# THE LANCET Oncology

# Supplementary appendix 1

This appendix formed part of the original submission and has been peer reviewed. We post it as supplied by the authors.

Supplement to: Sud A, Torr B, Jones ME, et al. Effect of delays in the 2-week-wait cancer referral pathway during the COVID-19 pandemic on cancer survival in the UK: a modelling study. *Lancet Oncol* 2020; published online July 20. http://dx.doi. org/10.1016/S1470-2045(20)30392-2.

# Supplementary Table 1: Assumptions and parameters

	Parameterisation, assumptions and justification	Ref
1	Cancer survival Predicted baseline 10-year survival for patients diagnosed with cancer during 2020 is accurately represented by available data from	[1]
1	PHE NCRAS on cancer survival collected 2008-2017.	[1]
	<b>Justification:</b> PHE NCRAS cancer data for 2008-2017 represent the best available estimates for 10-year cancer survival in England	
	for each tumour type under standard management in the NHS in England. We recognise nevertheless that these baseline survival	
	figures will have changed due to evolutions in practice and the emergence of new treatments.	
2	Net 10-year survival reflects cancer-specific mortality.	[1]
	<b>Justification:</b> Net survival is based on crude survival with adjustment for background age-specific population-level death rates. Thus,	1-1
	this is a reasonable approximation to cancer-specific mortality.	
	Notes: Net survival is censored at 100%. Generating these estimates requires that at least 10 patients are alive at the time of estimation	
	and there are at least 2 deaths in the time either side of estimation. Where net survival could not be generated for a particular age-	
	specific, stage-specific stratum, we utilise the stage-specific survival for the adjacent age-band (younger preferential to older) and	
	indicate this in the respective tables.	
3	The age-stage-specific 10-year survival can be approximated to the age-specific 10-year survival adjusted for the ratio of 5-year stage-	[2]
	specific survival.	
	Justification: Since cure rates for most cancers are only known 5-10 years post-diagnosis, we wanted to use 10-year stage-specific	
	survival data in our calculations. NCRAS only routinely generated stage-specific survival from 2013. Hence, to obtain stage-specific	
	10-year survival, re applied established methods of applying the ratio of stage-specific to all stage survival at 5 years to all-stage	
	survival at 10-years.	
	Notes: For brain cancers, all tumours are included as Staging as 1-4 is not performed.	
4	Cancer survival estimates are well reflected by the sex-average for all cancer types except for prostate, testicular, endometrial, ovarian,	[1]
	cervical and breast cancers.	
5	Life expectancy is that for the mid-age of the age-band, averaged for both sexes. For those age 80+, average life expectancy is that of	[3]
	the midpoint of age 80-90 band. Those who succumb to their cancer are not ascribed any life-years gained.	
5	All patients <60 years for Stage 1-3 disease have treatment with curative intent (definitive treatment). The stage-specific ratio of	
	definitive treatment [major resection: other] in those >60 years is uniform across age groups and is the average of that in age groups	
	<60.	
7	The impact of systemic pathway delays consequent from COVID-19-related disruption can be modelled from observational studies in	[4-12]
	which long-term survival has been correlated with different durations of delay to treatment.	
	Justification: Experimentally-derived estimates to quantify the impact of delay on survival would have constituted the optimal type	
	of evidence to inform assumptions in the model, but those do not exist as randomised trials comparing non-delayed versus dramatically	
	delayed surgery would be clearly unethical. Although there is a multitude of mathematical models of cancer growth and spread, it	
	remains unclear how faithfully these model correspond to surgical intervention, clinical staging, metastasis and outcome.	
	We reviewed the literature to identify studies of delay in treatment for which: (i) there was follow up for $\geq 5$ years comprising either	
	hazard ratios or % survival, (ii) longer durations of delay, (ii) long-term follow-up to evaluate the impact on long-term survival ( $\geq 5$	
	years) (iii) stage-specific data enabling partition of stage 1-3 from stage 4. We restricted the analysis to tumour types for which multiple	
	survival comparisons were available and multiple stages were included. We identified 11 suitable studies relating to colorectal cancer, breast cancer and bladder cancer.	
	Although the majority of these studies are based on crude survival ( <i>i.e.</i> all-cause) rather than net ( <i>i.e.</i> cancer-specific), because they	
	have been used to derive ratios in survival between groups experiencing different delays, we assume the effects due to background	
	mortality rates are largely 'cancelled out' in the ratio.	
8	Survival decrement due to delay can be modelled as a constant hazard ratio (delay-HR) applied across the subsequent 10 years.	[13]
5	Justification:	[15]
	Whilst this likely oversimplifies the temporal, spatial and tumour-type specific patterns of cancer progression, the observational data	
	available are insufficient to afford a more intricate model than a linear regression.	
	Notes:	
	Observational studies did not present trend HRs, so we estimated by linear regression a per-day HR, using the median delay associated	
	with each HR, or if medians were not presented we used the mid-point, except for the first (baseline) group where we assumed the	
	median occurred at $2/3$ the width of the interval (which was consistent with studies that reported a median and interval), and for the	
	last open-ended group we assumed the median occurred at the lower boundary plus half the width of the previous strata.	
	This per-day delay-HR is applied to the underlying NCRAS 10-year survival as follows:	
	• Per_year_Hazard_Rate_under_standard_conditions=-LN(100%-(100%-(10-year_survival)))/10	
	•Delay-HR_for_specified_period_of_delay =EXP(number_of_days_delay*per_day_delay-HR)	
	•Per_year_Hazard_Rate_POST-DELAY=Per_year_Hazard_Rate_under_standard_conditions* Delay-	
	HR_for_specified_period_of_delay	
	•10-year_fatality_POST-DELAY= (1-EXP(-1*_Per_year_Hazard_Rate_POST-DELAY_*10))	
	•10-year_survival_POST-DELAY=100%-10-year_fatality_POST-DELAY	
	•10-year_survival_CURRENT_COVID-ADJUSTED=10-year_survival_STANDARD*(100%likelihood_of_per-	
	surgical_COVID_death)*(100%likelihood_of_community_COVID_death)	
	•10-year_survival_POST-DELAY_COVID-ADJUSTED=_10-year_survival_POST-DELAY*(100%likelihood_of_peri-	
	surgical_COVID_death)* (100%likelihood_of_community_COVID_death)	
		1
	•average%delay-related_survival_reduction=10-year_survival_CURRENT_COVID-ADJUSTED - 10-year_survival-POST- DELAY_COVID-ADJUSTED	

