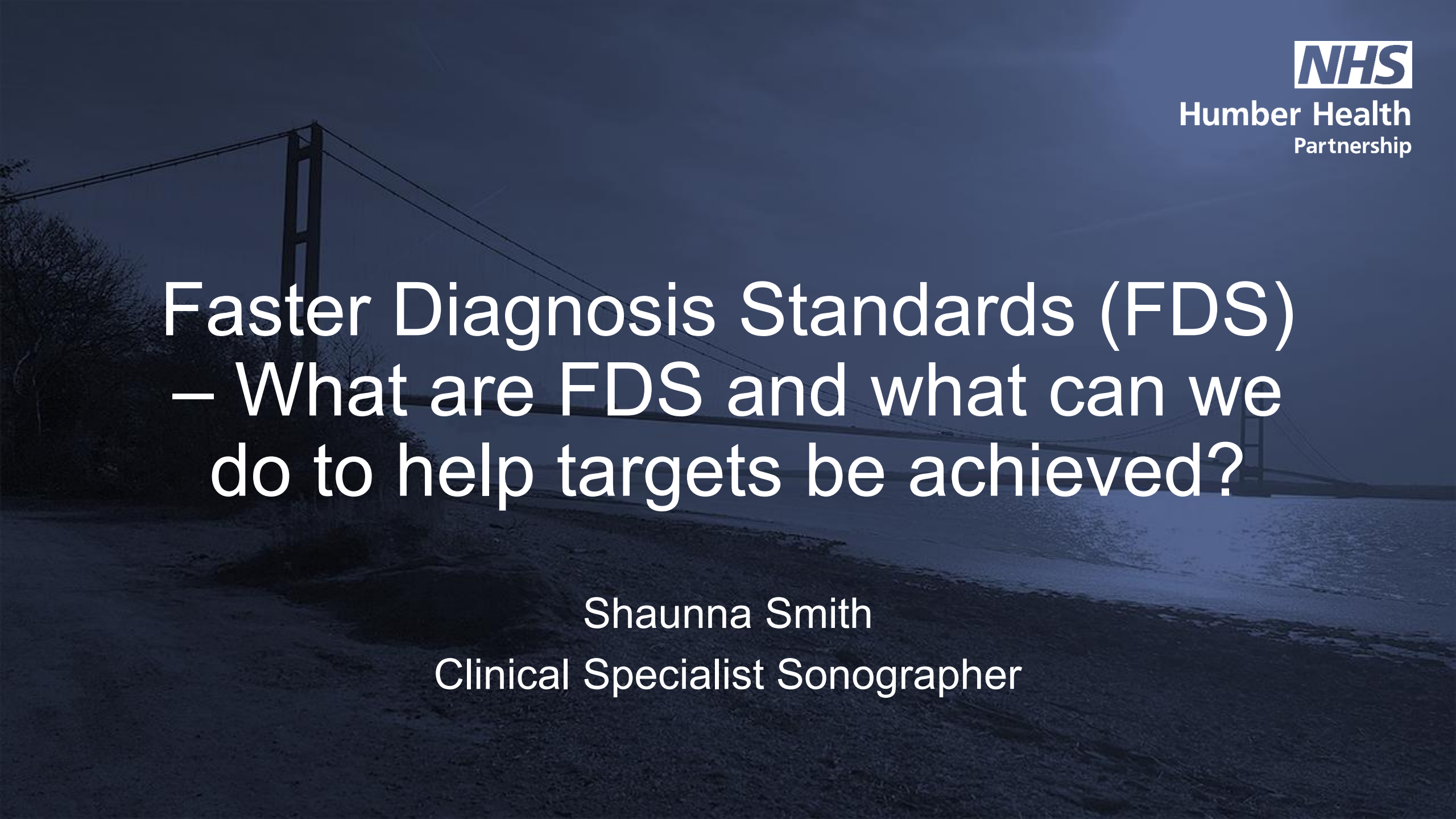

NHS
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Partnership

Faster Diagnosis Standards (FDS) – What are FDS and what can we do to help targets be achieved?

Shaunna Smith
Clinical Specialist Sonographer

Presentation Outline

NHS
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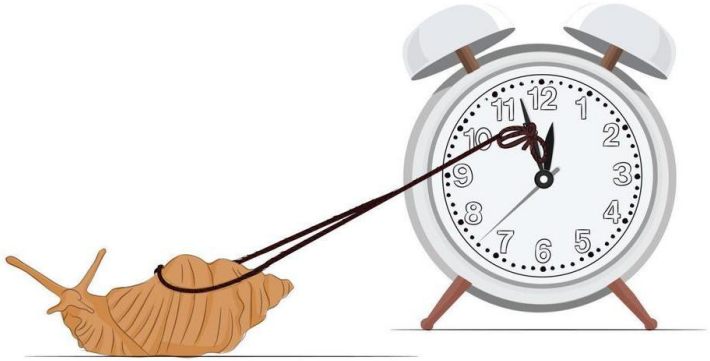
- Background to FDS
- Best timed pathways
- Where we are with meeting targets
- Sonographers led services in FDS
- Some Hull examples
    - Urology – haematuria, prostate, testicular Ca
    - Ovarian Ca

Two week wait

- Consultation with specialist within 14 days of referral
    - Could be in person or telephone

- 93% target
    - 83% in Yorkshire
    - 75% in the rest of England



Problems

1. Onward referrals - Had to wait significant amounts of time for onward investigations, therefore had to wait longer to have cancer diagnosed or excluded

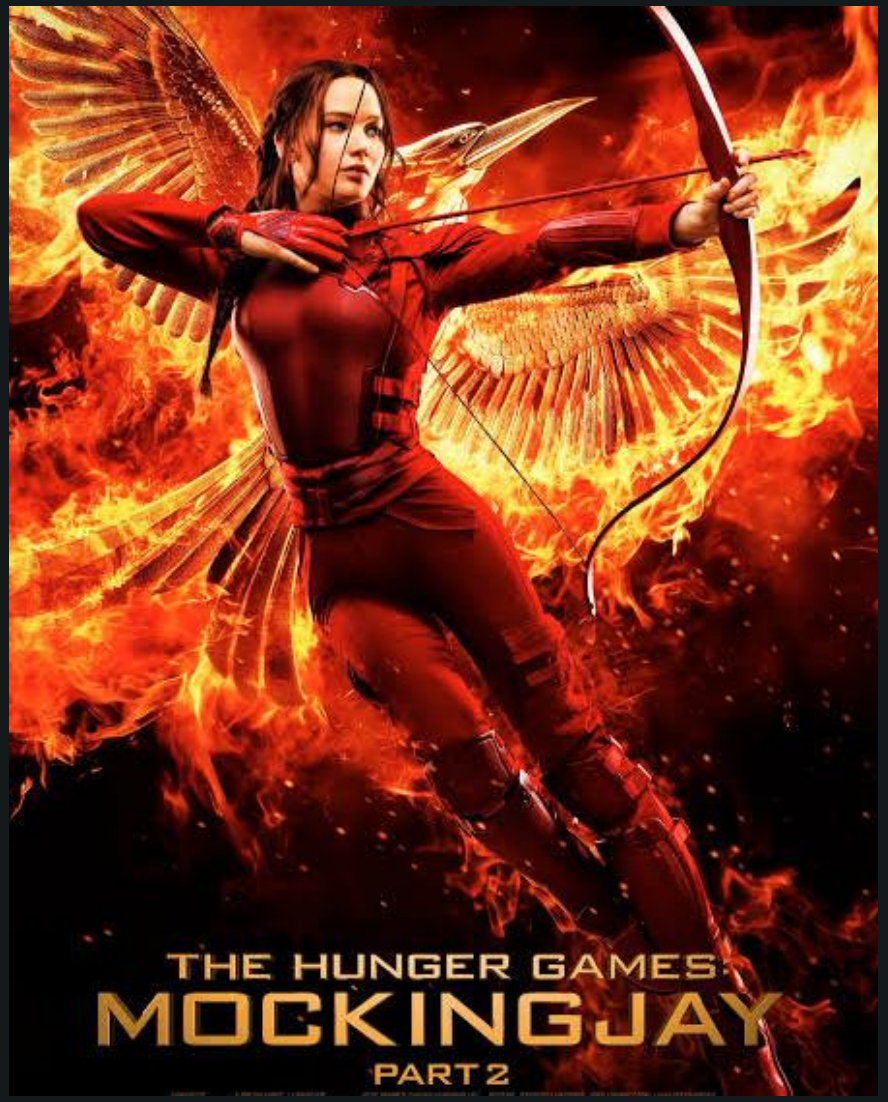
2. Treatment delays – wait time for results or having different tests on different days

3. No room for innovation – forgoing sophisticated tests to meet the targets

"I want you to find a bold and innovative way to do everything exactly the same way it's been done for 25 years!"

Idea of FDS first floated in 2015

Too interested in the cinema?

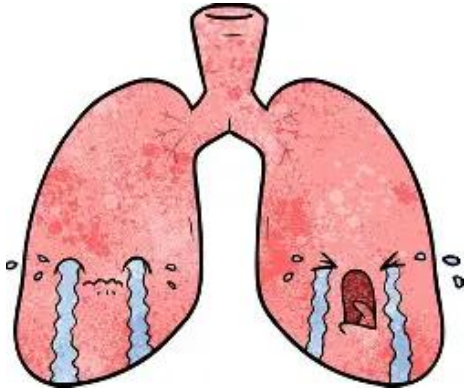


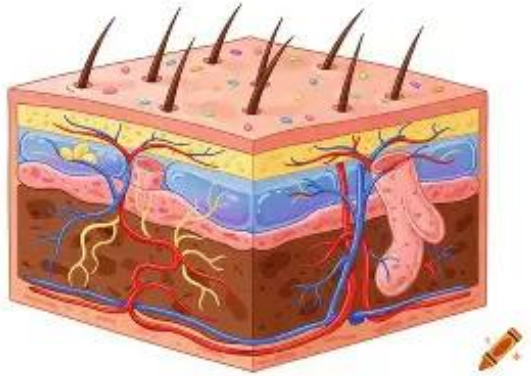
Personally I think apple are to blame…

2018 – Best Timed Pathways

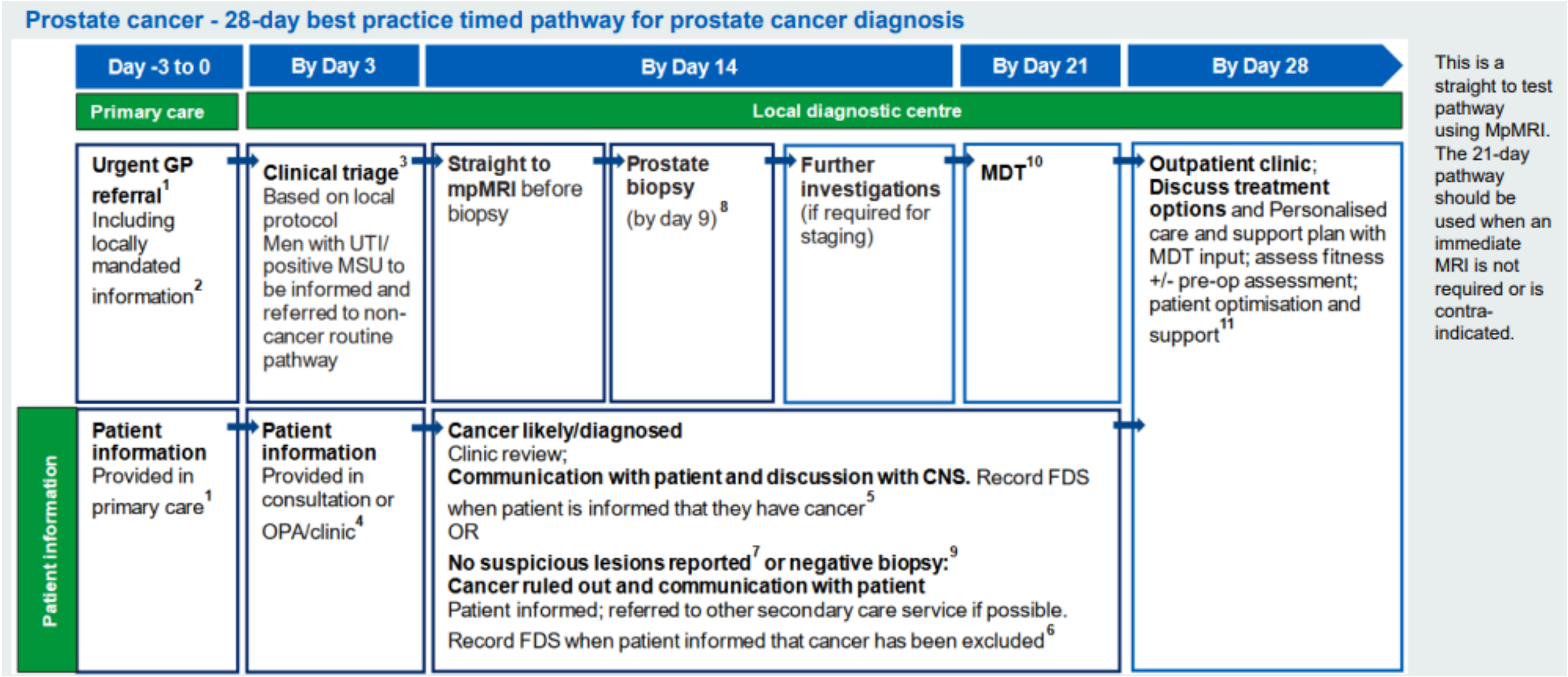
Outline best evidence structure and timing of various tumour specific pathways to meet FDS




Example..


Prostate cancer - 28-day best practice timed pathway for prostate cancer diagnosis
Day -3 to 0
By Day 3
By Day 14
By Day 21
By Day 28
Primary care
Local diagnostic centre
Urgent GP referral[1] Including locally mandated information[2]
Clinical triage[3] Based on local protocol Men with UTI/ positive MSU to be informed and referred to non-cancer routine pathway
Straight to mpMRI before biopsy
Prostate biopsy (by day 9)[8]
Further investigations (if required for staging)
MDT[10]
Outpatient clinic; Discuss treatment options and Personalised care and support plan with MDT input; assess fitness +/- pre-op assessment; patient optimisation and support[11]
Patient information
Patient information Provided in primary care[1]
Patient information Provided in consultation or OPA/clinic[4]
Cancer likely/diagnosed
Clinic review;
Communication with patient and discussion with CNS. Record FDS when patient is informed that they have cancer[5]
OR
No suspicious lesions reported[7] or negative biopsy:[9]
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[6]
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 contra-indicated.

FDS Hard Launch 2021

- 2-week-wait for first appointment removed as NHS initiatives with Faster Diagnostic Standards Pathways.
- Nine previous performance targets streamlined into three key performance indicators
- Standard ensures patients will be diagnosed with, or have cancer ruled out, within 28 days of being referred urgently by their GP for suspected cancer.

