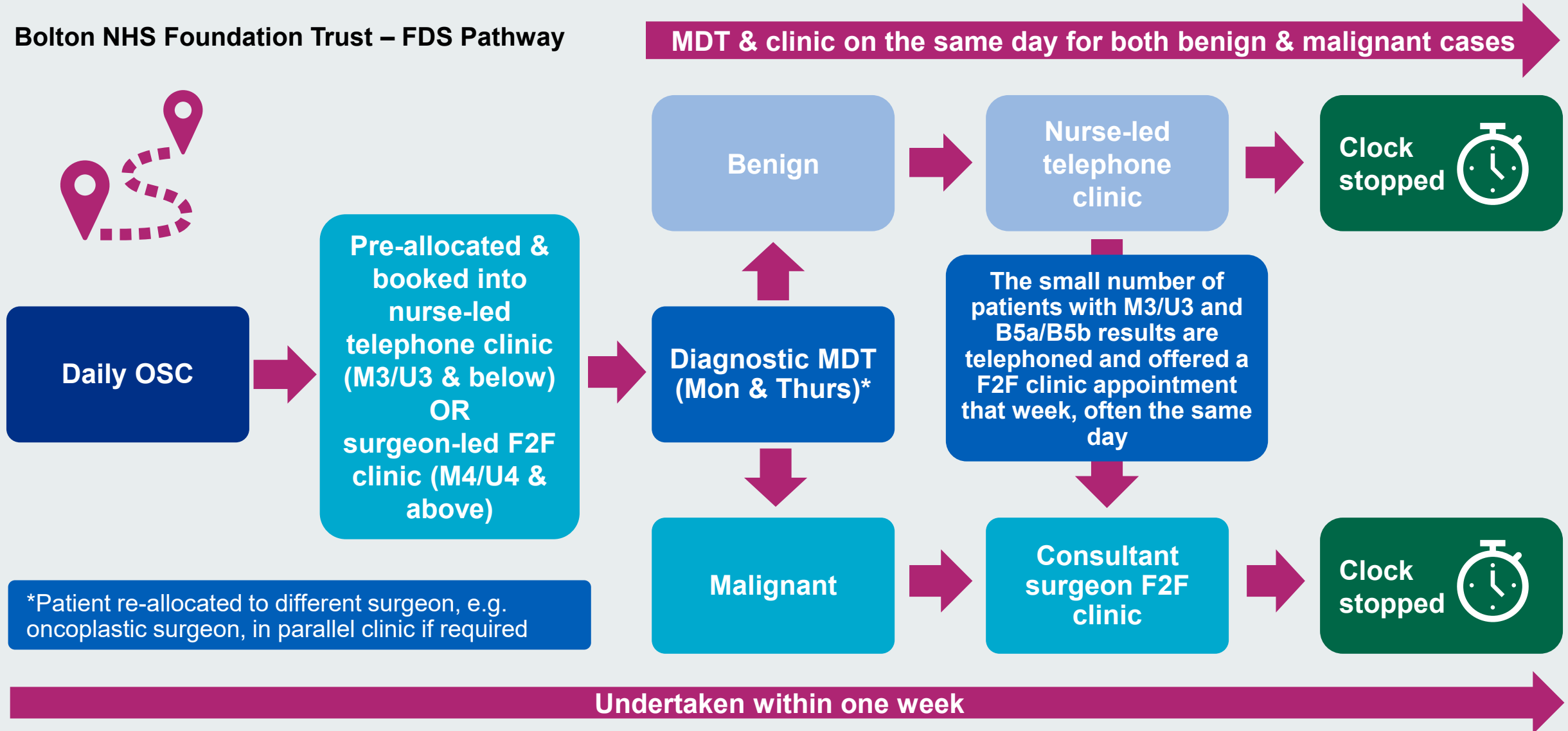
The benign telephone clinic approach:

- Stops the cancer clock and reduces the period of uncertainty for patients with benign conditions.
- Removes unnecessary F2F follow-up.
- Significantly reduces consultant administrative burden.

F2F follow-up is offered for patient-specific factors (e.g. language barrier).

Case study: Bolton NHS Foundation Trust

Bolton NHS Foundation Trust – FDS Pathway



Case study: Airedale General Hospital speeding up the pathology pathway

Speeding up the pathway - pathology challenges

- The service at Airedale General Hospital NHS Foundation Trust was experiencing significant demand in addition to consultant histopathologist reporting capacity issues leading to extended turnaround time for reporting.
- Ongoing vacancies with no ability to recruit substantively (national recruitment issues with insufficient appropriately qualified individuals).