9	The 'delay-HRs' capture tumour progression that is applicable more broadly by category for tumours of low, medium and high	[1]
	progressiveness,	
	Justification:	
	Our useable observational studies from 3 tumour types reveal clear differences between breast cancer compared to colorectal and bladder cancers. There are no relevant observational data available for the majority of tumour types, in particular those of poor	
	outcomes.	
	We classified cancers as being of low (5-year survival >90%), moderate (90-50%) or high (<50%) progressiveness based on 5-year survival.	
	We calculated a weighted average for the HR per day delay in treatment (the 'delay-HR') based on the number of patients in each study	
	for (i) breast cancer (ii) colorectal and bladder cancer. We apply the per-day delay-HR from breast cancer to tumours of low	
	progressiveness, and the weighted average for bladder and colorectal for tumours of moderate progressiveness. Because we have no observational data upon which to base a per-day hazard ratio for high progressiveness tumours ( <i>e.g.</i> oesophageal, gastric), we use the	
	same delay-HR from the moderate group; this is likely to be a conservative assumption.	
	The 5-year survival metric used as a proxy for overall tumour aggressiveness/progressiveness is that for Stage 2 disease as this approach	
	(i) excludes the indolent entities which may be included in stage 1 and (ii) disregards artefactual bias of the distribution of asymmetric	
	stage-at-ascertainment.	
10	The per-day 'delay-HR' for tumour progression is independent of disease stage.	[4-12]
11	<b>Justification:</b> Review of reported observational studies revealed no evidence of inter-stage heterogeneity on per-day delay-HRs. There are no impact additional impacts on treatment outcomes consequent from COVID19-related short-staffing, under-experienced,	
11	or redeployed staff.	
	Cancer diagnosis	
12	The diagnostic-conversion-rate is uniform across tumour-types within a tumour-referral-group, and uniform across age groups	
	Justification: data are not available specifying the diagnostic-conversion-rate by age- group and/or tumour-type specific referral	
13	category. There is no impact of delay to survival on cancers diagnosed via 2WW referral that are outside of the tumour-referral-group.	
15	<b>Justification:</b> data are not available specifying the details of the cancer diagnoses made outside of the tumour-referral-group, nor the	
	stage at which they are diagnosed.	
14	Cancer investigations with negative results ordered directly by GPs do not impact on resource availability for 2WW investigatory	
	referral.	
	<b>Justification:</b> There is wide variation across primary care in the availability of direct access to first-line investigations, for example,	
	USS for symptoms of gynaecological cancer and CT for symptoms of pancreatic cancer. Although they compete for the same resources, negative cases are not accounted for in routes-to-diagnosis datasets	
15	The risk of death associated with technical complications from specific invasive investigatory procedures is the product of the risk of	[14-17]
	complication and the fatality associated with the complication (Supplementary Table 11), for example colonic preformation. This is	[]
	uniform across age groups.	
	COVID-19-related mortality in cancer patients	
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17	Likelihood of nosocomial COVID-19 infection is a function of a per-day rate of infection of 2% that is stable and uniform across healthcare facilities. Justification: There have been multiple reports of high rates of nosocomial infection [18, 19] and high rates of infection amongst healthcare workers. Healthcare workers acquire immunity but the prevalence of infection in the community will fluctuate, so nosocomial infection rates will likely be dynamic [20]. To date, there has been no published per-day rate of infection in a hospital setting. We examined in our sensitivity analysis, daily nosocomial infection rates of 1%, 2%, 5% and 10%. In our sensitivity analysis, variation in the rate of nosocomial infection displays an inverse relationship with the impact of delay on survival i.e. the higher risk of nosocomial infection cancels out the health benefit of non-delay (Supplementary Table 2). Following estimate of infection rate of 1-2% per day from unpublished clinical data from a UK surgical oncology centre, as our default, we used an estimate of 2%, which may be conservatively high. Mortality from nosocomial COVID-19 is at rates equivalent to those reported in Wuhan for 44,672 molecularly-confirmed COVID-19 cases for patients acquiring infection nosocomially at surgery. Justification: The best UK data currently available capturing case fatality rates are from a UK series of 20,133 hospitalised COVID-19 patients (Docherty et al. 2020). However, these case fatality rates pertain only to hospitalized (severe) COVID-19 cases, not all-comers, current CFR estimates from Lombardy/elsewhere in Europe are also for hospital cases only. Therefore, acknowledging that mild/asymptomatic individuals are still likely under-represented in the Wuhan dataset of 44,672 molecularly-confirmed COVID-19 cases, these data currently represent the most comprehensive and largest dataset from which to estimate a CFR for all-comers with COVID-19.   Stage 1-3 patients cured of their disease are at a cancer-related elevati	[23, 24]
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17	Likelihood of nosocomial COVID-19 infection is a function of a per-day rate of infection of 2% that is stable and uniform across healthcare facilities. Justification: There have been multiple reports of high rates of nosocomial infection [18, 19] and high rates of infection amongst healthcare workers. Healthcare workers acquire immunity but the prevalence of infection in the community will fluctuate, so nosocomial infection rates will likely be dynamic [20]. To date, there has been no published per-day rate of infection in a hospital setting. We examined in our sensitivity analysis, daily nosocomial infection rates of 1%, 2%, 5% and 10%. In our sensitivity analysis, variation in the rate of nosocomial infection displays an inverse relationship with the impact of delay on survival i.e. the higher risk of nosocomial infection cancels out the health benefit of non-delay (Supplementary Table 2). Following estimate of infection rate of 1-2% per day from unpublished clinical data from a UK surgical oncology centre, as our default, we used an estimate of 2%, which may be conservatively high. Mortality from nosocomial COVID-19 is at rates equivalent to those reported in Wuhan for 44,672 molecularly-confirmed COVID-19 cases for patients acquiring infection nosocomially at surgery. Justification: The best UK data currently available capturing case fatality rates are from a UK series of 20,133 hospitalised COVID-19 cases, to all-comers. Current CFR estimates from Lombardy/elsewhere in Europe are also for hospital cases only. Therefore, acknowledging that mild'asymptomatic individuals are still likely under-represented in the Wuhan dataset of 44,672 molecularly-confirmed COVID-19 cases, these data currently represent the most comprehensive and largest dataset from which to estimate a CFR for all-comers with COVID-19.	[23, 24]
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	Cancer Therapy	
20	All patients with a given tumour stage have a single standard open operation. ICU stay and ward stay are standard for a given operation	[28]
	as per the median of values from 3 large surgical oncology centres. In regard of nosocomial exposure, day-case surgery is counted as	
	a half-day of hospital admission. For a specified tumour stage, the duration of inpatient say is equivalent for surgical and non-surgical	
	definitive treatments (for example radicle radiotherapy versus major resection).	
21	Adjuvant chemo-radiotherapy is continued using standard/modified protocols, as per clinical judgment. The additional specific risk of	
	nosocomial infection from these treatments is encompassed in 1 year of cancer-related elevation of case fatality rates.	

## Supplementary Table 2: Route to cancer diagnosis with distribution by age and stage.

Data from NHS England Clinical Commissioning Groups (2013-2016). 2WW, two week wait."