3 Key Performance Indicators

28 Days Faster Diagnosis Standard

Diagnosis/Exclusion of cancer by 28 days of referral (80%) (Prev 75%)

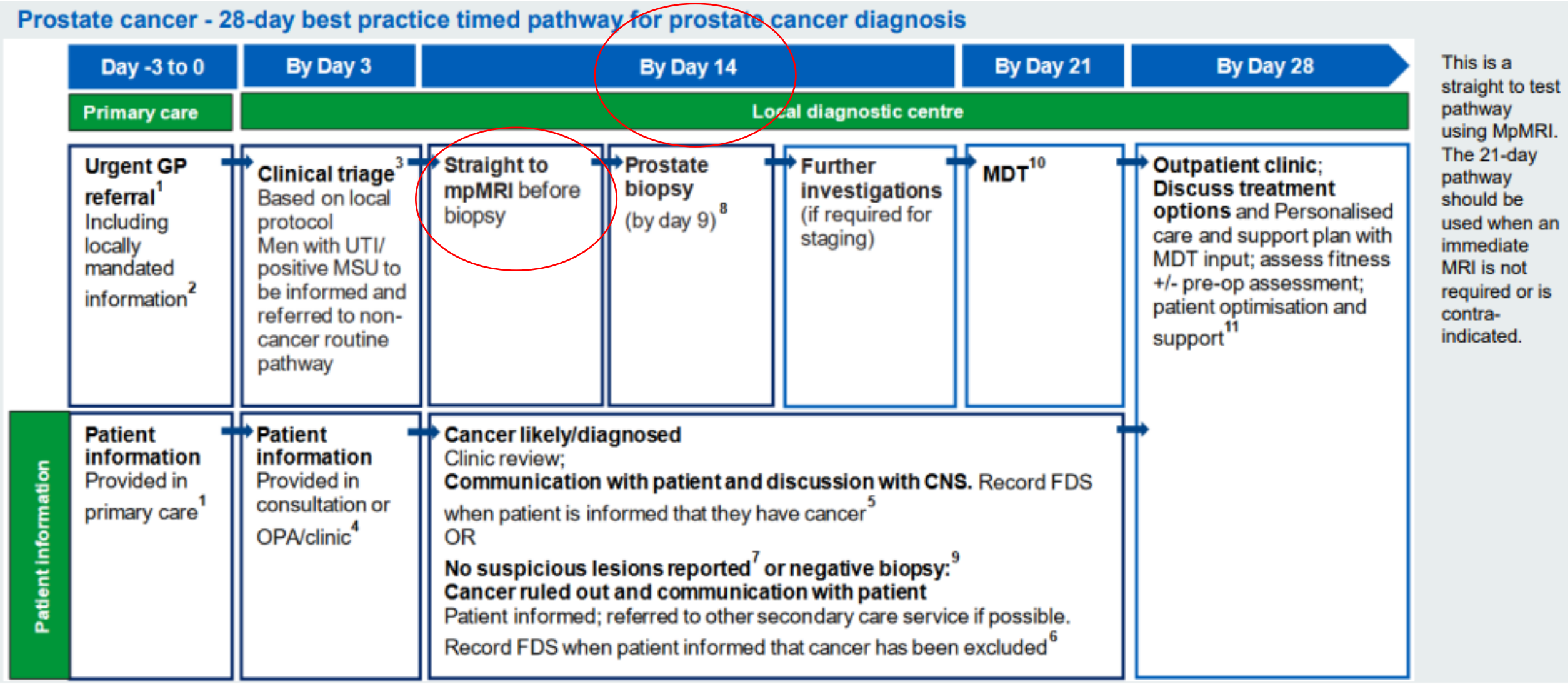
31 Day Treatment Standard

Start treatment within 31 days of a decision to treat (96%)

62 Day Treatment Standard

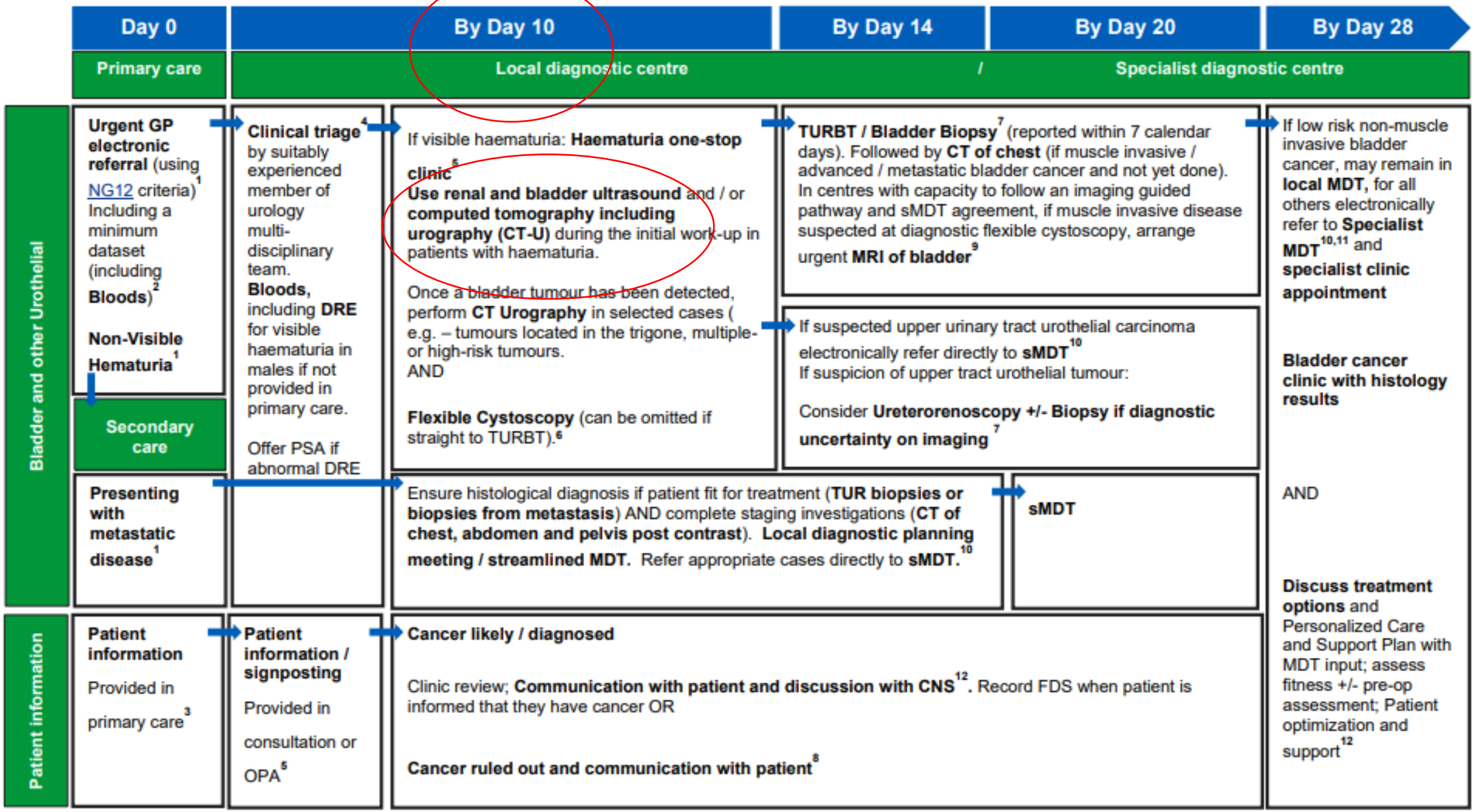
Commence treatment within 62 days of being referred (85%)

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

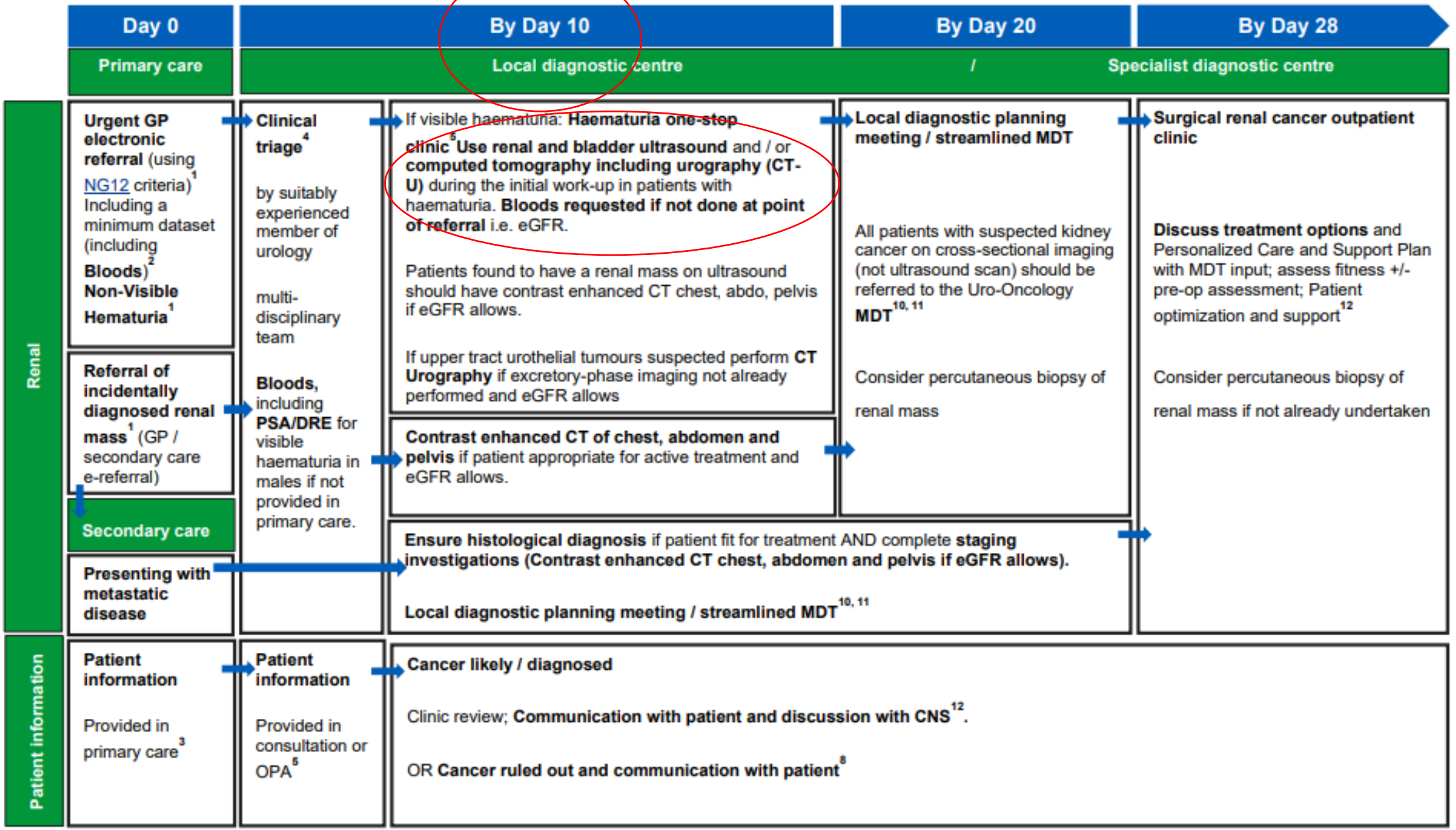


This is a straight to test pathway using MpMRI. The 21-day pathway should be used when an immediate MRI is not required or is contra-indicated.

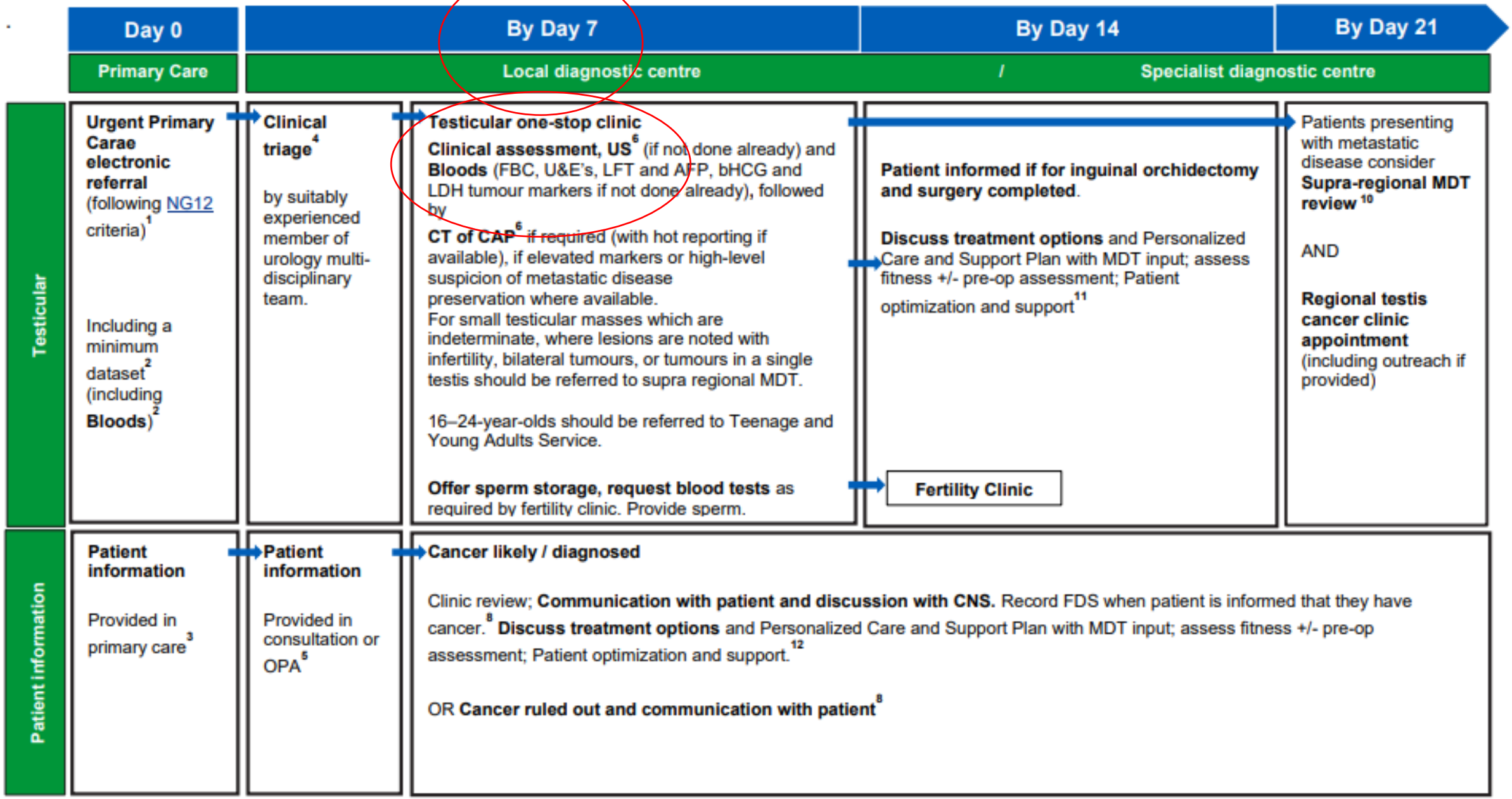
Bladder best practice timed pathway



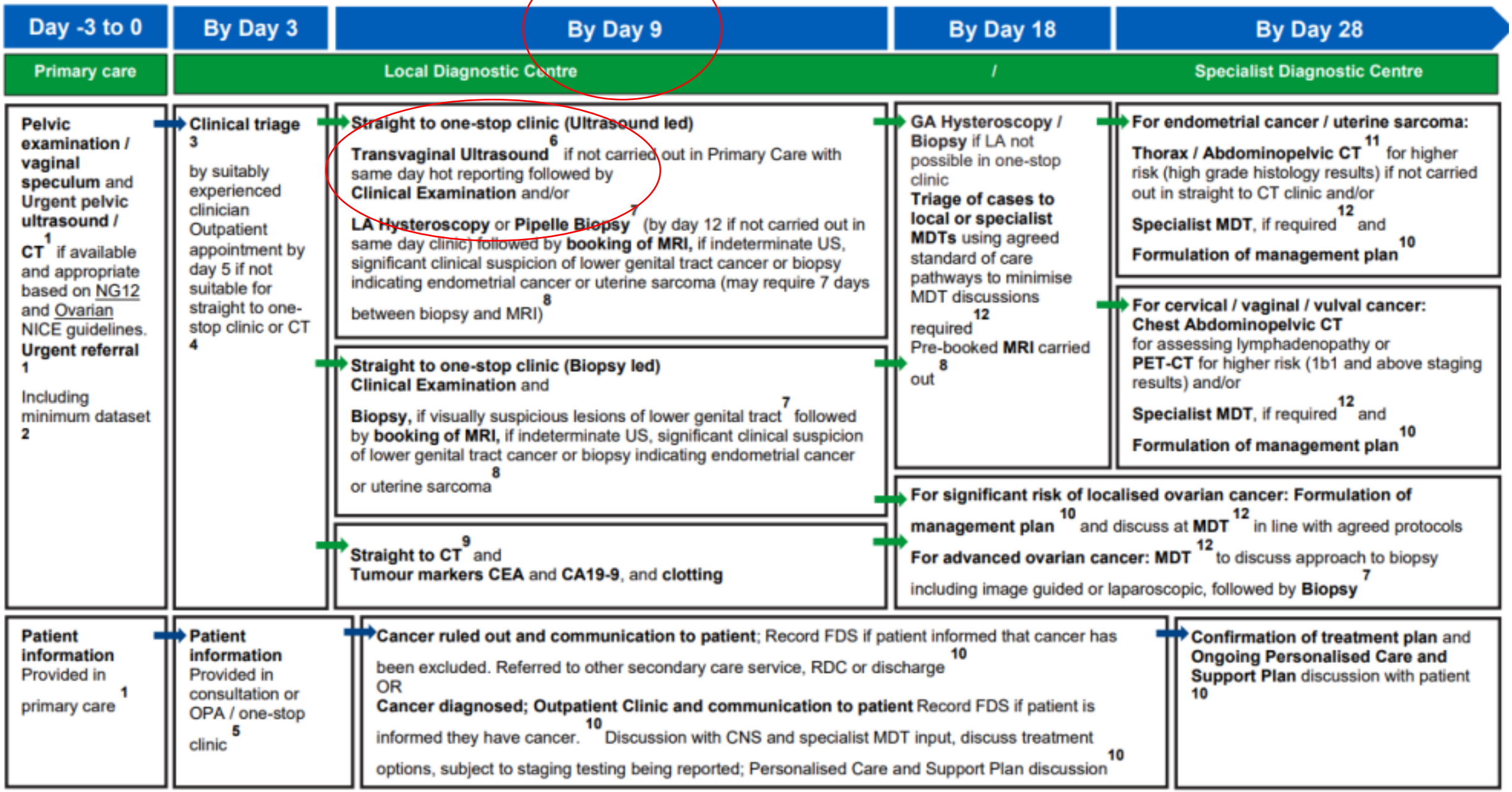
Renal best practice timed pathway



Testicular best practice timed pathway



Gynaecology



Need for speed?