Check	Airedale General Hospital – pathology quick wins
	Outsourcing of routine and non-urgent reporting to minimise back-log build-up.
	Increased flexibility in team working arrangements to undertake additional reporting sessions.
	Training biomedical scientists to undertake specimen dissection and reporting (Advanced Practice/Extended Practice roles).
	Engaging and working proactively with wider service teams to manage and prioritise clinically urgent/cancer cases.
	Communicating with respective specialty patient services managers (PSMs) regarding processes for flagging FIT/urgent requests.
	Participating in weekly cancer access meetings and diagnostic performance recovery huddles.
	Reporting in place through Power BI and engaged with informatics to support provision of improved data.

Impact on
turnaround
times



Reduced
average process
time



Increased % of
cases reported
within 7 & 10
days



Improved
performance

Case study: Manchester University NHS Foundation Trust (MFT) breast screening service

Context

Greater Manchester breast screening service is one of the largest breast screening services in England, operating four mobile units and two static screening centres, employing around 40 screening staff.

Following the Covid pandemic, the team needed to find ways to expand the workforce and offer more screening sessions during evenings and weekends.

Mammography was an early adopter of the four-tier workforce model, as part of the NHS Cancer Plan. The mammography associate (MA) level 4 apprenticeship was developed by the national Trailblazer Group. It combines supervised on the job clinical practice with academic study, with apprentices being fully competent to step into MA roles once they are qualified.

A key feature of the MA apprenticeship is that the costs are covered by the national Apprenticeship Levy, so trusts can build up their MA workforce without needing additional funding.

**Developing a new mammography workforce
model for primary breast screening**



Outcomes

Using the apprenticeship route enabled MFT to increase its Assistant Practitioner (AP) workforce. Its breast screening team now has an almost 50/50 balance of qualified radiographers and APs or MA apprentices.

MFT also participated in a remote supervision pilot programme, where two APs carried out mammography screening with remote radiographic supervision from a base unit. This was successful, and they are looking to implement this as normal practice.

Benefits

- Cost-effective way to train staff who are immediately 'job ready' to support the running of an efficient breast screening service.
- Apprentice roles are easy to recruit to and provide good opportunities for the local community.
- Applicants don't need a healthcare background or qualification, so the apprenticeship widens access to healthcare careers.
- Qualified MAs have the skills and experience to get involved in many other areas of breast cancer diagnosis and treatment.
- Rotations enable MAs to get involved with symptomatic clinics, family history clinics and assisting with biopsies and other procedures.
- Qualified MAs allow radiographers to develop their advanced practice skills, which in turn supports the senior skill mix shortages.

Case study: Greater Manchester Cancer Alliance GP with Cancer Role

Greater Manchester GP with Cancer Role (GPCR)

In October 2022, the alliance received funding from NHS England to pilot a mastalgia (breast pain) pathway across Greater Manchester and East Cheshire. The pilot aimed to strengthen the breast cancer workforce, improve primary-secondary care collaboration, and offer portfolio careers for GPs by integrating GPCRs into breast services. Six GPCRs were recruited and placed across breast service providers using standardised job descriptions and interview templates to reduce administrative burden. They completed an induction, competency framework and 16-week breast-specific online education programme (developed in collaboration with the National Breast Imaging Academy). Peer support and education events were also provided.

The GPCRs' roles and responsibilities include delivering mastalgia telephone clinics and triple assessment OSCs, working with family history colleagues to ensure equity of access to risk reducing medication for women at high risk of future breast cancer and supporting diagnostic MDTs. The model has created a number of benefits including: increased workforce capacity with minimal training time (independent in ~20 days); release of specialist capacity to meet FDS targets; and enabling system-wide roll-out of mastalgia and risk-reduction pathways. The model is now fully embedded and delivered as business-as-usual across breast surgical services. Since 2024, GPCRs have also supported breast oncology services, supporting new patient clinics, managing treatment side effects and general medical issues.

Induction programme

Competency framework

Online education programme

Peer support

Education events

GPCR Resources including:

- [Welcome pack and checklist](#)
- [Job advertisement](#)
- [Job description](#)
- [Person specification](#)
- [Education programme](#)
- [Clinical experiences](#)
- [Logbook](#)





GettingItRightFirstTime.co.uk



GettingItRightFirstTime.co.uk



[Getting It Right First Time \(GIRFT\)](#)



[@NHSGIRFT](#)