						Proportion	by age grou	р			Pro	portion by s	tage		Conversion t	o cancer	Cancer
Tumour Type	Tumour Referral Group	Route	Proportion by route	30-39	40-49	50-59	60-69	70-79	80+	1	2	3	4	st1-3	% Cancer diagnosis	% Cancer in Tumour Referral Group	diagnoses per year total
Bladder	Urology (exc.	2WW	42.9%	0.32%	2.10%	7.36%	23.40%	36.24%	30.58%	51.92%	29.09%	6.74%	12.26%	87.74%	16.90%	98.20%	
	Testicular)	Emergency	18.0%	0.6%	1.5%	3.9%	12.9%	26.5%	54.6%	23.02%	30.21%	9.43%	37.35%	62.65%			8,524
		Routine	39.1%	0.45%	2.02%	6.31%	19.57%	34.55%	37.10%	51.51%	25.95%	6.99%	15.55%	84.45%			
Brain	Brain	2WW	1.73%	8.72%	8.39%	16.44%	31.21%	25.17%	10.07%			1	1		1.00%	100.00%	
		Emergency	44.56%	15.35%	7.63%	13.49%	20.60%	22.92%	20.00%								8,102
		Routine	53.72%	20.1%	11.8%	16.9%	25.6%	19.5%	6.2%								
Breast	Breast	2WW	54.20%	6.10%	19.14%	16.22%	16.25%	20.53%	21.76%	31.22%	50.86%	12.97%	4.95%	95.05%	4.90%	99.30%	
		Screening	29.46%	0.03%	5.38%	33.16%	45.87%	14.24%	1.31%	68.19%	27.02%	3.90%	0.89%	99.11%			41,845
		Emergency	4.01%	1.93%	5.72%	8.90%	12.40%	21.06%	50.00%	17.47%	24.45%	10.36%	47.71%	52.29%			41,845
		Routine	12.34%	6.36%	19.59%	19.72%	19.68%	17.78%	16.88%	44.27%	36.57%	8.95%	10.22%	89.78%	1.30%	96.20%	
Cervix	Gynaecology	2WW	22.12%	16.55%	15.84%	18.12%	19.74%	17.32%	12.43%	29.29%	40.12%	14.97%	15.62%	84.38%	3.10%	97.40%	
		Screening	34.03%	63.75%	22.66%	9.97%	3.56%	0.06%		90.36%	7.24%	1.48%	0.91%	99.09%			2,128
		Emergency	9.57%	18.05%	13.80%	14.63%	16.60%	18.26%	18.67%	11.15%	21.19%	21.35%	46.31%	53.69%			2,128
		Routine	34.28%	44.59%	22.09%	12.71%	8.31%	6.49%	5.82%	67.35%	17.93%	6.68%	8.04%	91.96%			
Colorectal	Lower GI	2WW	32.20%	0.84%	3.13%	13.04%	21.54%	32.98%	28.47%	15.37%	28.20%	32.52%	23.90%	76.10%	2.80%	78.40%	
		Screening	9.79%			0.63%	62.47%	35.67%	1.23%	36.88%	25.96%	29.15%	8.01%	91.99%			32,979
		Emergency	24.19%	4.77%	4.17%	9.12%	15.91%	24.45%	41.58%	7.03%	24.97%	26.00%	41.99%	58.01%			32,919
		Routine	33.81%	2.88%	4.87%	13.72%	19.08%	30.18%	29.27%	22.63%	26.03%	28.33%	23.02%	76.98%			
Kidney	Urology (exc.	2WW	28.06%	2.29%	8.14%	17.67%	27.75%	27.47%	16.68%	45.25%	11.40%	21.75%	21.60%	78.40%	16.90%	98.20%	
	Testicular)	Emergency	22.09%	3.60%	5.52%	11.00%	19.25%	24.10%	36.54%	33.09%	7.10%	13.42%	46.39%	53.61%			8,764
		Routine	49.86%	3.79%	8.11%	17.05%	28.32%	27.60%	15.12%	54.59%	8.66%	18.03%	18.71%	81.29%			
Larynx	Head & Neck	2WW	47.98%	0.49%	5.17%	19.35%	33.30%	28.25%	13.43%	36.59%	19.35%	17.76%	26.31%	73.69%	2.90%	74.00%	
		Emergency	10.05%	1.24%	4.14%	13.79%	29.24%	28.00%	23.59%	5.44%	6.60%	19.61%	68.35%	31.65%			1,850
		Routine	41.98%	1.32%	4.75%	15.91%	31.43%	30.37%	16.21%	39.97%	19.00%	18.27%	22.76%	77.24%			
Liver	Upper GI	2WW	14.50%	0.74%	1.86%	10.09%	25.21%	34.34%	27.75%	7.63%	10.65%	15.61%	66.12%	33.88%	5.70%	85.90%	
		Emergency	42.68%	1.77%	2.71%	9.68%	20.66%	27.73%	37.45%	7.73%	9.14%	11.90%	71.23%	28.77%			4,712
		Routine	42.82%	2.20%	4.29%	14.57%	27.34%	32.09%	19.52%	17.86%	21.06%	14.18%	46.90%	53.10%			
Lung	Lung	2WW	28.21%	0.27%	2.19%	10.22%	30.21%	35.77%	21.34%	15.39%	9.90%	27.93%	46.78%	53.22%	10.90%	93.70%	
		Emergency	34.73%	0.35%	1.90%	7.56%	20.89%	32.17%	37.13%	9.32%	4.71%	14.43%	71.54%	28.46%			36,668
		Routine	37.06%	0.54%	2.13%	9.82%	27.90%	37.01%	22.60%	26.57%	10.00%	21.71%	41.71%	58.29%			
Melanoma	Skin	2WW	63.10%	10.44%	14.18%	17.82%	23.00%	20.31%	14.25%	71.49%	20.45%	6.46%	1.60%	98.40%	4.40%	98.10%	
		Emergency	2.07%	5.62%	5.91%	10.54%	18.52%	24.04%	35.37%	46.45%	21.69%	9.07%	22.79%	77.21%			12,110
		Routine	34.83%	9.37%	9.77%	13.32%	20.73%	24.64%	22.17%	69.82%	20.82%	6.21%	3.16%	96.84%		ļ	
Oesophagus	Upper GI	2WW	44.95%	0.37%	2.98%	12.86%	28.97%	31.01%	23.81%	7.37%	16.10%	41.20%	35.33%	64.67%	5.70%	85.90%	
		Emergency	19.91%	0.57%	2.24%	8.74%	19.52%	27.15%	41.78%	7.22%	12.37%	27.08%	53.33%	46.67%			7,427
		Routine	35.14%	0.60%	3.02%	13.02%	29.56%	32.43%	21.38%	20.66%	16.47%	33.92%	28.95%	71.05%			

Oral cavity	Head & Neck	2WW	44.14%	2.93%	9.66%	22.36%	29.43%	20.87%	14.76%	27.27%	15.79%	10.40%	46.54%	53.46%	2.90%	74.00%	
		Emergency	4.77%	3.25%	8.52%	18.86%	22.52%	23.53%	23.33%	13.85%	8.82%	8.06%	69.27%	30.73%			2,629
		Routine	51.08%	3.49%	8.21%	20.53%	28.64%	22.20%	16.93%	37.03%	13.39%	8.23%	41.36%	58.64%			
Oropharynx	Head & Neck	2WW	58.86%	1.35%	12.10%	34.70%	33.82%	14.18%	3.84%	2.84%	6.10%	13.42%	77.65%	22.35%	2.90%	74.00%	
		Emergency	6.30%	2.06%	9.34%	28.32%	31.96%	19.94%	8.39%	3.17%	5.74%	10.10%	80.99%	19.01%			2,905
		Routine	34.84%	1.46%	11.95%	33.23%	32.66%	15.67%	5.03%	6.51%	8.89%	14.61%	69.98%	30.02%			
Ovary	Gynaecology	2WW	33.49%	4.20%	8.42%	20.97%	28.94%	25.44%	12.03%	31.94%	7.81%	41.66%	18.59%	81.41%	3.10%	97.40%	
		Emergency	28.03%	6.86%	7.36%	12.16%	19.96%	25.38%	28.29%	15.72%	3.20%	42.44%	38.64%	61.36%			6,398
		Routine	38.48%	13.01%	13.53%	18.81%	22.22%	19.54%	12.89%	51.11%	6.48%	27.67%	14.74%	85.26%			
Pancreas	Upper GI	2WW	19.29%	0.24%	2.10%	9.44%	26.04%	36.07%	26.09%	5.79%	14.72%	13.72%	65.77%	34.23%	5.70%	85.90%	
		Emergency	46.13%	0.62%	2.42%	8.34%	18.71%	29.72%	40.20%	6.21%	11.57%	8.32%	73.90%	26.10%			8,260
		Routine	34.58%	1.31%	4.05%	11.79%	27.96%	32.31%	22.58%	8.14%	18.71%	12.35%	60.80%	39.20%			
Prostate	Urology (exc.	2WW	47.20%	0.01%	0.94%	9.63%	32.95%	38.22%	18.24%	27.95%	21.59%	25.96%	24.50%	75.50%	16.90%	98.20%	
	Testicular)	Emergency	7.82%	0.04%	0.43%	4.26%	16.52%	28.84%	49.91%	17.43%	7.92%	9.40%	65.25%	34.75%			40,834
		Routine	44.99%	0.02%	1.26%	11.83%	36.53%	35.77%	14.59%	43.50%	25.13%	19.23%	12.14%	87.86%			
Stomach	Upper GI	2WW	31.03%	0.37%	2.98%	12.86%	28.97%	31.01%	23.81%	8.26%	18.47%	27.16%	46.11%	53.89%	5.70%	85.90%	
		Emergency	31.65%	1.91%	3.20%	7.66%	13.97%	26.96%	46.31%	7.44%	14.78%	15.77%	62.02%	37.98%			5,332
		Routine	37.33%	1.96%	4.93%	10.50%	20.45%	32.98%	29.18%	20.14%	20.58%	21.86%	37.42%	62.58%			
Testis	Testis	2WW	61.21%	61.68%	22.44%	10.93%	3.42%	1.17%	0.37%	86.62%	7.82%	3.08%	2.48%	97.52%	9.00%	75.00%	
		Emergency	9.11%	65.41%	19.04%	7.99%	3.05%	2.62%	1.89%	52.88%	12.33%	17.30%	17.50%	82.50%			1,355
		Routine	29.68%	60.87%	19.86%	11.16%	5.22%	1.92%	0.98%	81.75%	8.24%	5.56%	4.46%	95.54%			
Thyroid	Head & Neck	2WW	23.20%	28.27%	19.01%	18.14%	15.08%	12.24%	7.26%	44.39%	9.96%	18.97%	26.67%	73.33%	2.90%	74.00%	
		Emergency	6.36%	11.86%	9.79%	12.55%	18.76%	19.45%	27.59%	31.41%	7.67%	10.55%	50.36%	49.64%			2,673
		Routine	70.44%	27.79%	21.33%	20.17%	15.95%	10.21%	4.56%	58.67%	11.17%	17.02%	13.15%	86.85%			
Uterus	Gynaecology	2WW	57.73%	0.24%	2.28%	19.08%	35.80%	29.16%	13.44%	75.67%	7.47%	11.00%	5.86%	94.14%	3.10%	97.40%	
		Emergency	7.61%	1.63%	6.45%	13.74%	19.75%	25.59%	32.83%	42.18%	7.50%	20.01%	30.31%	69.69%			7,604
		Routine	34.66%	2.82%	10.05%	23.45%	26.99%	22.78%	13.91%	75.70%	7.36%	10.54%	6.41%	93.59%			