Figure 3: deaths from cancer (per 100,000 inhabitants), OECD countries, 2020

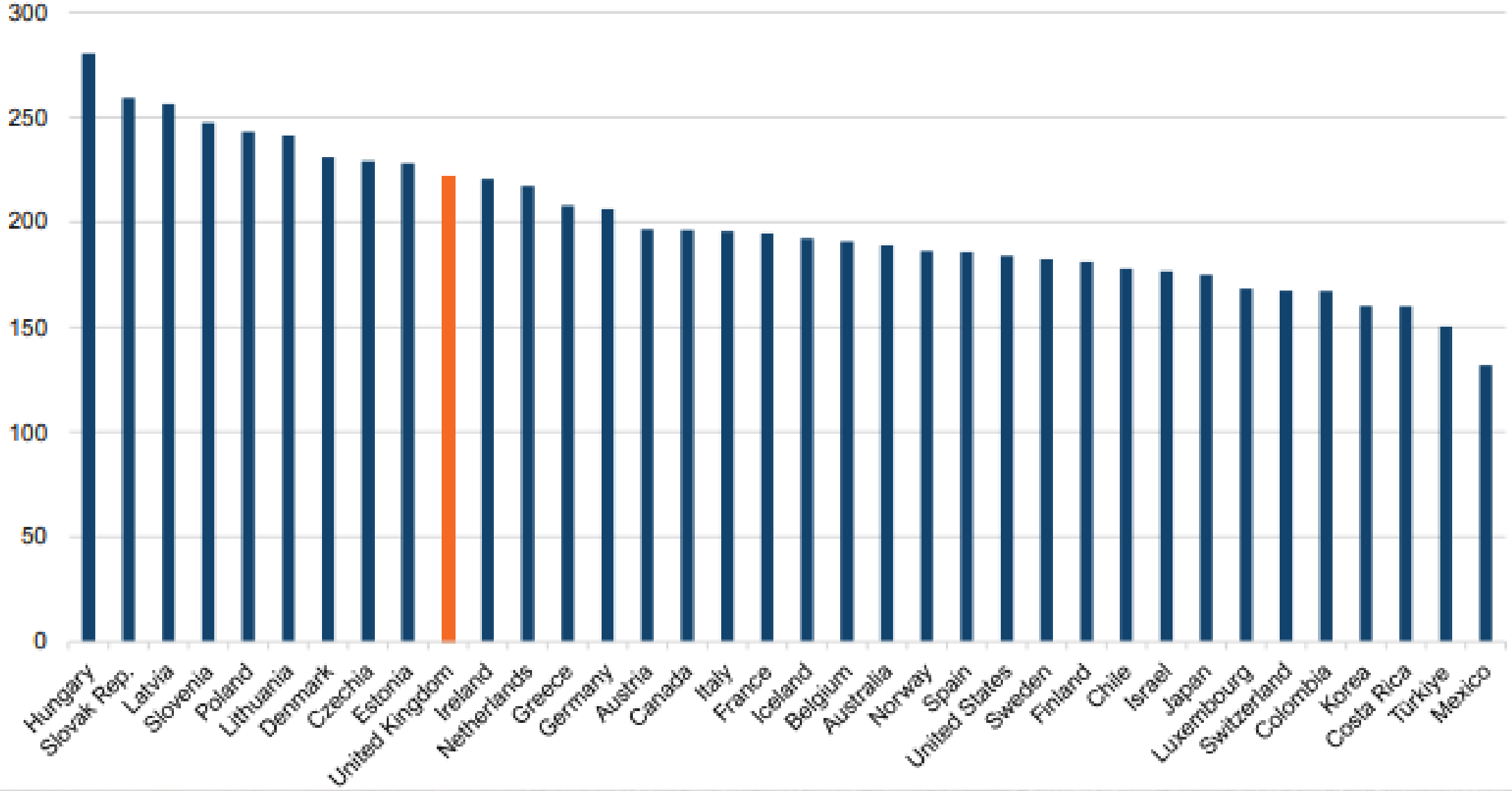
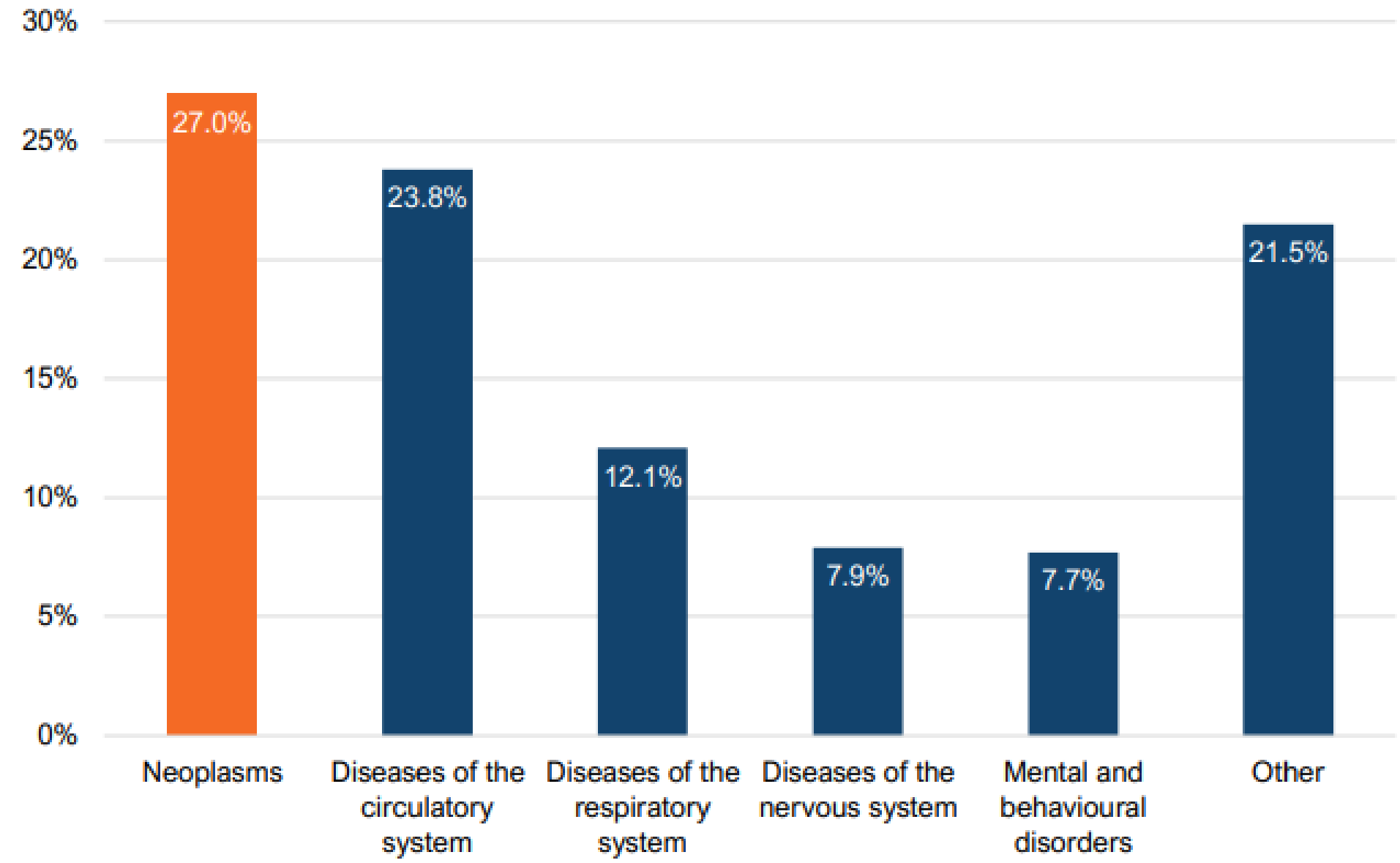


Figure 7: most common causes of death as a proportion of all deaths, 2024, England



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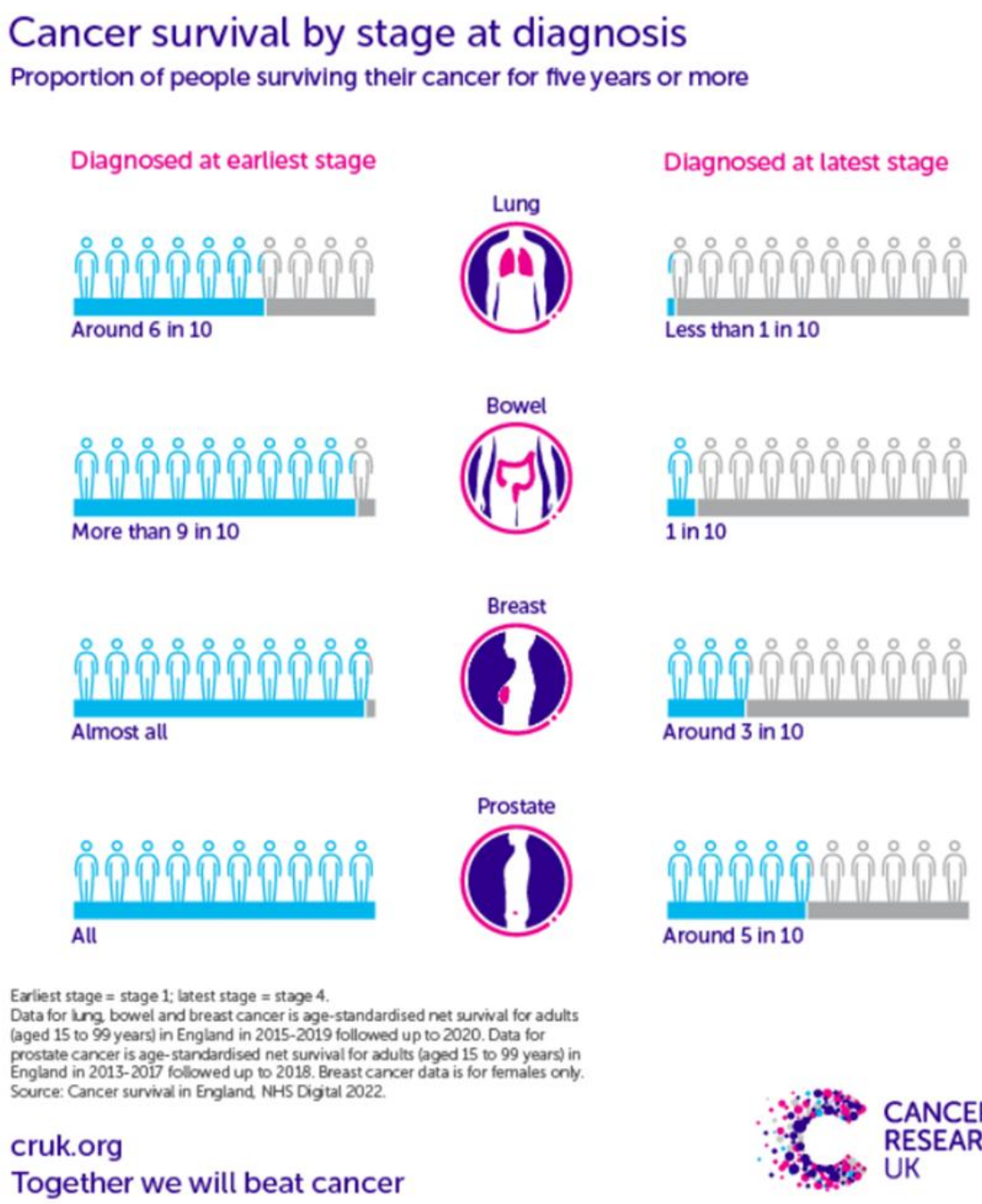
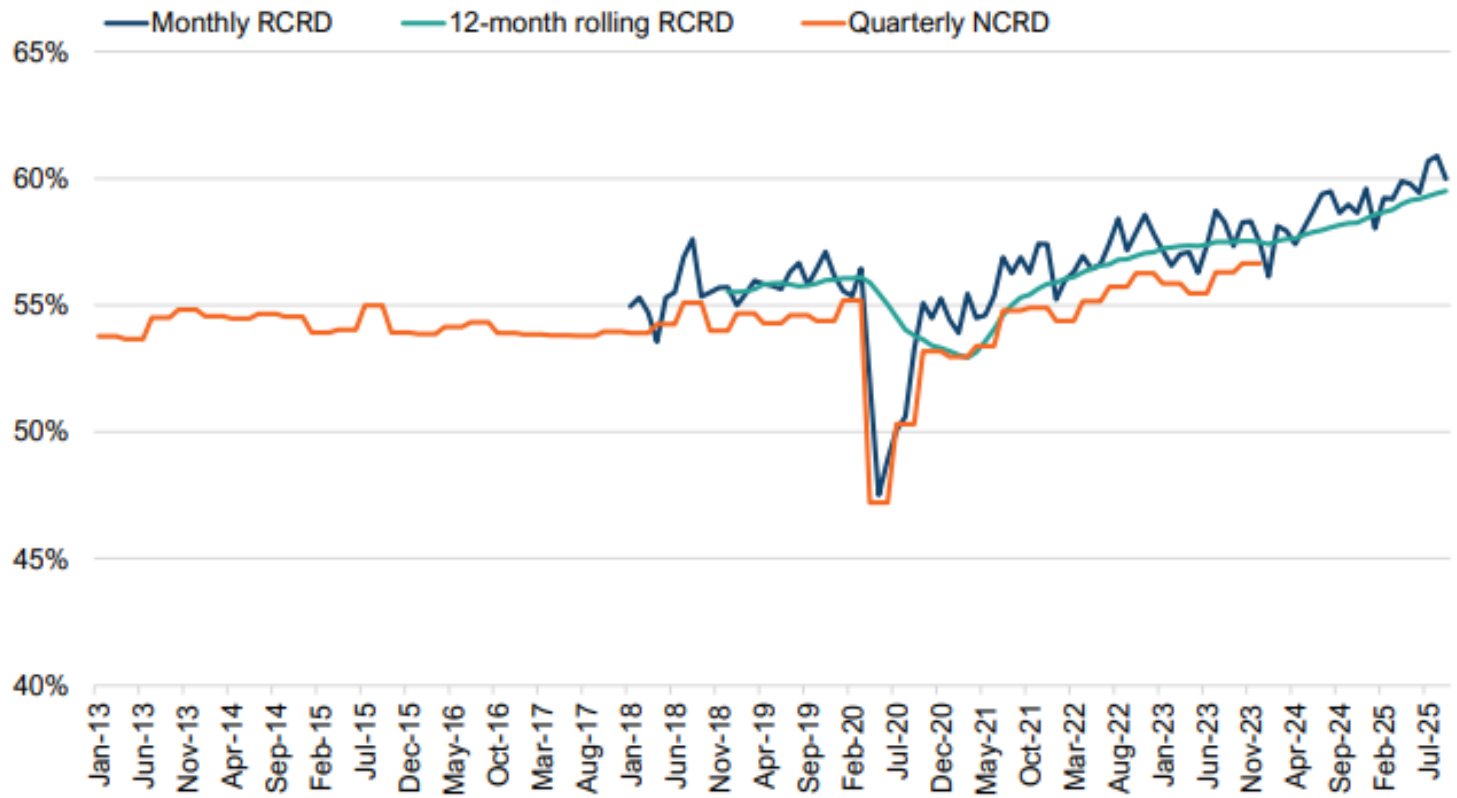
5 year survival significantly increased at early stage

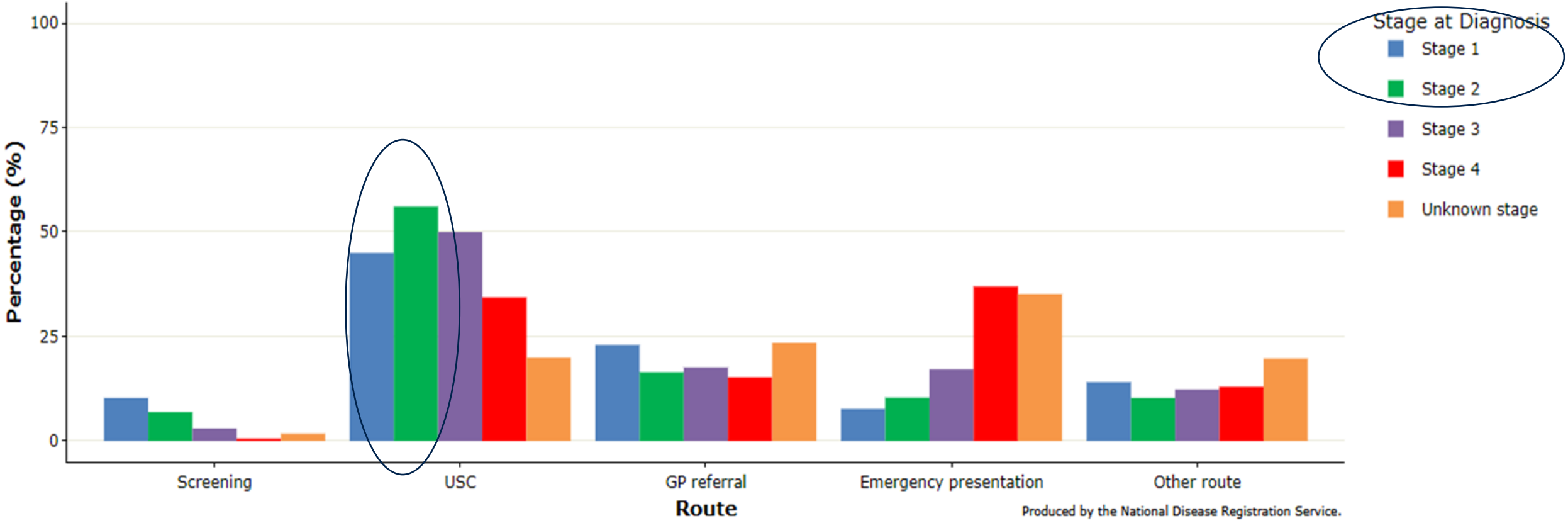


Early diagnosis rates in 2024 and 2025 have been at their highest ever level.