## Supplementary Table 3 - Impact on 10-year net survival of differing periods of diagnostic delay to cancer treatment

20 common cancer types.

			2 mont	h delay					4 mont	h delay					6 mont	h delay		
Tumour Type	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+
Bladder	10.11%	9.53%	9.08%	9.91%	11.18%	11.62%	21.78%	20.75%	19.91%	21.37%	23.19%	21.91%	34.24%	33.07%	32.01%	33.62%	34.77%	29.48%
Brain (all)	7.38%	8.98%	11.64%	12.27%	11.53%	11.44%	16.59%	19.73%	24.04%	23.83%	21.06%	21.41%	27.56%	31.82%	35.84%	33.11%	27.44%	28.59%
Breast (all hormone marker statuses)	3.14%	2.09%	1.59%	1.36%	2.38%	5.02%	6.75%	4.53%	3.47%	2.98%	5.15%	10.50%	10.86%	7.38%	5.67%	4.87%	8.34%	16.38%
Cervix	3.44%	5.62%	7.67%	10.08%	12.01%	10.88%	8.06%	12.89%	17.19%	21.67%	23.68%	19.43%	14.15%	21.99%	28.38%	33.95%	33.45%	24.77%
Colorectal	6.38%	7.13%	6.77%	6.63%	8.29%	10.65%	14.53%	16.08%	15.33%	15.02%	18.33%	22.17%	24.51%	26.82%	25.70%	25.20%	29.76%	33.41%
Kidney	3.08%	4.01%	5.30%	6.59%	8.29%	11.59%	7.24%	9.35%	12.20%	14.94%	18.32%	23.00%	12.76%	16.30%	20.90%	25.08%	29.77%	32.73%
Larynx	6.93%	9.07%	8.51%	9.53%	10.21%	11.02%	15.67%	19.91%	18.83%	20.71%	21.75%	22.54%	26.22%	32.04%	30.62%	32.87%	33.69%	33.26%
Liver	11.66%	11.97%	11.37%	10.48%	8.74%	10.45%	20.92%	21.90%	20.17%	18.00%	14.20%	18.33%	26.79%	28.56%	25.56%	22.13%	16.67%	22.97%
Lung	10.90%	12.41%	11.71%	10.89%	8.67%	5.23%	23.07%	23.62%	21.15%	19.02%	14.05%	7.58%	35.45%	32.11%	27.25%	23.75%	16.47%	8.25%
Melanoma of skin	1.92%	2.43%	3.01%	3.49%	4.53%	7.94%	4.55%	5.74%	7.07%	8.16%	10.50%	17.59%	8.13%	10.20%	12.46%	14.30%	18.14%	28.67%
Oesophagus	11.75%	11.40%	11.33%	10.77%	8.99%	3.70%	21.19%	20.21%	20.09%	18.75%	14.73%	5.06%	27.26%	25.58%	25.43%	23.33%	17.42%	5.35%
Oral cavity	8.09%	10.98%	12.05%	12.16%	12.03%	11.43%	18.02%	23.18%	24.41%	24.18%	23.34%	21.23%	29.57%	35.53%	35.58%	34.51%	32.39%	28.14%
Oropharynx	7.40%	9.20%	10.82%	12.22%	11.75%	9.84%	16.64%	20.16%	22.93%	24.13%	21.77%	16.80%	27.64%	32.36%	35.26%	34.14%	28.77%	20.54%
Ovary	4.48%	8.79%	11.29%	12.23%	11.74%	11.04%	10.39%	19.38%	23.59%	24.05%	21.81%	19.99%	18.00%	31.37%	35.71%	33.88%	28.90%	25.81%
Pancreas	9.40%	8.70%	8.92%	6.85%	5.58%	7.98%	15.43%	13.95%	14.43%	10.40%	8.16%	12.71%	18.26%	16.22%	16.89%	11.64%	8.92%	14.71%
Prostate	0.43%	0.43%	0.20%	0.00%	0.00%	2.36%	0.94%	0.94%	0.44%	0.00%	0.00%	5.11%	1.56%	1.56%	0.73%	0.00%	0.00%	8.28%
Stomach	12.45%	12.44%	12.29%	11.93%	11.24%	6.72%	24.37%	24.29%	23.23%	22.11%	20.26%	10.26%	34.17%	33.93%	31.34%	29.22%	26.05%	11.53%
Testis	0.37%	0.23%	0.48%	0.23%	0.40%	1.03%	0.81%	0.50%	1.06%	0.50%	0.88%	2.25%	1.34%	0.82%	1.75%	0.82%	1.46%	3.70%
Thyroid	0.07%	0.40%	0.85%	0.14%	1.64%	0.00%	0.16%	0.88%	1.86%	0.31%	3.58%	0.00%	0.26%	1.44%	3.06%	0.52%	5.84%	0.00%
Uterus	1.48%	3.25%	3.73%	5.39%	7.44%	9.22%	3.53%	7.62%	8.70%	12.39%	16.66%	19.96%	6.34%	13.40%	15.22%	21.19%	27.51%	31.56%

#### Supplementary Table 4 - Impact on 10-year net survival of 3 months diagnostic delay

All diagnoses; 20 common tumour types (England 2007-2017), stratified by stage/subtype of cancer diagnosis.

Red indicates the highest tertile of survival decrement; green indicates the lowest tertile of survival decrement.

\* low confidence 5-year survival estimate for age-specific/stage-specific stratum; N/A: no cases in this age stratum.

					Group	-	n
Tumour Type Bladder	Stage	30-39	40-49	50-59	60-69	70-79	80+
Bladder	1	9.70%*	10.09%	10.31%	9.54%	7.98%	5.09%
	2	18.35%*	17.95%	18.23%	18.23%	17.29%	12.06%
	3	18.41%*	18.04%*	18.42%	18.04%	16.44%	10.03%
Breast (ER+, HER2-)	1	1.18%	0.80%	0.35%	0%	0%	2.05%
	2	4.49%	3.03%	2.90%	2.29%	2.95%	6.80%
	3	8.53%	7.30%	7.94%	8.10%	8.33%	9.36%
Breast (ER-, HER2-)	1	3.04%	2.34%	3.19%	2.58%	2.24%	3.67%
	2	6.79%	6.23%	6.20%	7.15%	8.23%	7.37%
	3	10.02%*	10.03%	9.99%	9.83%	9.21%	8.92%*
Breast (HER2+)	1	0.43%	0.86%	1.10%	1.52%	1.67%	4.18%
	2	3.66%	2.83%	2.91%	3.67%	5.04%	8.17%
	3	8.57%	5.39%	7.15%	7.37%	9.30%	9.42%
Breast (all hormone marker statuses)	1	1.65%	1.03%	0.56%	0.31%	0.03%	4.10%
	2	4.87%	3.46%	3.14%	3.13%	4.54%	8.02%
	3	8.90%	7.38%	7.80%	8.08%	9.38%	9.20%
Breast (other combination of hormone markers)	1	2.04%	1.41%	0.30%	0.43%	0%	5.25%
	2	4.26%	3%	3.09%	2.96%	4.77%	8.11%
	3	9.06%	7.16%	7.54%	7.56%	9.23%	9.30%
Cervix	1	2.25%	3.23%	3.34%	11.33%	12.22%	12.82%*
	2	15.28%	16.61%	16.76%	15.38%	17.91%	16.52%
	3	17.65%*	16.76%*	16.2%*	16.16%*	16.82%*	15.39%*
Colorectal	1	0.75%	2.71%	2.95%	3.27%	5.26%	12.67%
	2	8.17%	8.42%	7.95%	8.88%	10.90%	13.59%
	3	14.31%	15.17%	14.72%	15.05%	17.07%	16.78%
Kidney	1	1.23%	2.45%	5.02%	7.74%	10.84%	17.17%
	2	9.92%*	10.35%	7.89%	11.77%	15.06%	15.63%
	3	14.65%	13.71%	15.03%	14.95%	16.01%	17.18%
Larynx	1	3.64%*	5.23%	10.65%	8.81%	6.96%	10.22%
	2	13.57%*	16.61%	12.25%	16.28%	17.84%	17.21%
	3	15.12%*	17.73%	17.26%	18.26%	17.31%	17.03%*
Liver	1	18.59%*	18.53%*	18.45%	17.97%	15.98%	17.11%*
	2	17.05%*	17.59%*	16.58%	15.94%	14.26%	16.3%*
	3	7.34%*		6.67%*		6.78%*	
Lung	-	3.55%	8.48%* 10.66%	16.55%	6.35% 17.74%	17.52%	8.06%*
Dung	1						13%
	2	18.54%*	18.57%	18.25%	16.75%	11.74%	5.49%
Melanoma of skin	3	12.85%*	11.94%	9.44%	6.71%	3.54%	1.08%
	1	0.42%	1.10%	0.56%	0.19%	0%	1.16%
	2	12.03%	12.40%	14.26%	14.48%	15.28%	17.20%
Ossenharus	3	16.97%	16.41%	17.41%	17.64%	17.86%	17.04%
Oesophagus	1	18.25%*	18.41%	16.71%	17.75%	17.84%	12.87%
	2	16.74%*	16.09%	18.05%	16.41%	14.03%	3.85%
	3	15.3%*	14.48%	11.74%	11.22%	7.54%	1.52%
Ovary	1	2.77%	3.93%	5.92%	5.45%	6.39%	3.26%
	2	14.7%*	14.40%	16.07%	15.75%	16.97%	17.42%
	3	17.13%	17.77%	15.26%	13.12%	9.95%	6.72%

Pancreas	1	17.34%*	16.72%*	16.87%*	16.71%	11.35%	14.38%*
	2	13.05%*	11.95%*	12.30%	9.73%	8.47%	11.96%*
	3	3.92%*	3.14%*	3.4%*	3.39%*	3.36%*	6.35%*
Prostate	1	1.06%*	1.06%	0.04%	0%	0%	1.89%
	2	0%*	0%	0%	0%	0%	1.78%
	3	1.34%*	1.34%	1.32%	0.70%	1.01%	6.75%
Stomach	1	13.3%*	13.42%	15.93%	15.53%	15.53%	15.20%
	2	18.35%*	18.28%*	18.19%	17.40%	15.35%	8.05%
	3	15.12%*	14.90%	15.72%	13.62%	11.21%	3.95%
Testis	1	0.19%	0.06%	0.30%	0%	0%*	0.31%*
	2	0.61%	1.30%	1.26%*	2.22%*	2.22%*	N/A
	3	5.46%*	5.7%*	5.56%*	8.13%*	9.66%*	N/A
Thyroid	1	0.05%	0%	1.18%	0%	1.38%	0.67%*
	2	2.39%*	3.67%	0%	0.04%	1.42%	0.69%*
	3	0.52%*	0.83%	2.35%	0.73%	3.90%	1.05%
Uterus	1	1.34%	2.83%	3.30%	5.12%	7.08%	8.66%
	2	9.6%*	8.88%	9.76%	13%	16.19%	17.32%
	3	16.73%*	16.04%	17.82%	18.26%	16.27%	13.68%

#### Supplementary Table 5 is provided as a separate XLSX file.

#### Supplementary Table 6 - Absolute survival benefit from investigatory referral.

Absolute survival benefit describes referral (and subsequent management of cancer) versus no referral.

Per patient referred (by age group and nosocomial infection rate).

Different age groups and differing levels of nosocomial infection rates (0.5%, 1%, 2.5%, 5%) considered.