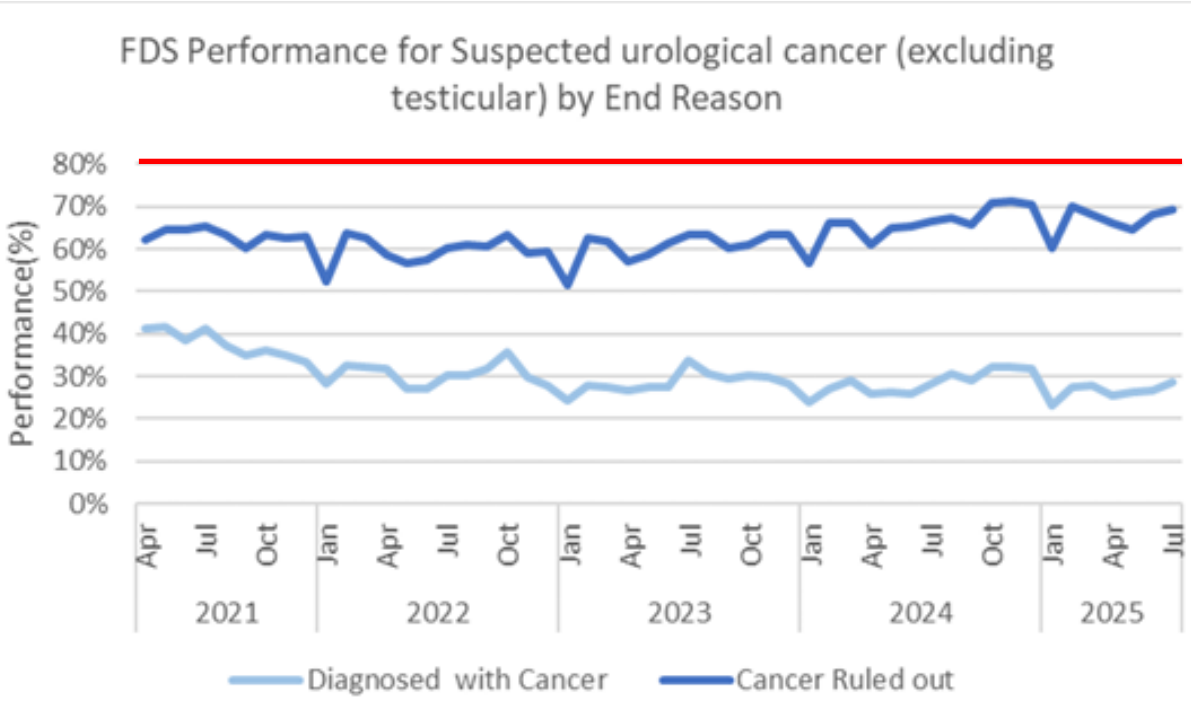
Around 10,000 more people diagnosed at stages 1 and 2 since FDS became a performance target

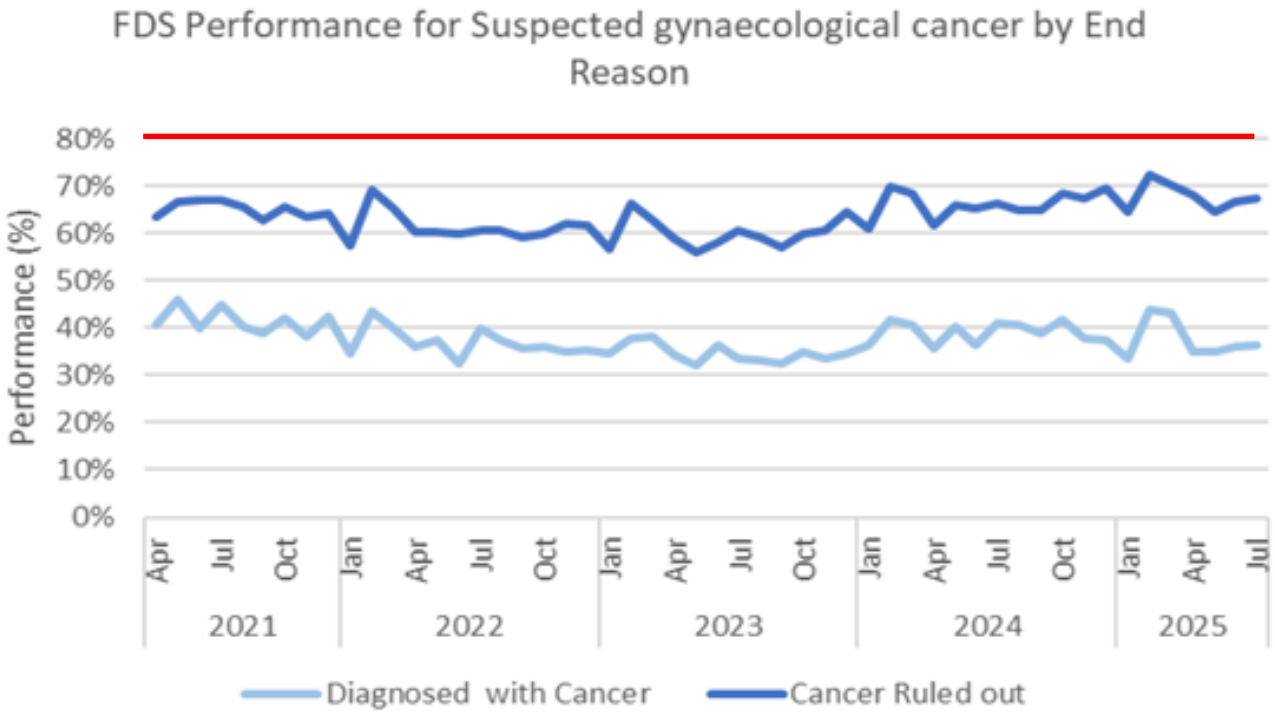
Figure 9: proportion of rapid cancer registrations (RCRD) and full cancer registrations (NCRD) diagnosed at stage 1 and 2, January 2013 to September 2025, England




100
75
50
25
0
Percentage (%)
Screening
USC
GP referral
Emergency presentation
Other route
Route
Stage at Diagnosis
Stage 1
Stage 2
Stage 3
Stage 4
Unknown stage
Produced by the National Disease Registration Service.


EXCELLENT!





[Cancer Waiting Time Statistics: Faster Diagnosis Standard: Statistics on End Reason]

Can we do more?

Sonographer led services

In our trust sonographers play a key role in achieving FDS

Sonographer role extension has been an underpinning part of the expansion of radiology services for over three decades.

Widely supported by radiologists and referring clinicians alike.

Evidence suggests they can provide holistic care, cut waiting times, ease staff pressures and increase job satisfaction.

Considerations

- Education and Training for your staff/team
- Protocols for training and competent sonographers
- Who will be the clinical lead and gold standard?
- Safety Considerations – written consent required etc.
- Are PGDs required?
- **Patients Journey through the system**
- Patient Information Leaflets
- Audit


NHS
SONOGRAPHER

Sonographer led services Hull

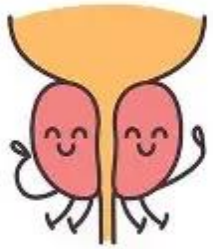
- Rapid Diagnostic Service
- Haematuria
- Prostate cancer
- Testicular cancer
- Ovarian cancer
- HCC (in development)

Hull urology cancer performance Sept 23 – Sept 24:

Diagnosis or cancer ruled out within 28 days of referral
53.8% (75%) informed by day 28

One month (31-day) wait from diagnosis to first definitive treatment:
71.6% (96%) of people treated for urological cancers began first definitive treatment within 31 days of receiving their diagnosis

Two month (62-day) wait from urgent referral to first definitive treatment:
35.8% (85%) of people treated for urological cancers received first definitive treatment within 62 days of being referred



Haematuria

Haematuria – Traditional Pathway

Humber Health Partnership

Various route referral into urology

*Urology GIRFT recommended pathway**

One stop clinic – ultrasound & cystoscopy*

60% were found to be normal

High risk patients have additional CT Urogram

40% were having a CT examination, regardless of the ultrasound findings

Long waits to enter clinics to find out treatment options

Return for CT staging if bladder cancer found

6% cancer detection rate on whole pathway

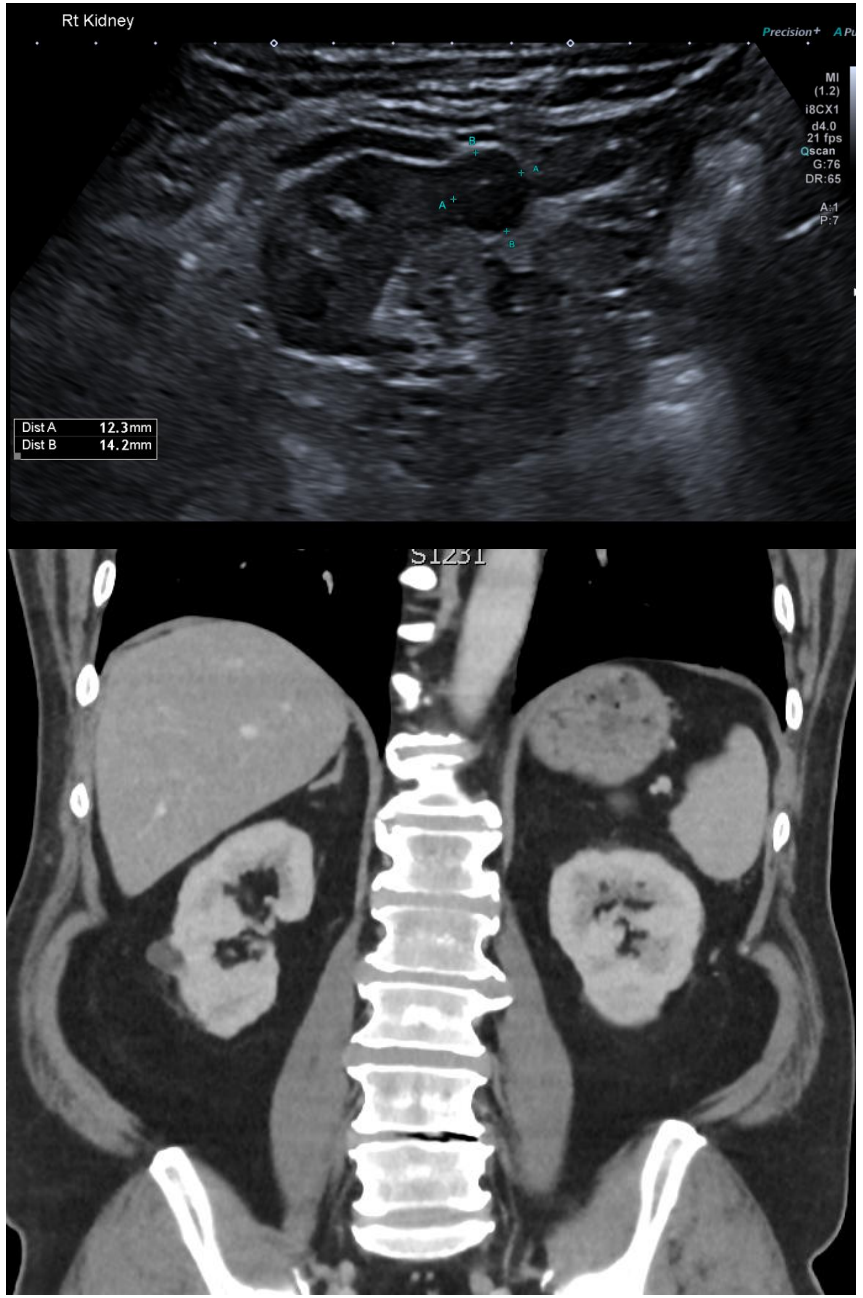
One-stop US imaging capacity

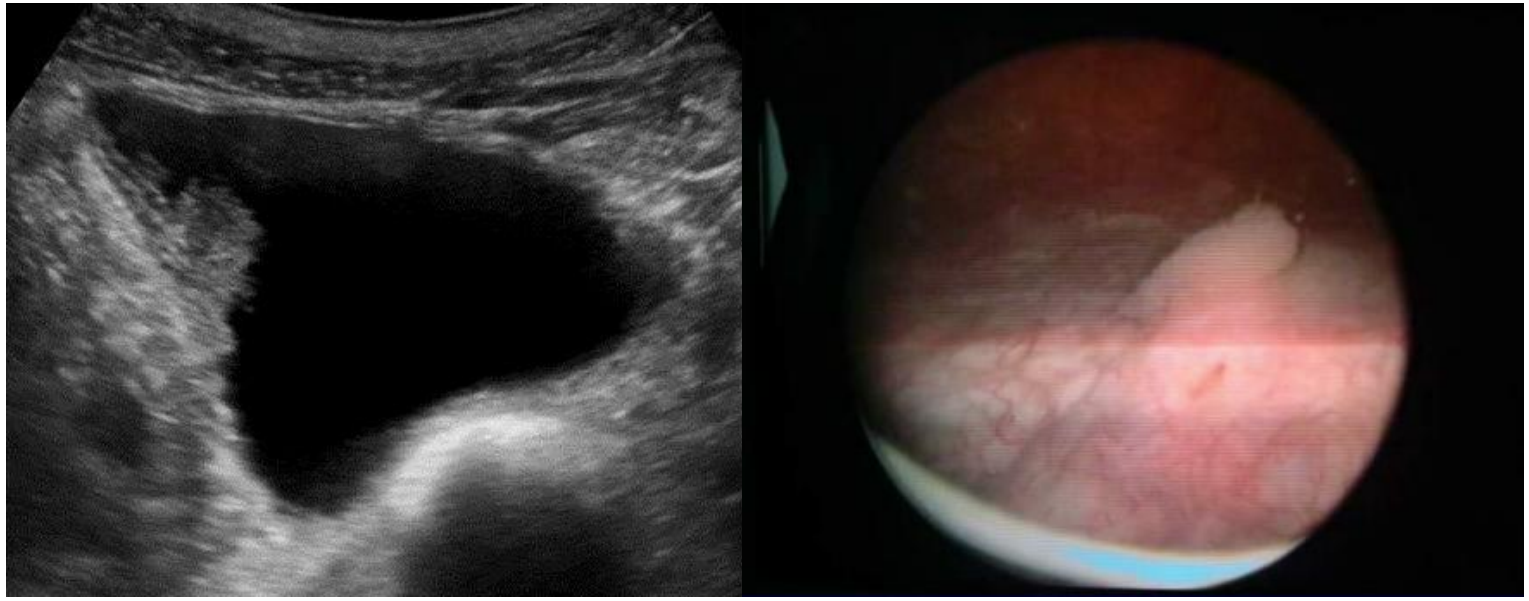
	Number of lists	Number of patients	
Potential capacity	26	312	
Lists cancelled by Urology including bank holidays	5	60	These spaces were back filled by general US patients
Lists not filled but ultrasound not informed	4	48	Some slots backfilled by ultrasound when became aware no clinic patients booked- This is dependent on clerical staff being available to contact patients by phone.
Actual slots used by Urology	17	204	
Patients booked		134	
Patients attended		101	
% potential capacity used		32.3%	

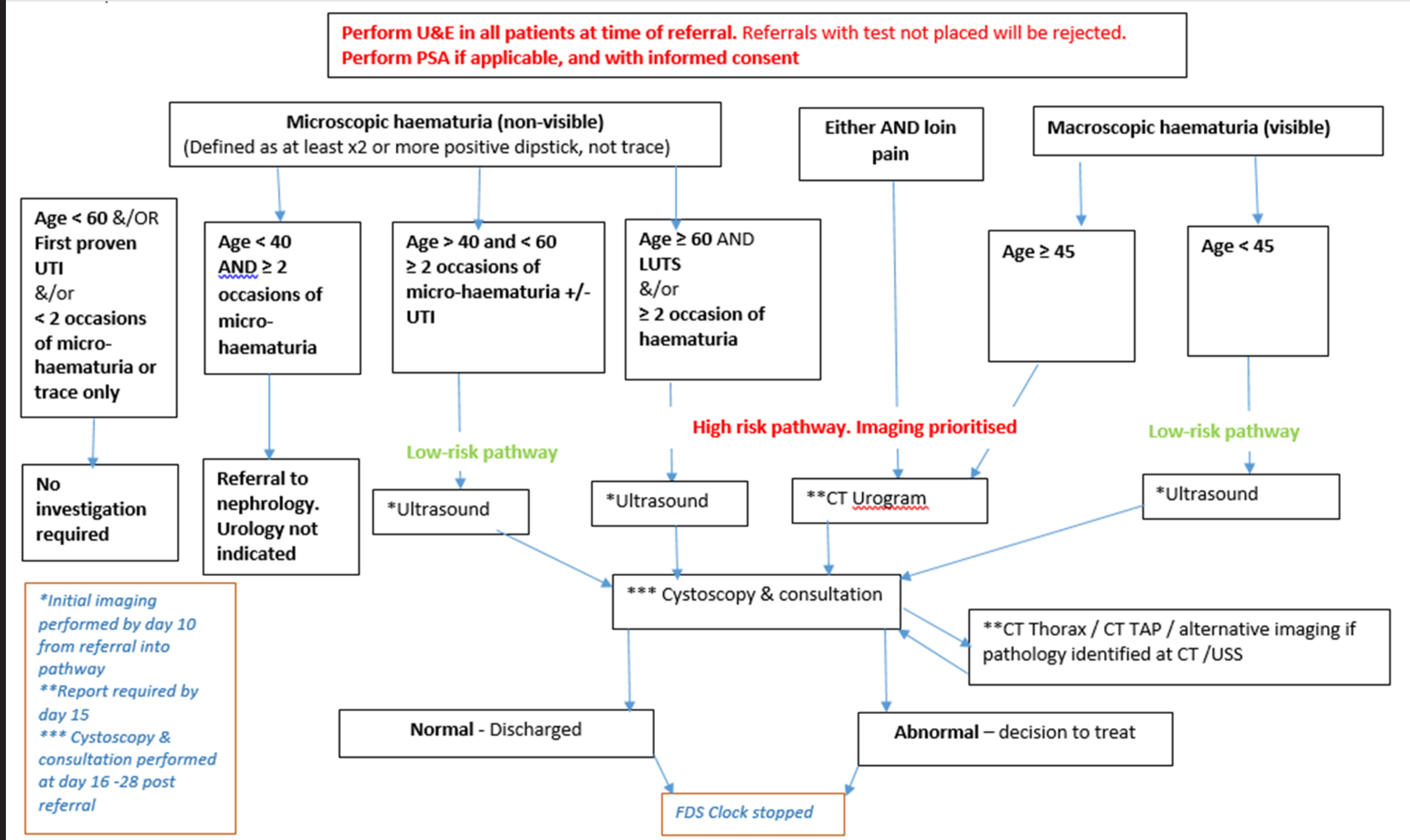
Traditional one stop

Actually, is the ultrasound needed?