Green indicates net survival advantage for investigatory referral per referred patient; Red indicates net survival diasadvantage for investigatory referral

Nosocomial Infection Rate (for investigatory referral)			0.5	0%					1	%					2.5	0%					59	%		
Age (years)	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+
Bladder	9.70%	10.10%	10.33%	9.57%	8.03%	5.17%	9.70%	10.09%	10.31%	9.54%	7.98%	5.09%	9.69%	10.08%	10.28%	9.46%	7.82%	4.86%	9.68%	10.07%	10.23%	9.33%	7.57%	4.48%
Brain	0.78%	0.72%	0.55%	0.41%	0.28%	0.27%	0.78%	0.71%	0.55%	0.39%	0.24%	0.20%	0.78%	0.71%	0.53%	0.34%	0.12%	-0.03%	0.77%	0.70%	0.49%	0.25%	-0.09%	-0.41%
Breast	3.81%	4.10%	4.21%	4.21%	3.83%	2.77%	3.80%	4.09%	4.20%	4.19%	3.79%	2.69%	3.80%	4.09%	4.18%	4.13%	3.66%	2.46%	3.80%	4.08%	4.14%	4.03%	3.45%	2.08%
Cervix	2.31%	2.14%	1.95%	1.64%	1.11%	0.64%	2.31%	2.14%	1.94%	1.62%	1.07%	0.57%	2.31%	2.13%	1.92%	1.56%	0.94%	0.34%	2.30%	2.12%	1.88%	1.47%	0.74%	-0.03%
Colorectal	1.36%	1.31%	1.32%	1.30%	1.13%	0.83%	1.35%	1.31%	1.31%	1.28%	1.09%	0.75%	1.35%	1.30%	1.29%	1.21%	0.95%	0.51%	1.35%	1.29%	1.25%	1.12%	0.73%	0.12%
Kidney	11.95%	11.59%	11.03%	10.33%	9.20%	5.76%	11.95%	11.59%	11.01%	10.29%	9.14%	5.67%	11.94%	11.58%	10.98%	10.19%	8.94%	5.41%	11.93%	11.56%	10.92%	10.04%	8.64%	4.99%
Larynx	1.26%	1.13%	1.15%	1.05%	0.93%	0.73%	1.26%	1.13%	1.15%	1.03%	0.89%	0.65%	1.26%	1.12%	1.12%	0.97%	0.75%	0.40%	1.25%	1.11%	1.09%	0.87%	0.54%	0.01%
Liver	0.50%	0.55%	0.47%	0.38%	0.25%	0.35%	0.50%	0.55%	0.46%	0.36%	0.21%	0.27%	0.50%	0.54%	0.44%	0.31%	0.09%	0.05%	0.50%	0.53%	0.41%	0.22%	-0.12%	-0.32%
Lung	3.37%	2.16%	1.69%	1.41%	0.90%	0.38%	3.37%	2.16%	1.68%	1.39%	0.85%	0.30%	3.37%	2.15%	1.66%	1.32%	0.73%	0.08%	3.36%	2.14%	1.62%	1.23%	0.51%	-0.30%
Melanoma of skin	4.03%	3.97%	3.89%	3.78%	3.55%	2.89%	4.03%	3.97%	3.88%	3.76%	3.50%	2.81%	4.03%	3.96%	3.86%	3.70%	3.37%	2.57%	4.02%	3.95%	3.82%	3.60%	3.16%	2.18%
Oesophagus	0.99%	0.91%	0.90%	0.80%	0.55%	0.10%	0.99%	0.90%	0.89%	0.78%	0.50%	0.02%	0.98%	0.90%	0.87%	0.72%	0.38%	-0.20%	0.98%	0.89%	0.83%	0.62%	0.17%	-0.57%
Oral cavity	0.87%	0.70%	0.59%	0.53%	0.44%	0.31%	0.87%	0.70%	0.58%	0.51%	0.40%	0.24%	0.86%	0.70%	0.56%	0.45%	0.28%	0.01%	0.86%	0.69%	0.53%	0.36%	0.07%	-0.36%
Oropharynx	0.37%	0.34%	0.29%	0.20%	0.12%	0.03%	0.37%	0.34%	0.28%	0.19%	0.08%	-0.04%	0.37%	0.33%	0.26%	0.13%	-0.04%	-0.26%	0.37%	0.32%	0.23%	0.04%	-0.24%	-0.64%
Ovary	2.16%	1.78%	1.44%	1.10%	0.81%	0.66%	2.16%	1.78%	1.43%	1.08%	0.77%	0.58%	2.15%	1.78%	1.41%	1.02%	0.64%	0.35%	2.15%	1.76%	1.38%	0.92%	0.43%	-0.03%
Pancreas	0.32%	0.28%	0.29%	0.18%	0.11%	0.18%	0.32%	0.28%	0.28%	0.16%	0.07%	0.11%	0.32%	0.27%	0.26%	0.11%	-0.05%	-0.11%	0.31%	0.26%	0.23%	0.02%	-0.25%	-0.49%
Prostate	12.25%	12.23%	12.32%	12.31%	12.08%	10.09%	12.24%	12.23%	12.31%	12.28%	12.02%	10.02%	12.24%	12.22%	12.26%	12.18%	11.87%	9.79%	12.23%	12.20%	12.20%	12.02%	11.62%	9.41%
Stomach	1.19%	1.17%	1.01%	0.90%	0.75%	0.24%	1.19%	1.17%	1.00%	0.88%	0.71%	0.16%	1.19%	1.16%	0.98%	0.82%	0.57%	-0.06%	1.18%	1.15%	0.94%	0.72%	0.36%	-0.43%
Testis	6.45%	6.50%	6.38%	6.39%	6.19%	5.76%	6.45%	6.49%	6.37%	6.37%	6.15%	5.68%	6.45%	6.49%	6.35%	6.31%	6.01%	5.43%	6.44%	6.47%	6.31%	6.21%	5.79%	5.03%
Thyroid	1.57%	1.54%	1.49%	1.52%	1.34%	1.40%	1.56%	1.53%	1.48%	1.50%	1.30%	1.32%	1.56%	1.53%	1.46%	1.44%	1.17%	1.08%	1.56%	1.52%	1.43%	1.34%	0.96%	0.68%
Uterus	2.73%	2.59%	2.54%	2.36%	2.08%	1.74%	2.73%	2.59%	2.53%	2.34%	2.03%	1.65%	2.73%	2.58%	2.51%	2.27%	1.90%	1.41%	2.72%	2.57%	2.47%	2.17%	1.68%	1.01%

#### Supplementary Table 7: Survival benefit per referred patient of prompt investigatory refferal versus 2-, 4-, and 6-month delay.

Per patient referred (by age group and nosocomial infection rate).

Different age groups and differing levels of nosocomial infection rates (0.5%, 1%, 2.5%, 5%) considered.

Red indicates net survival advantage for investigatory referral compared to delay; Green indicates net survival diasadvantage for investigatory referral compared to delay.

Nosocomial COVID-19 Infection Rate (for investigatory referral)		0.50%							1	%					2.5	0%					5	%		
2 month delay																			-					
	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+
Bladder	1.47%	1.38%	1.31%	1.12%	0.82%	0.09%	1.46%	1.38%	1.30%	1.10%	0.78%	0.02%	1.46%	1.37%	1.28%	1.05%	0.65%	-0.21%	1.46%	1.36%	1.25%	0.95%	0.45%	-0.58%
Brain	0.07%	0.09%	0.11%	0.10%	0.08%	0.04%	0.07%	0.09%	0.10%	0.09%	0.04%	-0.03%	0.07%	0.08%	0.08%	0.03%	-0.09%	-0.26%	0.06%	0.07%	0.05%	-0.06%	-0.29%	-0.63%
Breast	0.14%	0.09%	0.07%	0.05%	0.07%	0.06%	0.14%	0.09%	0.06%	0.03%	0.03%	-0.01%	0.14%	0.09%	0.04%	-0.03%	-0.09%	-0.23%	0.14%	0.08%	0.01%	-0.12%	-0.29%	-0.60%
Cervix	0.09%	0.14%	0.19%	0.17%	0.09%	-0.02%	0.09%	0.14%	0.18%	0.15%	0.05%	-0.09%	0.08%	0.13%	0.16%	0.10%	-0.07%	-0.31%	0.08%	0.12%	0.13%	0.01%	-0.27%	-0.68%
Colorectal	0.10%	0.11%	0.10%	0.08%	0.09%	0.06%	0.09%	0.11%	0.09%	0.06%	0.05%	-0.02%	0.09%	0.10%	0.07%	0.01%	-0.07%	-0.24%	0.09%	0.09%	0.04%	-0.08%	-0.28%	-0.62%
Kidney	0.40%	0.52%	0.68%	0.78%	0.81%	0.45%	0.40%	0.52%	0.68%	0.76%	0.77%	0.38%	0.40%	0.51%	0.66%	0.71%	0.64%	0.15%	0.39%	0.50%	0.62%	0.61%	0.43%	-0.22%
Larynx	0.11%	0.14%	0.13%	0.12%	0.11%	0.09%	0.11%	0.14%	0.12%	0.10%	0.07%	0.01%	0.10%	0.13%	0.10%	0.05%	-0.05%	-0.21%	0.10%	0.12%	0.07%	-0.04%	-0.25%	-0.59%
Liver	0.19%	0.20%	0.18%	0.12%	0.06%	-0.02%	0.19%	0.19%	0.18%	0.10%	0.02%	-0.10%	0.19%	0.19%	0.16%	0.05%	-0.11%	-0.32%	0.18%	0.18%	0.12%	-0.04%	-0.31%	-0.69%
Lung	0.59%	0.67%	0.63%	0.46%	0.27%	-0.01%	0.59%	0.67%	0.62%	0.44%	0.22%	-0.08%	0.58%	0.66%	0.60%	0.38%	0.10%	-0.30%	0.58%	0.65%	0.56%	0.29%	-0.10%	-0.68%
Melanoma of skin	0.08%	0.10%	0.12%	0.13%	0.15%	0.26%	0.08%	0.10%	0.11%	0.11%	0.11%	0.19%	0.08%	0.09%	0.10%	0.06%	-0.01%	-0.03%	0.07%	0.08%	0.06%	-0.03%	-0.21%	-0.41%
Oesophagus	0.37%	0.36%	0.35%	0.29%	0.13%	-0.06%	0.37%	0.36%	0.35%	0.27%	0.09%	-0.14%	0.37%	0.35%	0.33%	0.21%	-0.04%	-0.36%	0.36%	0.34%	0.29%	0.12%	-0.24%	-0.73%
Oral cavity	0.09%	0.12%	0.13%	0.11%	0.08%	0.02%	0.09%	0.12%	0.13%	0.09%	0.04%	-0.05%	0.09%	0.12%	0.11%	0.04%	-0.08%	-0.28%	0.08%	0.11%	0.07%	-0.05%	-0.28%	-0.65%
Oropharynx	0.03%	0.04%	0.05%	0.03%	0.00%	-0.05%	0.03%	0.04%	0.04%	0.01%	-0.04%	-0.12%	0.03%	0.03%	0.02%	-0.04%	-0.16%	-0.34%	0.03%	0.02%	-0.01%	-0.13%	-0.36%	-0.71%
Ovary	0.11%	0.21%	0.27%	0.25%	0.18%	0.06%	0.11%	0.21%	0.26%	0.23%	0.13%	-0.01%	0.11%	0.21%	0.24%	0.18%	0.01%	-0.24%	0.10%	0.20%	0.21%	0.09%	-0.19%	-0.61%
Pancreas	0.16%	0.14%	0.14%	0.07%	0.01%	-0.05%	0.16%	0.14%	0.14%	0.05%	-0.03%	-0.13%	0.15%	0.14%	0.12%	-0.01%	-0.15%	-0.35%	0.15%	0.13%	0.08%	-0.10%	-0.35%	-0.72%
Prostate	0.05%	0.05%	0.02%	-0.02%	-0.04%	-0.06%	0.05%	0.05%	0.01%	-0.04%	-0.08%	-0.14%	0.05%	0.04%	-0.01%	-0.09%	-0.20%	-0.36%	0.04%	0.03%	-0.04%	-0.18%	-0.40%	-0.73%
Stomach	0.33%	0.33%	0.32%	0.26%	0.19%	-0.02%	0.33%	0.32%	0.31%	0.24%	0.15%	-0.09%	0.32%	0.32%	0.29%	0.19%	0.03%	-0.31%	0.32%	0.31%	0.26%	0.10%	-0.18%	-0.68%
Testis	0.02%	0.01%	0.03%	0.00%	-0.01%	-0.01%	0.02%	0.01%	0.02%	-0.02%	-0.05%	-0.09%	0.02%	0.00%	0.00%	-0.08%	-0.17%	-0.31%	0.01%	-0.01%	-0.03%	-0.17%	-0.37%	-0.68%
Thyroid	0.00%	0.00%	0.01%	-0.02%	-0.01%	-0.07%	0.00%	0.00%	0.00%	-0.03%	-0.05%	-0.15%	0.00%	0.00%	-0.02%	-0.09%	-0.17%	-0.37%	-0.01%	-0.01%	-0.05%	-0.18%	-0.37%	-0.74%
Uterus	0.04%	0.09%	0.10%	0.14%	0.17%	0.17%	0.04%	0.09%	0.09%	0.12%	0.13%	0.09%	0.04%	0.08%	0.07%	0.06%	0.01%	-0.13%	0.03%	0.07%	0.04%	-0.03%	-0.19%	-0.51%
4 month delay																								
Bladder	3.17%	3.02%	2.89%	2.45%	1.75%	0.24%	3.16%	3.01%	2.88%	2.43%	1.71%	0.16%	3.16%	3.01%	2.86%	2.36%	1.58%	-0.06%	3.16%	2.99%	2.82%	2.26%	1.37%	-0.43%
Brain	0.16%	0.20%	0.23%	0.22%	0.17%	0.14%	0.16%	0.19%	0.23%	0.20%	0.13%	0.07%	0.16%	0.19%	0.21%	0.15%	0.01%	-0.16%	0.16%	0.18%	0.17%	0.06%	-0.19%	-0.53%
Breast	0.31%	0.21%	0.15%	0.12%	0.19%	0.21%	0.31%	0.21%	0.15%	0.10%	0.15%	0.14%	0.31%	0.20%	0.13%	0.05%	0.03%	-0.09%	0.30%	0.19%	0.10%	-0.04%	-0.17%	-0.46%
Cervix	0.20%	0.33%	0.43%	0.39%	0.21%	0.03%	0.20%	0.32%	0.42%	0.37%	0.17%	-0.05%	0.20%	0.32%	0.40%	0.31%	0.05%	-0.27%	0.20%	0.31%	0.37%	0.22%	-0.15%	-0.64%
Colorectal	0.23%	0.26%	0.24%	0.22%	0.26%	0.21%	0.23%	0.25%	0.23%	0.20%	0.22%	0.14%	0.23%	0.25%	0.21%	0.15%	0.09%	-0.09%	0.22%	0.24%	0.18%	0.06%	-0.11%	-0.47%
Kidney	0.94%	1.21%	1.58%	1.80%	1.84%	0.97%	0.94%	1.21%	1.57%	1.78%	1.79%	0.89%	0.94%	1.21%	1.55%	1.72%	1.66%	0.66%	0.93%	1.20%	1.52%	1.61%	1.43%	0.28%
Larynx	0.25%	0.31%	0.29%	0.28%	0.28%	0.26%	0.25%	0.31%	0.28%	0.26%	0.24%	0.18%	0.24%	0.30%	0.26%	0.21%	0.12%	-0.05%	0.24%	0.29%	0.23%	0.12%	-0.09%	-0.43%
Liver	0.35%	0.36%	0.33%	0.22%	0.12%	0.01%	0.35%	0.36%	0.32%	0.20%	0.08%	-0.06%	0.34%	0.35%	0.30%	0.15%	-0.05%	-0.28%	0.34%	0.34%	0.27%	0.06%	-0.25%	-0.65%
Lung	1.25%	1.28%	1.14%	0.81%	0.46%	0.02%	1.25%	1.27%	1.13%	0.79%	0.42%	-0.05%	1.24%	1.27%	1.11%	0.74%	0.29%	-0.27%	1.24%	1.26%	1.07%	0.64%	0.09%	-0.64%
Melanoma of skin	0.19%	0.24%	0.29%	0.33%	0.41%	0.67%	0.19%	0.24%	0.29%	0.31%	0.37%	0.60%	0.19%	0.23%	0.27%	0.26%	0.24%	0.37%	0.18%	0.22%	0.23%	0.17%	0.04%	0.00%
Oesophagus	0.67%	0.64%	0.63%	0.52%	0.23%	-0.06%	0.67%	0.64%	0.62%	0.50%	0.19%	-0.13%	0.67%	0.63%	0.60%	0.44%	0.07%	-0.36%	0.66%	0.62%	0.57%	0.34%	-0.13%	-0.73%