And is a one stop the right way forward?






Perform U&E in all patients at time of referral. Referrals with test not placed will be rejected.
Perform PSA if applicable, and with informed consent
Microscopic haematuria (non-visible)
(Defined as at least x2 or more positive dipstick, not trace)
Either AND loin pain
Macroscopic haematuria (visible)
Age < 60 &/OR First proven UTI &/or < 2 occasions of micro-haematuria or trace only
Age < 40 AND ≥ 2 occasions of micro-haematuria
Age > 40 and < 60 ≥ 2 occasions of micro-haematuria +/- UTI
Age ≥ 60 AND LUTS &/or ≥ 2 occasion of haematuria
Age ≥ 45
Age < 45
High risk pathway. Imaging prioritised
Low-risk pathway
Low-risk pathway
No investigation required
Referral to nephrology. Urology not indicated
*Ultrasound
*Ultrasound
**CT Urogram
*Ultrasound
*** Cystoscopy & consultation
**CT Thorax / CT TAP / alternative imaging if pathology identified at CT /USS
Normal - Discharged
Abnormal – decision to treat
FDS Clock stopped
**Initial imaging performed by day 10 from referral into pathway*
***Report required by day 15*
**** Cystoscopy & consultation performed at day 16 -28 post referral*

Haematuria – New Pathway

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One route into urology
Haematuria DOS

Cystoscopy arranged at same time as first consultation in urology

This date then placed onto radiology request

Imaging arranged prior to cystoscopy allowing time for reporting

Decision to treat/decision to discharge given at cystoscopy appointment

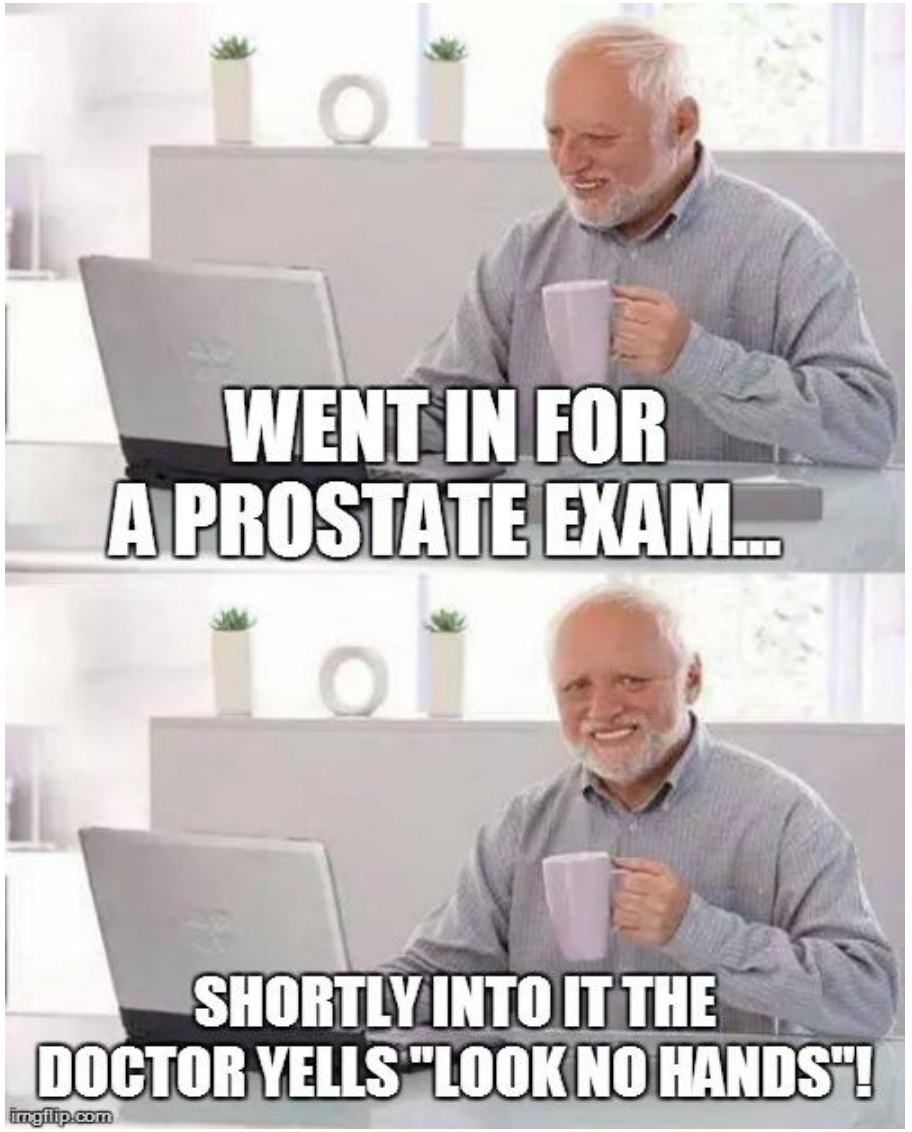
FDS pre pathway changes

Referral → patient informed of results = 65 day average

FDS post pathway changes

Referral → patient informed of results = 25 day average

Suspected Prostate Cancer



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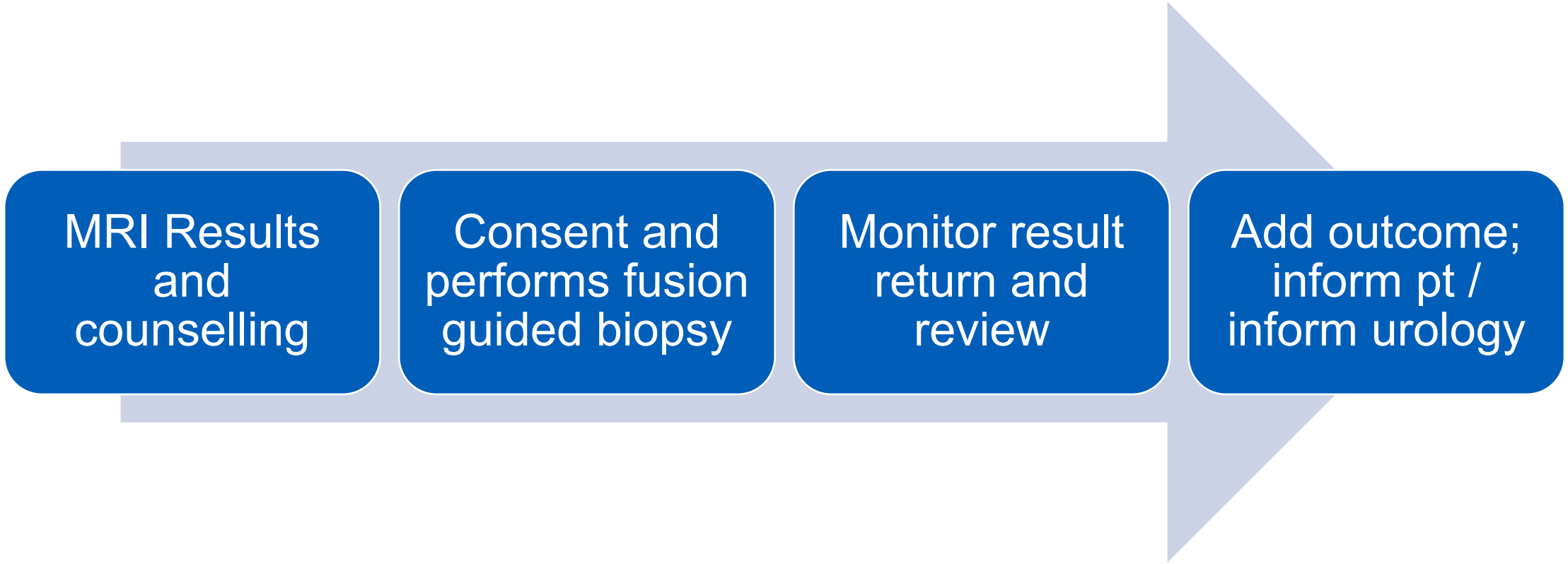
Sonographer role in PCa pathway



Prostate Outcomes

- Histology results emailed to prostate trackers
- Prostate trackers contact sonographer who performed biopsy
- Sonographer reviews histology, places outcome onto report & informs patient if benign
- Outcome emailed to urology & trackers
- Clock stopped if benign. MDT discussion if abnormal

Outcome Code	Description	Histology	Action
RPP1 Outcome1	Prostate Cancer	Gleason 3+3 and above	MDT discussion or clinical review
RPP 2 Outcome 2	Clinically significant Benign disease	High Grade PIN, ASAP	Not for MDT but follow up in urology. **Sonographer contacts patient with results.** Contact recorded and 2ww clock stopped
RPP 3 Outcome 3	Disparity between MRI and biopsy. ie PIRADS 4 and 5 on MRI	High Grade PIN, ASAP or benign disease	MDT Discussion required **Sonographer contacts patient with results.** Contact recorded and 2ww clock stopped
RPP 4 Outcome 4	Clinically insignificant Benign disease. (Includes low grade PIN, acute inflammation and prostatitis)		Not for MDT. **Sonographer contacts patient with results.** Contact recorded and 2ww clock stopped.

Prostate Summary

FDS pre pathway changes

- Referral → patient informed of results
- 48 day average if positive
- 69 day average if benign

FDS post pathway changes

- Referral → patient informed of results = 27 day average

Prostate cancer performance

Diagnosis or cancer ruled out within 28 days of referral

88.1% (80%) informed by day 28

One month (31-day) wait from diagnosis to first definitive treatment:

80.9% (96%) of people treated for urological cancers began first definitive treatment within 31 days of receiving their diagnosis

Two month (62-day) wait from urgent referral to first definitive treatment:

68.1% (85%) of people treated for urological cancers received first definitive treatment within 62 days of being referred

Suspected Testicular Cancer

GP Pathway

NHS
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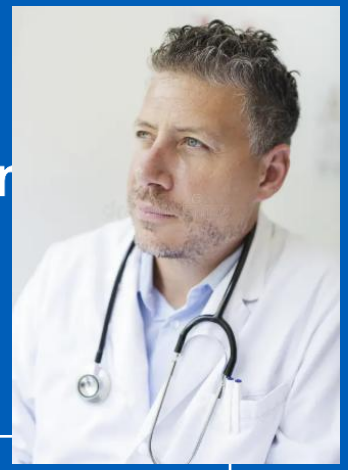
Man finds lump → Man waits & hopes it will go away → Man 'fesses up and goes to GP → Man gets referred for scan → Referral details are questionable → Man has scan. It's abnormal → Man goes back to GP → Man gets referred to urology → Man gets seen → Surgery planned

Pathway ~ 66 days

Urology Pathway

Hur



Man finds lump → Man is sensible & goes to GP → GP Sensible. Man gets referred to urology → Urologist is nice, sonographers like him → Patient has scan same day → Man has scan. It's abnormal → Man goes back to see lovely urologist → Surgery planned

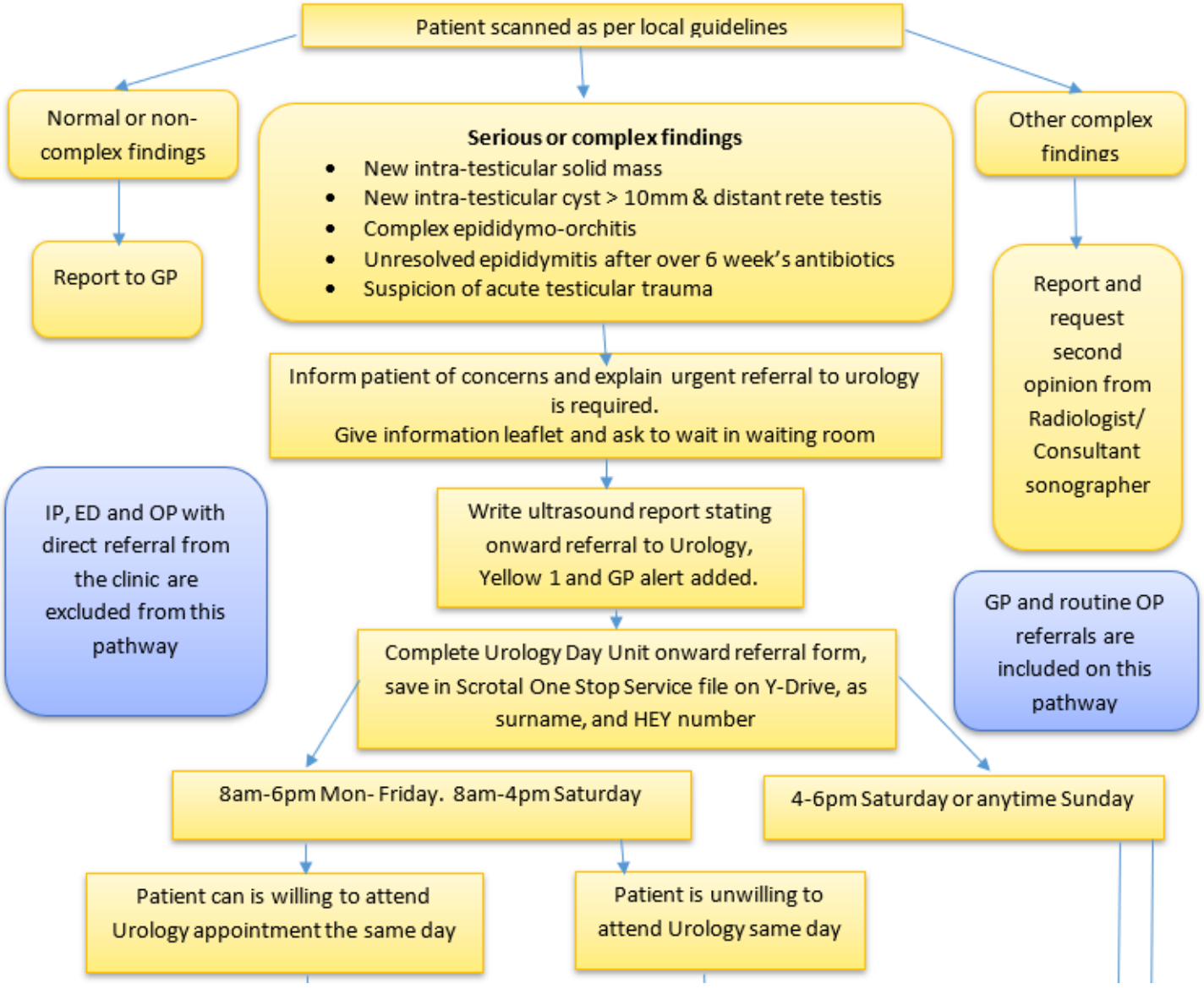
Common referral to treatment pathway 20 days

Pathway considerations:

- Direct to urology is clinician and patient dependent
- Clinical information on US referral triage
  - Routine – 42 days (or more)
  - Urgent < 7 days
- Alert of US report; does it get read?
- Sonographers commonly faced with giving bad news
- Can we fast track?

Referrals from Primary

Flow Chart for Management of Incidental Significant and/or complex Scrotal Pathology



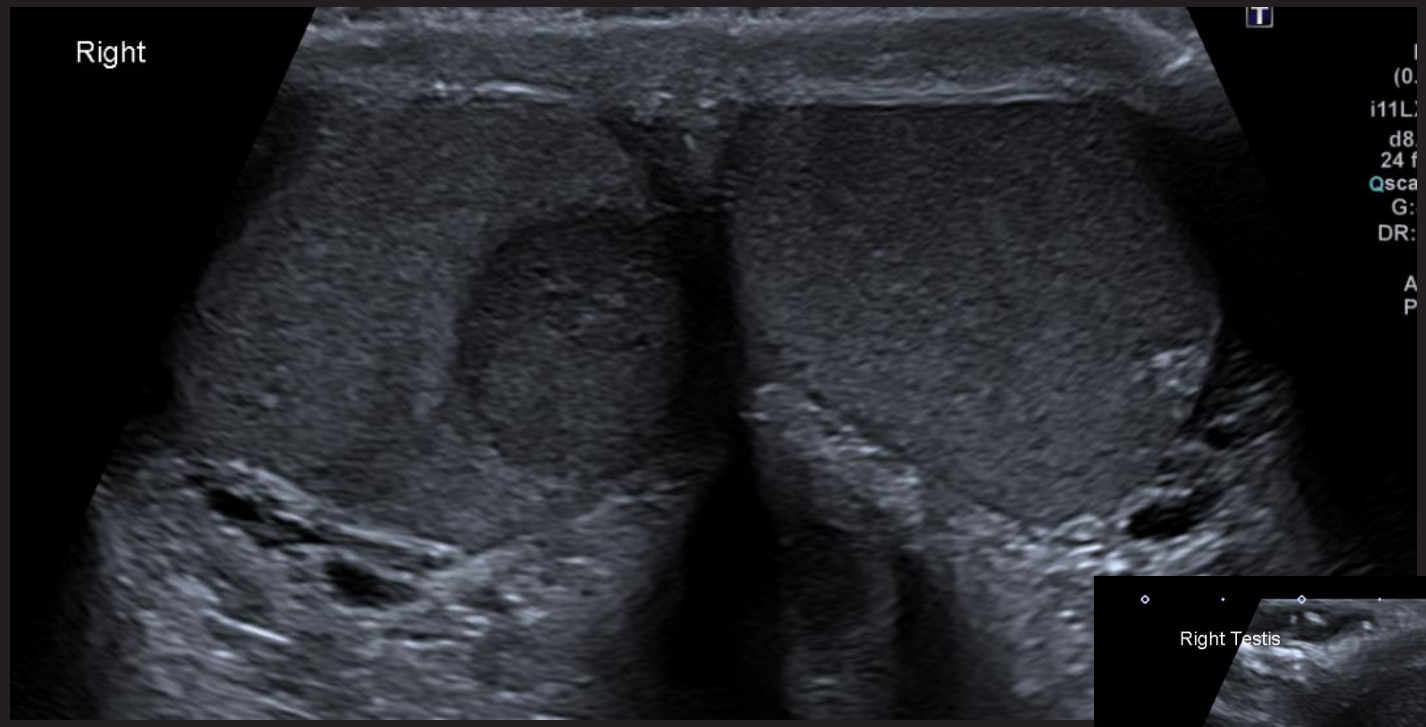
Testicular cancer pathway summary

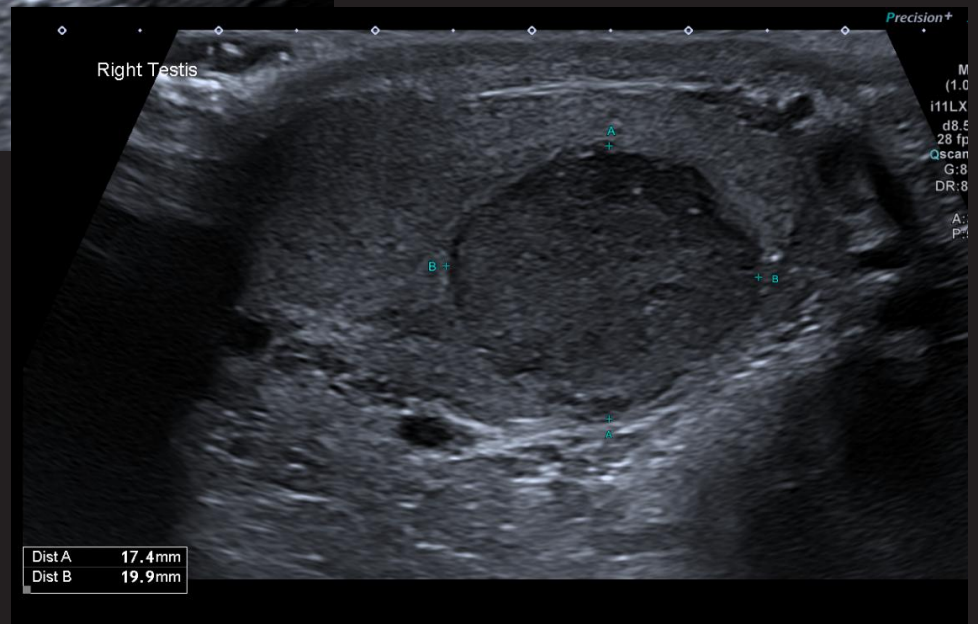
Humber Health Partnership

- **Motivator:** Unnecessary steps & delays in GP pathway
- **Concern:** patients having verbal results but delays in accessing GP appointments for discussion & onward referrals
- **Solution:** sonographer led onward referral process

- **Result:** Quicker access to management and support for patients

Case 2: 37 y/o. GP referral. Hard lump. Urgent scan at triage



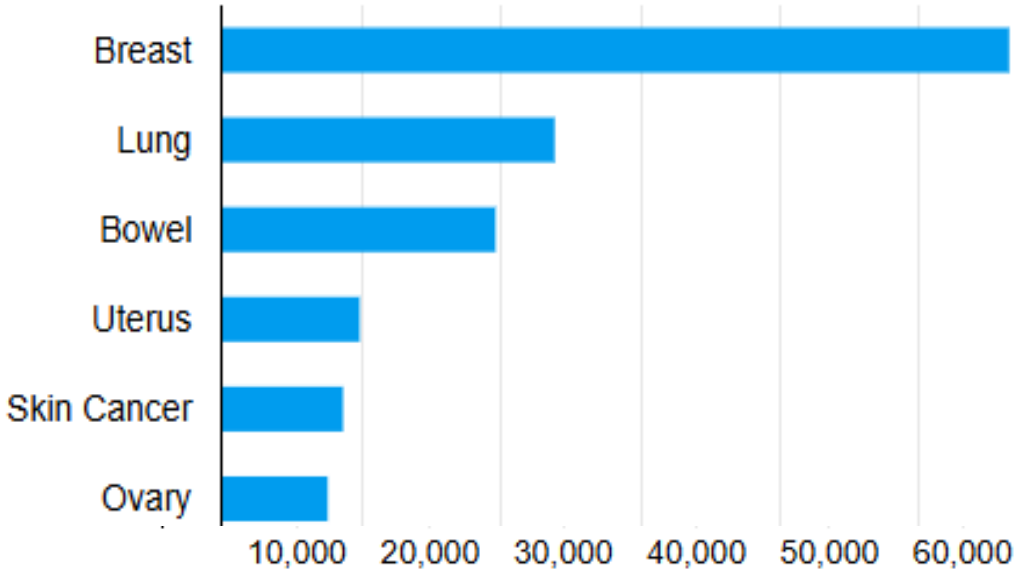


Mixed germ cell tumour

Referred from GP 13/10/2025. Scan, sonographer direct referred to urology day unit & patient seen 14/10/25, orchidectomy 25/10/2025

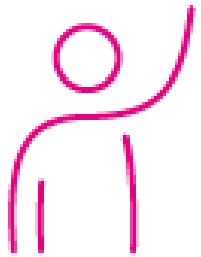
Total scan to treatment – 12 days

Suspected Ovarian Cancer



Survival

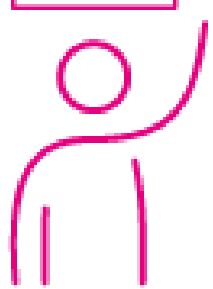
35%



Survive ovarian cancer for 10 or more years, 2013-2017, England

Survival

76%



Survive breast cancer for 10 or more years, 2013-2017, England

Survival

78%

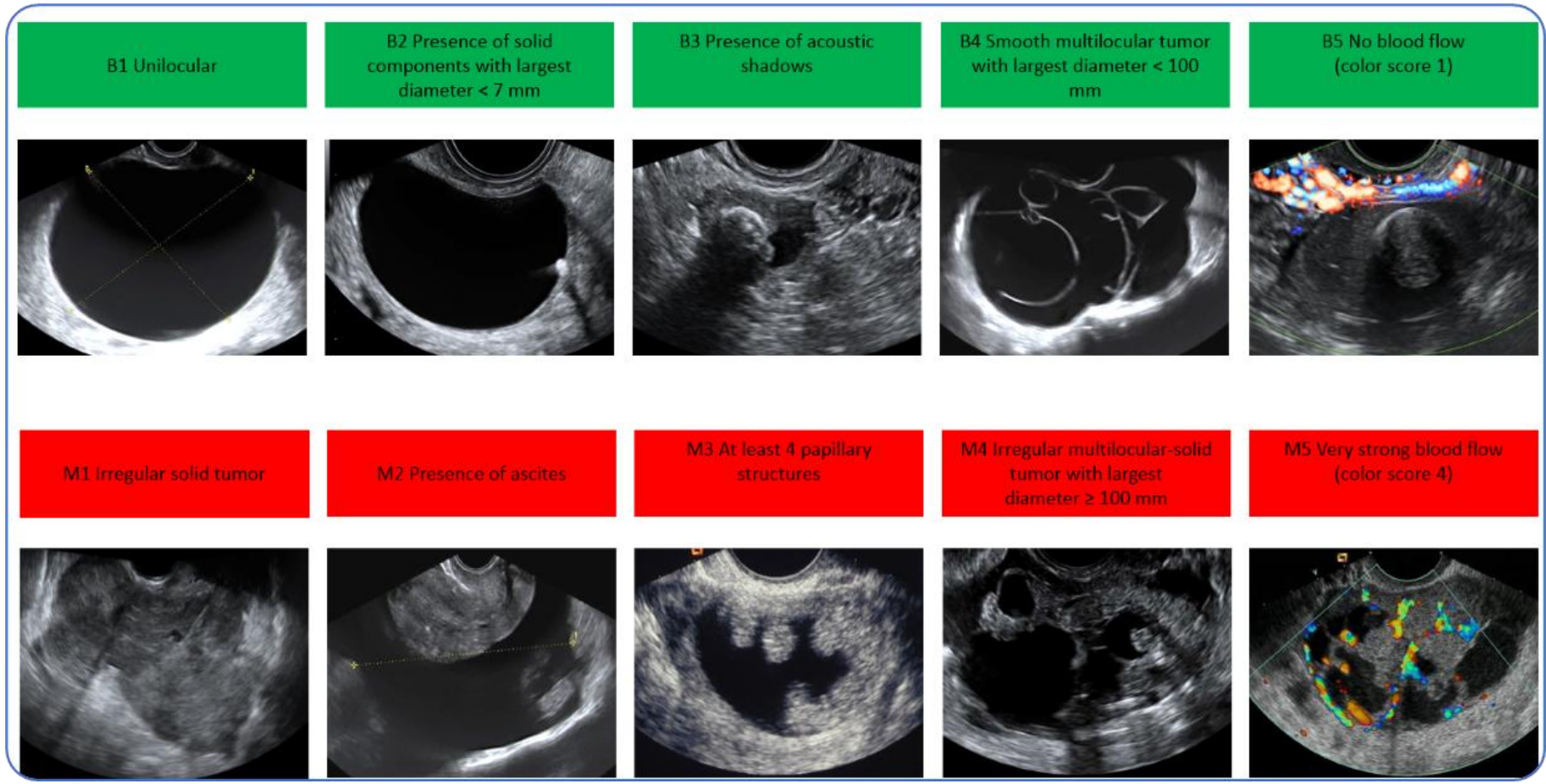
Survive prostate cancer for 10 or more years, 2013-2017, England

Suspected Ovarian Cancer – IOTA Simple Rules

When the simple rules applied conclusive in approximately 75% of adnexal masses (for malignant/benign

25% indeterminate

Unable to determine tumour subtype



ADNEX

Diagnostic risk prediction model

3 clinical predictors
6 ultrasound predictors

Estimates the risk of five tumour types

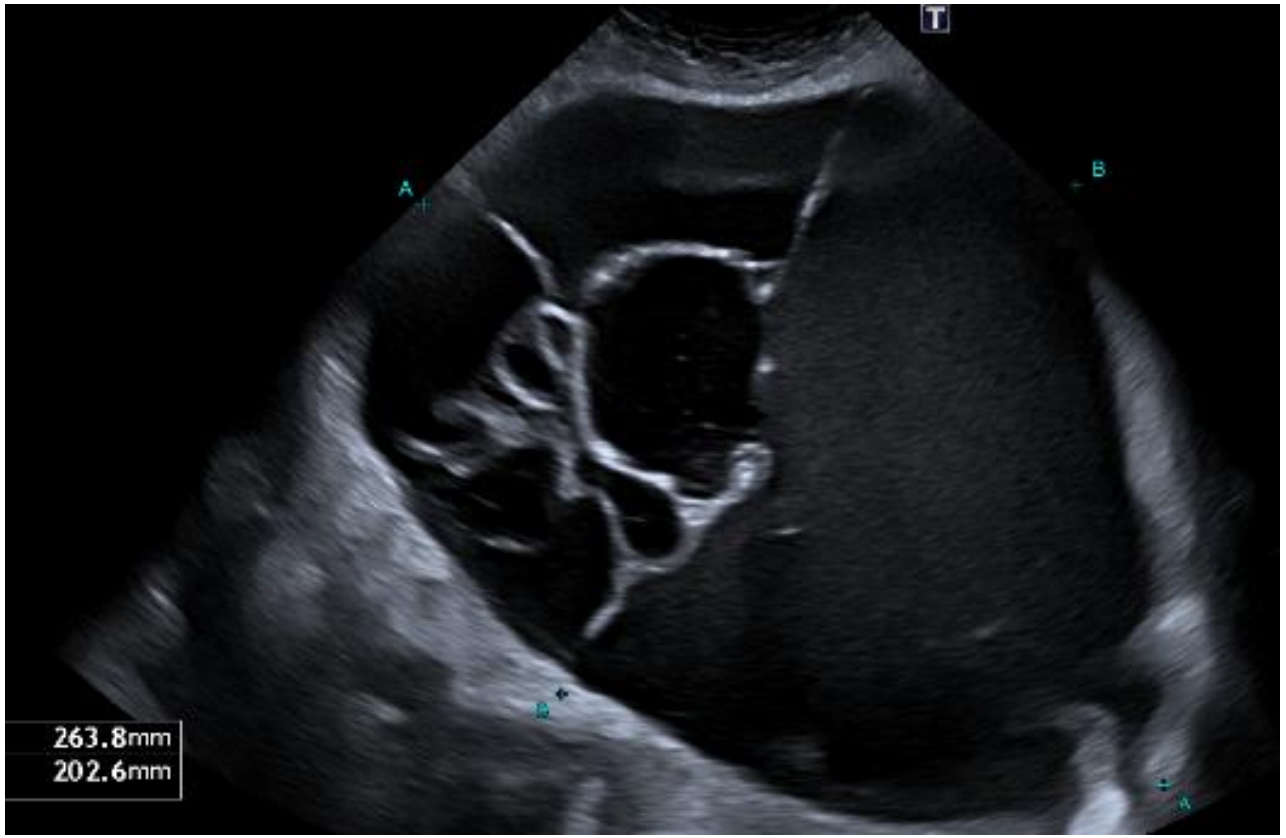
- Benign
- Borderline
- Stage I primary invasive
- Stage II-IV
- Metastatic

Clinical Predictors:

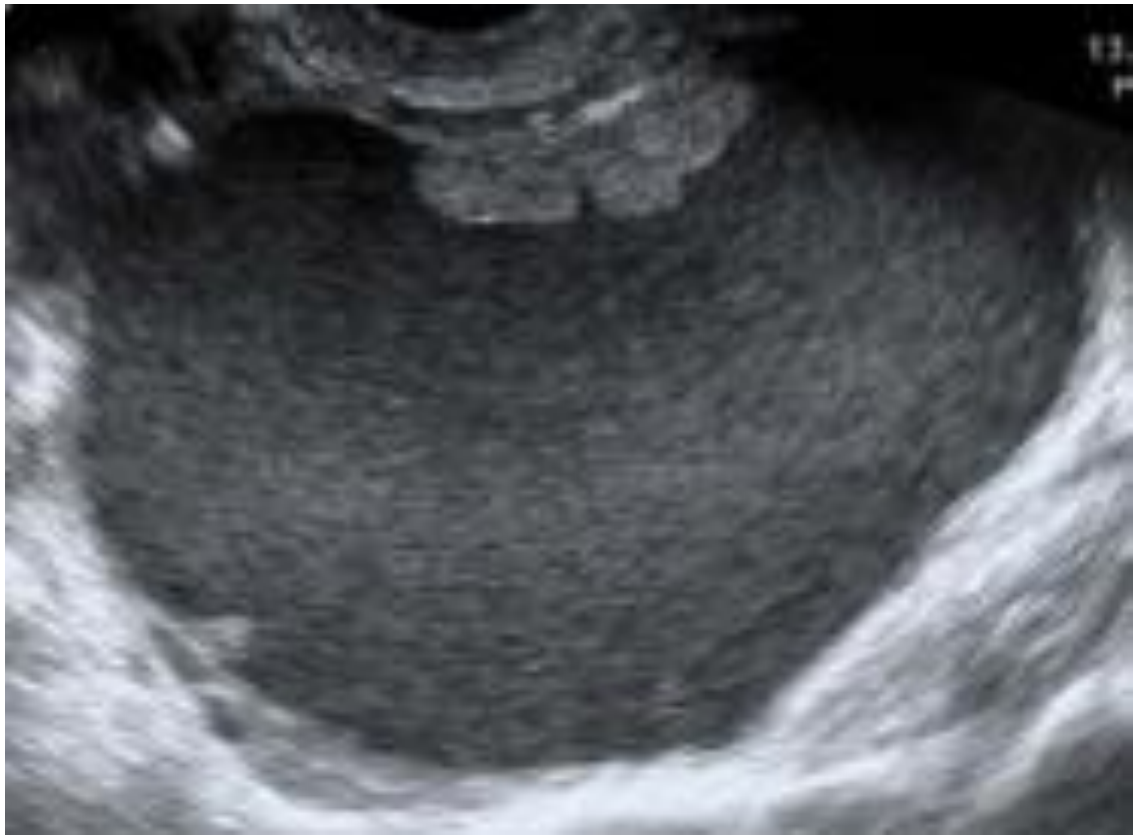
- Age (years)
- Serum CA-125 (U/mL)
- Type of centre to which the patient has been referred for ultrasound examination (i.e. oncology centre).

Ultrasound Predictors

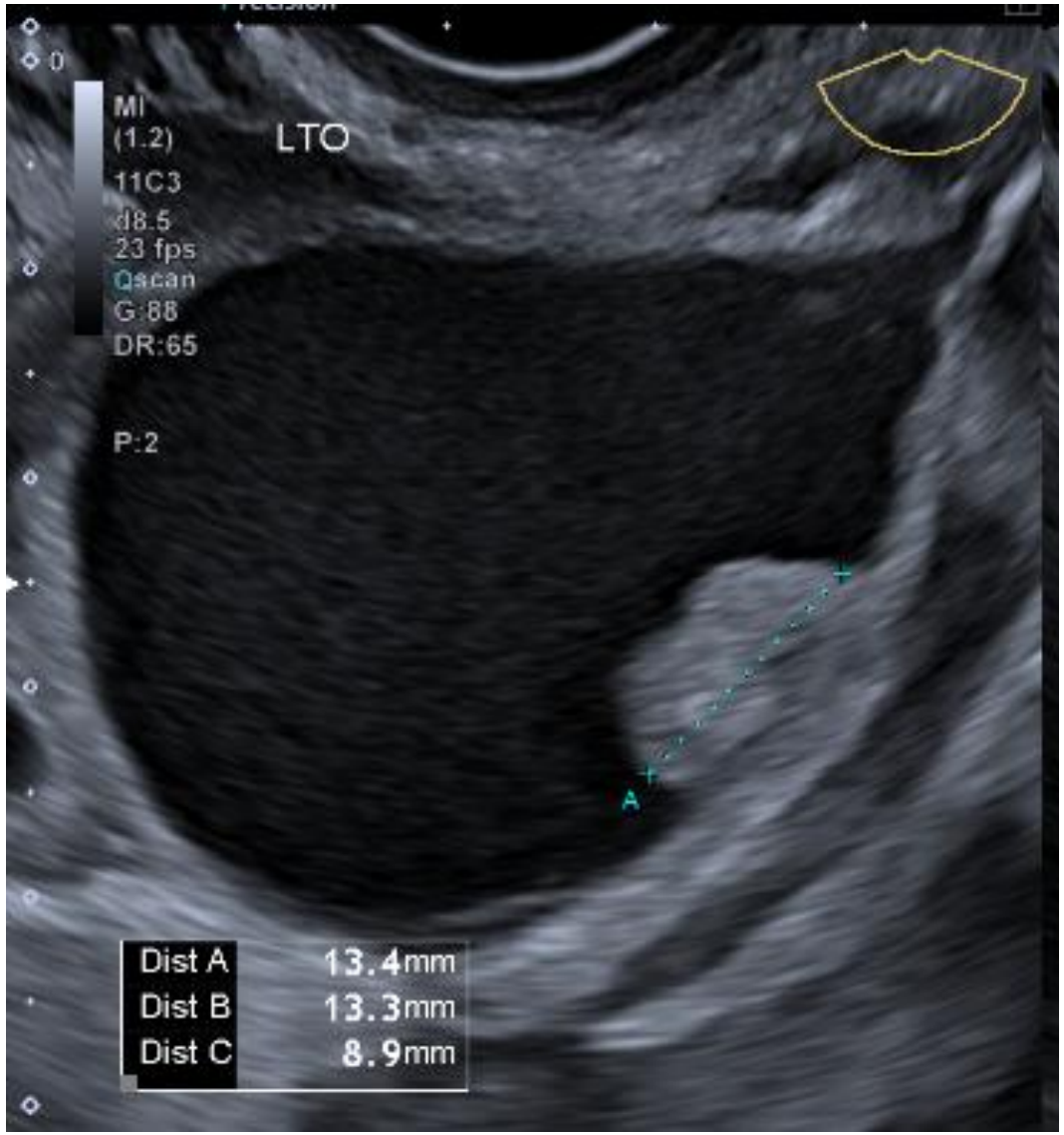
Maximal diameter of the lesion (mm)



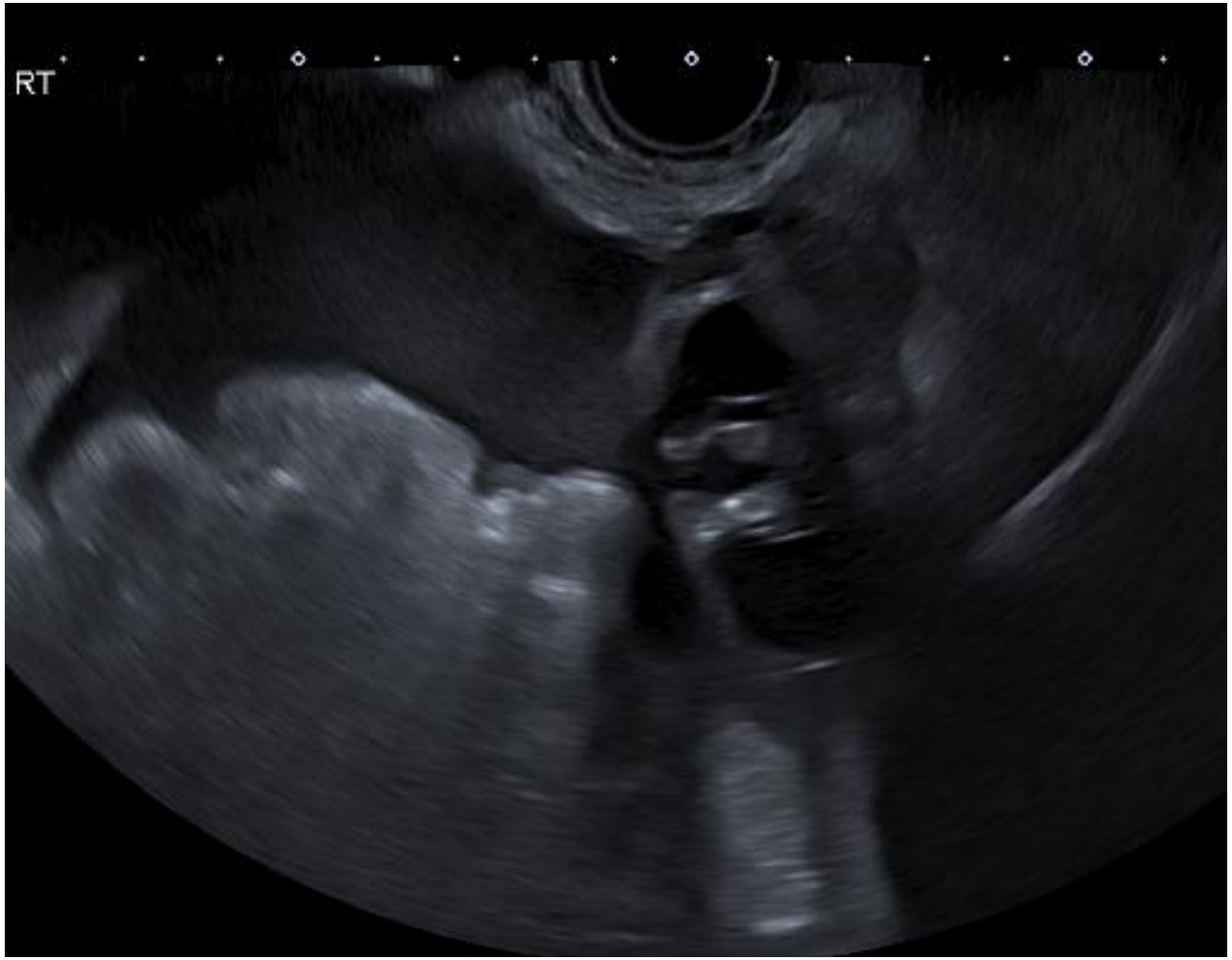
Number of papillary projections



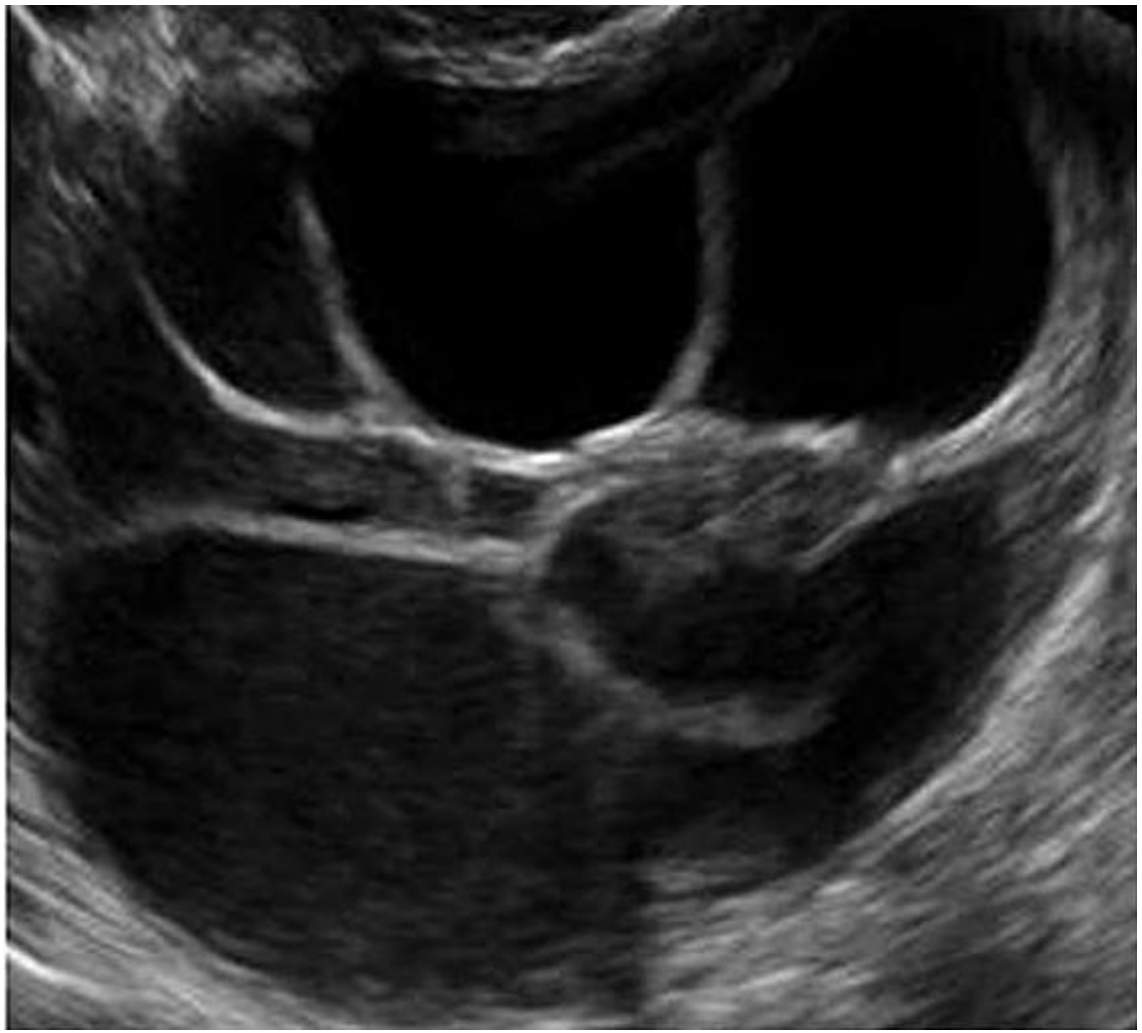
Maximum diameter of solid tissue



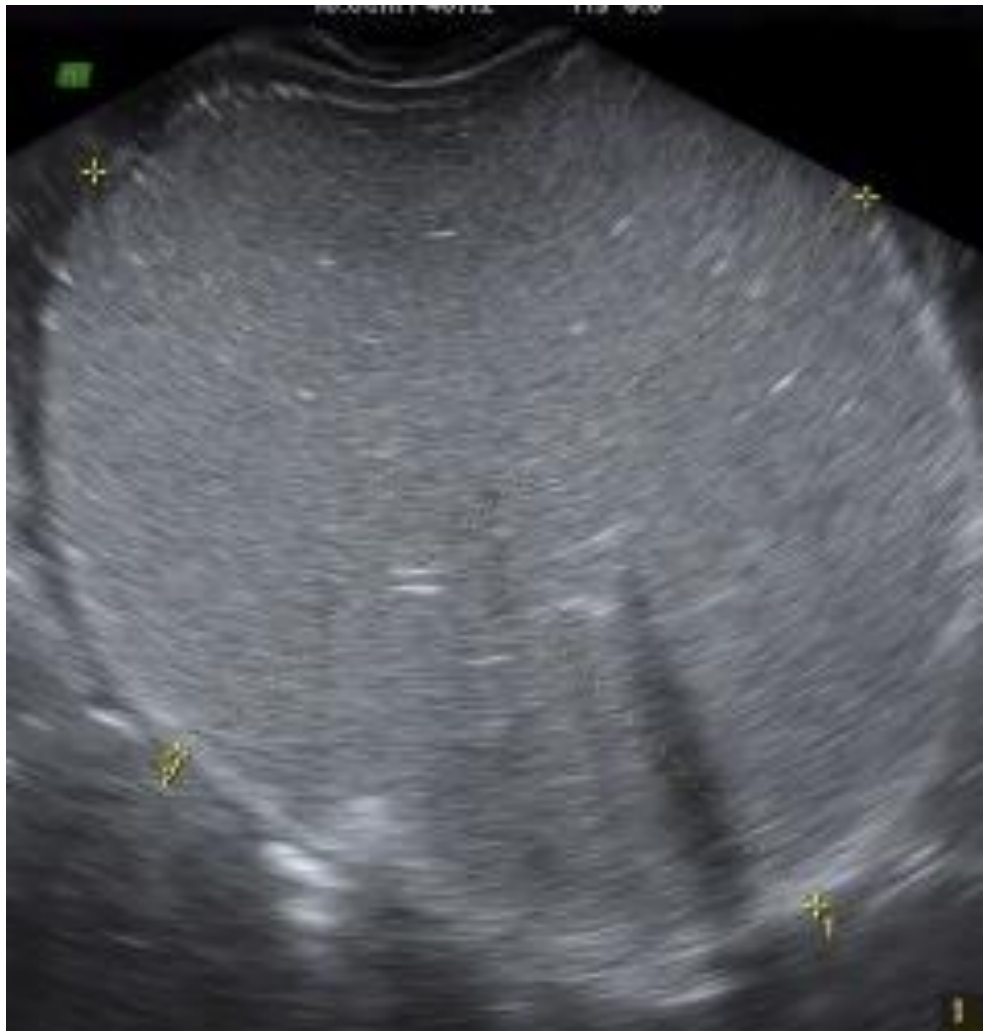
Ascites



Presence of more than 10 cyst locules



Acoustic shadows



How it looks:

Age

62 Years

14 100

Oncology center

Is your center a tertiary referral center with a specific gynecological unit?

No | Yes

Maximal diameter of the lesion

Largest of the diameters measured in three perpendicular planes

100 mm

8 400

Maximal diameter of the largest solid part

Note: The maximal diameter of the largest solid part can never be larger than the maximal diameter of the lesion.

32 mm

0 400

Cyst locules

Is the lesion multilocular or multilocular-solid with more than 10 cystic locules that are separated by septa?

0-10 | >10

Number of papillations (papillary projections)

Papillations must be at least 3 mm. Note: If papillations are present the maximum diameter of the largest solid part cannot be 0!

None | 1 | 2 | 3 | >3

Acoustic shadow present

Presence of acoustic shadows is defined as loss of an acoustic echo behind a sound-absorbing structure

No | Yes

Ascites present

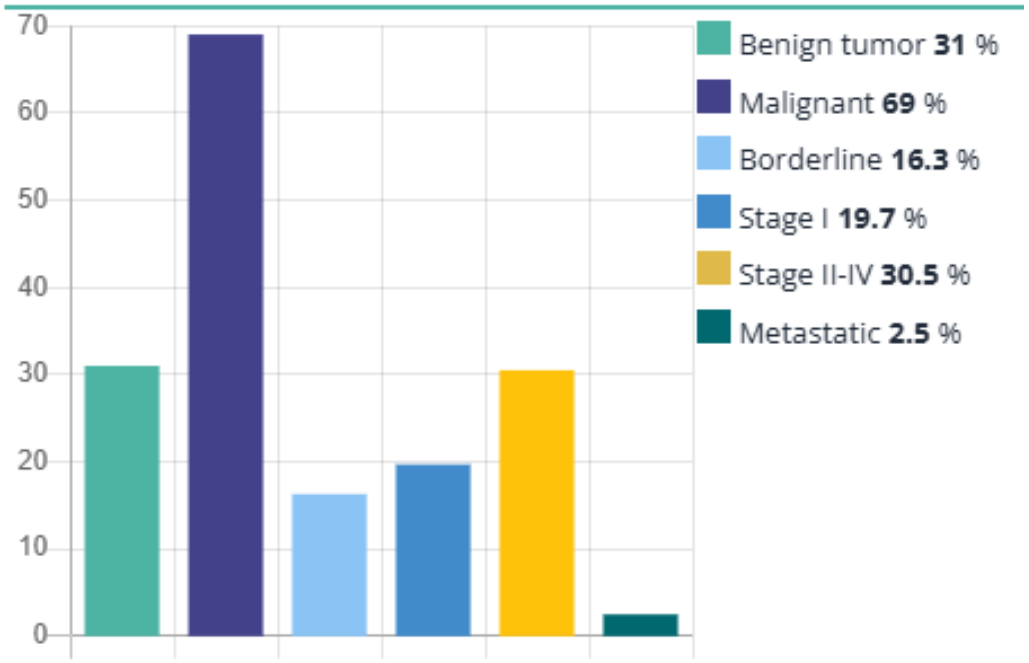
Is there ascites outside the pelvis present?

No | Yes

Serum CA-125

89 u/ml

1 30000



Pilot Aims:

- Performance compared to histology?

- Performance compared to MRI?

Could MRI capacity could be relieved with its implementation?

Could it help support FDS?

Step down indeterminate lesions that were benign

Escalate sinister masses

Results

ADNEX stage	Histology findings
2-4	FIGO 2B
Benign	Benign Cystadenoma
1	FIGO 1A
2-4	FIGO 3B
Benign	Cystadenoma
Stage 1	FIGO 1C
Benign	Cystadenoma
2-4	FIGO 2A
Benign	Cystadenoma
Borderline	Mucinous borderline tumour
2-4	Omental, peritoneal and ovarian involvement.
2-4	High grade tumour involving tubes, ovary and peritoneum
Borderline	Mucinous borderline tumour
Benign	Cystadenoma
Stage 1	FIGO 2B
Benign	Cystadenoma
Benign	Cystadenoma
2-4	Metastatic colon cancer
1	Primary uterine sarcoma

MRI result	Histology findings
FIGO 3A1	FIGO 2B
Cystadenoma – size of concern	Benign
Borderline	Borderline
Malignant/borderline	FIGO 1C
Benign	FIGO 1C
Cystadenoma	Cystadenoma
Unsure for MDT discussion	FIGO 2A
Cystadenoma	Cystadenoma
Cystadenoma	Cystadenoma
FIGO 3C2	Peritoneal, ovarian and omental involvement
? borderline ? benign	FIGO 2B
Cystadenoma	Cystadenoma
Malignant	Borderline
? borderline	Cystadenoma

ADNEX = 100% agreement with histology

(n=21)

Results

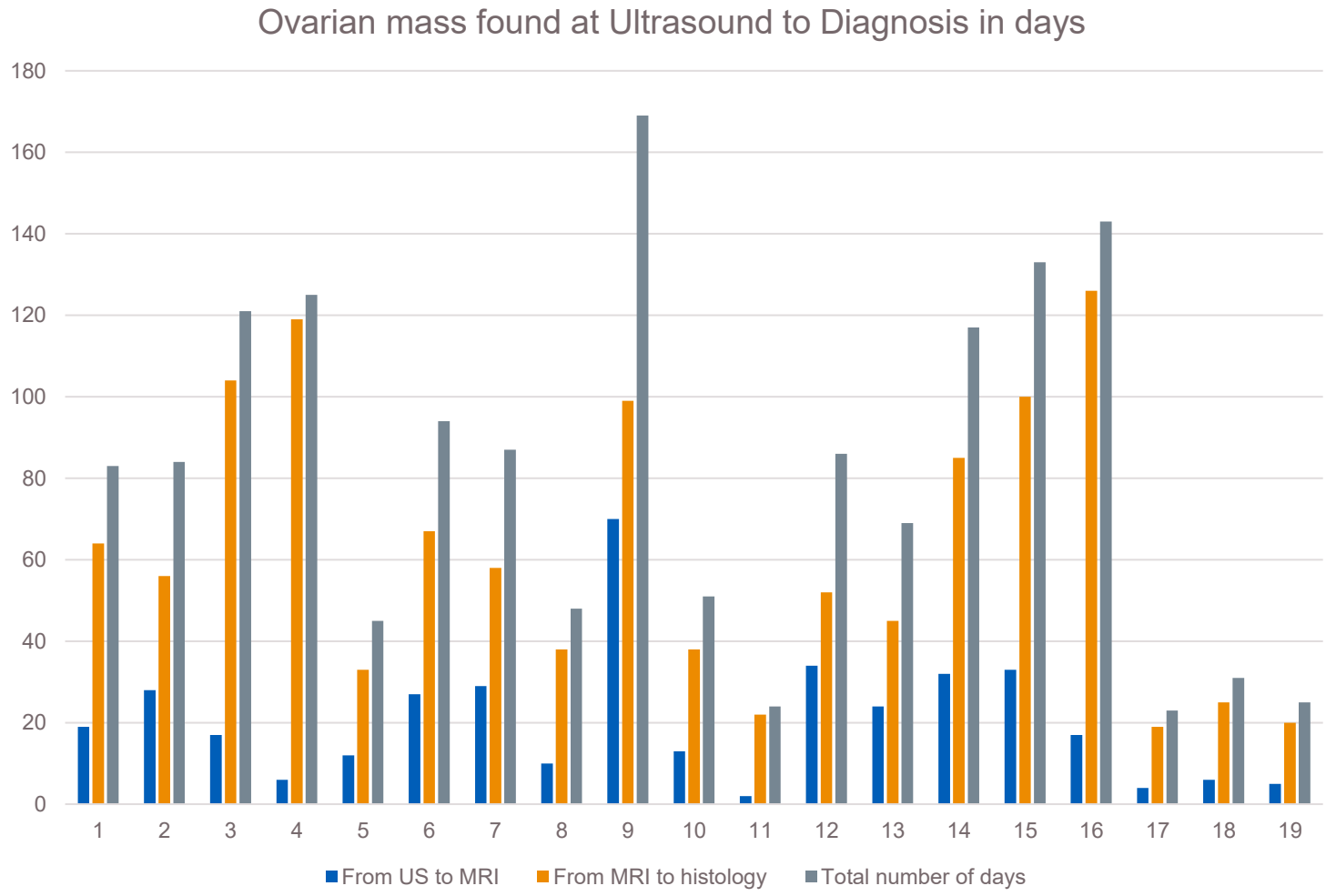
Average 20 days from US to MRI

Average 61 days from US suspicion to removal

	Shortest wait	Longest wait
MRI/CT	2 days	70 days
Surgery	20 days	126 days

x2 of these radiology escalation - the two shortest waits

MRI/CT	2 days	5 days
Surgery	20 days	25 days



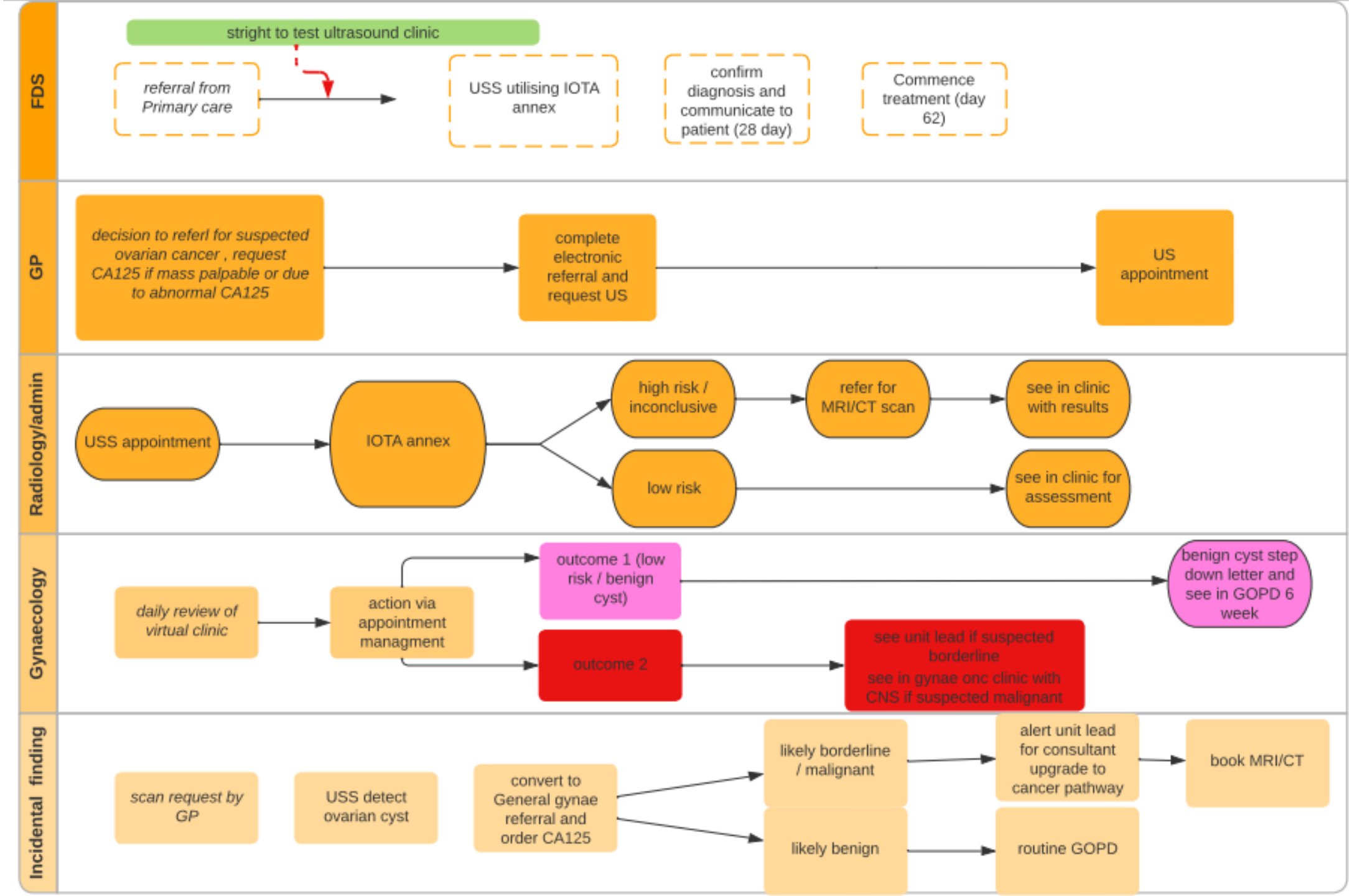
Results

Escalation within radiology drastically reduced waiting

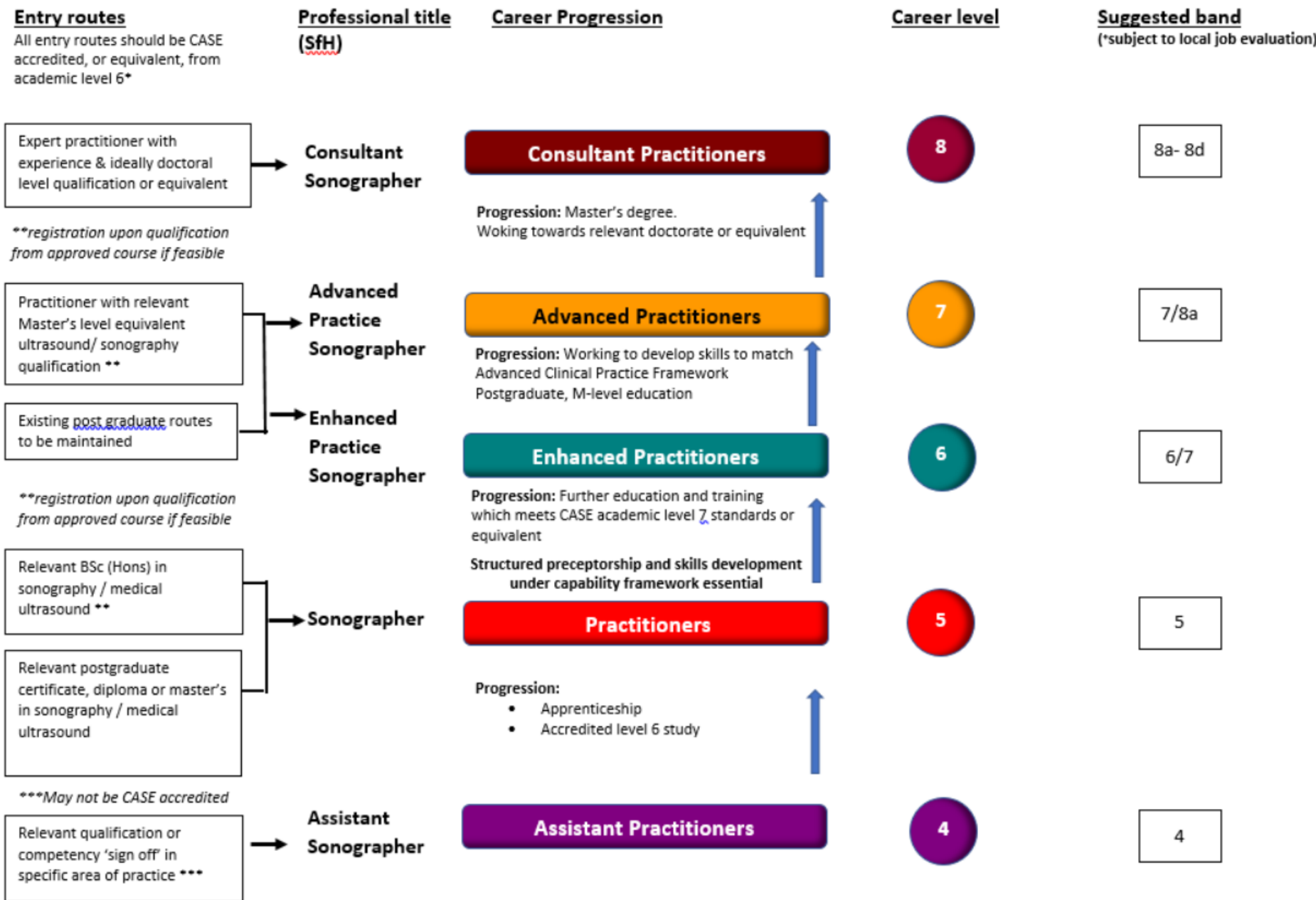
	Fast tracked case
MRI/CT	6 days
Surgery	19 days

x2 of these radiology escalation - the two shortest waits

MRI/CT	2 days	5 days
Surgery	20 days	25 days


FDS
stright to test ultrasound clinic
referral from Primary care
USS utilising IOTA annex
confirm diagnosis and communicate to patient (28 day)
Commence treatment (day 62)
GP
decision to referl for suspected ovarian cancer , request CA125 if mass palpable or due to abnormal CA125
complete electronic referral and request US
US appointment
Radiology/admin
USS appointment
IOTA annex
high risk / inconclusive
refer for MRI/CT scan
see in clinic with results
low risk
see in clinic for assessment
Gynaecology
daily review of virtual clinic
action via appointment managment
outcome 1 (low risk / benign cyst)
benign cyst step down letter and see in GOPD 6 week
outcome 2
see unit lead if suspected borderline
see in gynae onc clinic with CNS if suspected malignant
Incidental finding
scan request by GP
USS detect ovarian cyst
convert to General gynae referral and order CA125
likely borderline / malignant
alert unit lead for consultant upgrade to cancer pathway
book MRI/CT
likely benign
routine GOPD

Outline Career and Progression Framework – Final V4. Updated March 2023



* Entry routes into sonography should be CASE equivalent i.e. the education and learning outcomes should meet CASE learning outcomes for the relevant academic level of study. See explanatory narrative for further details for non-CASE accredited awards.

Summary

Sonographers can have a positive impact on faster diagnostic pathways

Improves outcomes for patients and helps meet targets

Increase job satisfaction

Everyone is a winner!

Summary Continued

- Significant pressures are being faced with all FDS pathways and solutions are not always working harder, but we can work smarter.

- Don’t underestimate the skill set of sonographers. Role extension and advanced practice goes beyond purely clinical acumen.

- Dynamic multi-disciplinary team approach, driven by sonographers, has led to tangible improvements in both patient care, and performance.

United By Compassion: Driving For Excellence