Oxy         0.57%         0.57%         0.57%         0.57%         0.17%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.47%         0.57%         0.27%         0.47%         0.57%         0.27%         0.47%         0.57%         0	n	-																					1		
Oxy         0.55%         0.57%         0.57%         0.57%         0.17%         0.27%         0	Oral cavity	0.21%	0.26%	0.27%	0.24%	0.20%	0.10%	0.20%	0.26%	0.27%	0.22%	0.16%	0.03%	0.20%	0.26%	0.25%	0.17%	0.04%	-0.20%	0.20%	0.25%	0.21%	0.08%	-0.17%	-0.57%
Pancesa         0.26%         0.25%         0.24%         0.14%         0.04%         0.04%         0.26%         0.25%         0.21%         0.14%         0.13%         0.01%         0.05%         0.03%         <	Oropharynx	0.08%	0.09%	0.10%	0.07%	0.04%	-0.03%	0.08%	0.09%	0.10%	0.06%	0.00%	-0.10%	0.07%	0.09%	0.08%	0.00%	-0.12%	-0.32%	0.07%	0.08%	0.04%	-0.09%	-0.32%	-0.69%
Prostate         0.12%         0.12%         0.05%         0.02%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%         0.01%         0.02%        <	Ovary	0.25%	0.47%	0.57%	0.51%	0.36%	0.17%	0.25%	0.47%	0.57%	0.49%	0.32%	0.09%	0.25%	0.47%	0.55%	0.43%	0.20%	-0.13%	0.25%	0.46%	0.51%	0.34%	-0.01%	-0.50%
Shomach         O.64w         <	Pancreas	0.26%	0.23%	0.24%	0.11%	0.04%	-0.04%	0.26%	0.23%	0.23%	0.09%	0.00%	-0.12%	0.25%	0.22%	0.21%	0.04%	-0.13%	-0.34%	0.25%	0.21%	0.18%	-0.05%	-0.33%	-0.71%
Tesis0.05%	Prostate	0.12%	0.12%	0.05%	-0.02%	-0.04%	-0.05%	0.12%	0.11%	0.04%	-0.04%	-0.08%	-0.13%	0.11%	0.11%	0.02%	-0.09%	-0.20%	-0.35%	0.11%	0.10%	-0.01%	-0.18%	-0.40%	-0.72%
Thypical       0.01w       0.01w      <	Stomach	0.64%	0.64%	0.61%	0.50%	0.38%	0.01%	0.64%	0.64%	0.60%	0.48%	0.34%	-0.06%	0.64%	0.63%	0.58%	0.42%	0.21%	-0.28%	0.63%	0.62%	0.54%	0.33%	0.00%	-0.66%
Unrise0.100.210.240.340.430.430.450.100.210.230.350.240.210.210.25	Testis	0.05%	0.03%	0.06%	0.01%	0.02%	0.06%	0.05%	0.03%	0.06%	0.00%	-0.02%	-0.02%	0.05%	0.02%	0.04%	-0.06%	-0.14%	-0.24%	0.04%	0.01%	0.00%	-0.15%	-0.34%	-0.61%
Generate Line         Source	Thyroid	0.00%	0.01%	0.02%	-0.01%	0.02%	-0.07%	0.00%	0.01%	0.02%	-0.03%	-0.02%	-0.15%	0.00%	0.00%	0.00%	-0.09%	-0.14%	-0.37%	-0.01%	-0.01%	-0.04%	-0.18%	-0.34%	-0.74%
Bladder         4988         4.818         2.65%         3.86%         2.64%         0.35%         4.84%         2.60%         0.27%         0.30%         0.27%         0.32%         0.37%         0.23%         0.31%         0.24%         0.21%         0.31%         0.31%         0.31%         0.31%         0.31%         0.33%         0.23%         0.33%         0.23%         0.33%         0.23%         0.30%         0.33%         0.33%         0.23%         0.30%         0.33%         0.33%         0.33%         0.23%         0.05%         0.39%         0.33% <t< td=""><td>Uterus</td><td>0.10%</td><td>0.21%</td><td>0.24%</td><td>0.33%</td><td>0.43%</td><td>0.45%</td><td>0.10%</td><td>0.21%</td><td>0.23%</td><td>0.32%</td><td>0.39%</td><td>0.37%</td><td>0.10%</td><td>0.21%</td><td>0.21%</td><td>0.26%</td><td>0.27%</td><td>0.14%</td><td>0.09%</td><td>0.20%</td><td>0.18%</td><td>0.17%</td><td>0.07%</td><td>-0.23%</td></t<>	Uterus	0.10%	0.21%	0.24%	0.33%	0.43%	0.45%	0.10%	0.21%	0.23%	0.32%	0.39%	0.37%	0.10%	0.21%	0.21%	0.26%	0.27%	0.14%	0.09%	0.20%	0.18%	0.17%	0.07%	-0.23%
Brain       0.75%       0.32%       0.35%       0.43%       0.24%       0.24%       0.27%       0.34%       0.27%       0.34%       0.35%       0.35%       0.25% <th< td=""><td>6 month delay</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>	6 month delay																								
Breast       0.50%       0.34%       0.20%       0.34%       0.50%       0.30%       0.30%       0.20%       0.31%       0.20%       0.40%       0.20%       0.40%       0.20%       0.40% <t< td=""><td>Bladder</td><td>4.98%</td><td>4.81%</td><td>4.65%</td><td>3.86%</td><td>2.64%</td><td>0.35%</td><td>4.98%</td><td>4.81%</td><td>4.64%</td><td>3.84%</td><td>2.60%</td><td>0.27%</td><td>4.97%</td><td>4.80%</td><td>4.62%</td><td>3.77%</td><td>2.47%</td><td>0.05%</td><td>4.97%</td><td>4.78%</td><td>4.58%</td><td>3.67%</td><td>2.25%</td><td>-0.32%</td></t<>	Bladder	4.98%	4.81%	4.65%	3.86%	2.64%	0.35%	4.98%	4.81%	4.64%	3.84%	2.60%	0.27%	4.97%	4.80%	4.62%	3.77%	2.47%	0.05%	4.97%	4.78%	4.58%	3.67%	2.25%	-0.32%
CarvixO.56%0.56%0.76%0.61%0.32%0.06%0.36%0.66%0.28%0.26%0.56%0.56%0.56%0.16%0.24%0.25%0.45% <th< td=""><td>Brain</td><td>0.27%</td><td>0.32%</td><td>0.35%</td><td>0.31%</td><td>0.24%</td><td>0.21%</td><td>0.27%</td><td>0.31%</td><td>0.35%</td><td>0.30%</td><td>0.19%</td><td>0.14%</td><td>0.27%</td><td>0.31%</td><td>0.33%</td><td>0.24%</td><td>0.07%</td><td>-0.09%</td><td>0.27%</td><td>0.30%</td><td>0.29%</td><td>0.15%</td><td>-0.13%</td><td>-0.47%</td></th<>	Brain	0.27%	0.32%	0.35%	0.31%	0.24%	0.21%	0.27%	0.31%	0.35%	0.30%	0.19%	0.14%	0.27%	0.31%	0.33%	0.24%	0.07%	-0.09%	0.27%	0.30%	0.29%	0.15%	-0.13%	-0.47%
Colorectal0.40%0.44%0.41%0.40%0.40%0.40%0.40%0.41%0.40%0.41%0.40%0.41%0.40%0.41%0.40% <td>Breast</td> <td>0.50%</td> <td>0.34%</td> <td>0.26%</td> <td>0.21%</td> <td>0.34%</td> <td>0.37%</td> <td>0.50%</td> <td>0.34%</td> <td>0.25%</td> <td>0.19%</td> <td>0.30%</td> <td>0.30%</td> <td>0.50%</td> <td>0.33%</td> <td>0.23%</td> <td>0.14%</td> <td>0.18%</td> <td>0.07%</td> <td>0.49%</td> <td>0.32%</td> <td>0.20%</td> <td>0.04%</td> <td>-0.02%</td> <td>-0.30%</td>	Breast	0.50%	0.34%	0.26%	0.21%	0.34%	0.37%	0.50%	0.34%	0.25%	0.19%	0.30%	0.30%	0.50%	0.33%	0.23%	0.14%	0.18%	0.07%	0.49%	0.32%	0.20%	0.04%	-0.02%	-0.30%
Kidey1.662.1283.083.011.4141.6662.1282.1713.0182.651.3131.652.1182.882.8181.1051.6552.1082.6482.108<	Cervix	0.36%	0.56%	0.72%	0.61%	0.32%	0.06%	0.36%	0.56%	0.71%	0.60%	0.28%	-0.02%	0.36%	0.55%	0.69%	0.54%	0.16%	-0.24%	0.35%	0.54%	0.66%	0.45%	-0.04%	-0.61%
Larynx0.41%0.50%0.48%0.48%0.46%0.46%0.42%0.41%0.46%0.42%0.44%0.42%0.44%0.46%0.41%0.41%0.45%0.45%0.45%0.45%0.40% <th< td=""><td>Colorectal</td><td>0.40%</td><td>0.44%</td><td>0.41%</td><td>0.39%</td><td>0.45%</td><td>0.36%</td><td>0.40%</td><td>0.43%</td><td>0.41%</td><td>0.37%</td><td>0.41%</td><td>0.28%</td><td>0.39%</td><td>0.43%</td><td>0.39%</td><td>0.32%</td><td>0.28%</td><td>0.05%</td><td>0.39%</td><td>0.42%</td><td>0.35%</td><td>0.23%</td><td>0.07%</td><td>-0.33%</td></th<>	Colorectal	0.40%	0.44%	0.41%	0.39%	0.45%	0.36%	0.40%	0.43%	0.41%	0.37%	0.41%	0.28%	0.39%	0.43%	0.39%	0.32%	0.28%	0.05%	0.39%	0.42%	0.35%	0.23%	0.07%	-0.33%
Liver0.44%0.47%0.42%0.42%0.42%0.44%0.44%0.44%0.44%0.44%0.44%0.44%0.44%0.46%0.43%0.20%0.42%0.43%	Kidney	1.66%	2.12%	2.71%	3.03%	3.01%	1.41%	1.66%	2.12%	2.71%	3.01%	2.96%	1.33%	1.65%	2.11%	2.68%	2.94%	2.81%	1.10%	1.65%	2.10%	2.64%	2.83%	2.58%	0.72%
Lng1.92%1.74%1.47%1.02%0.55%0.03%1.92%1.74%1.46%1.00%0.50%0.10%1.41%0.41%0.43%0.26%0.17%1.41%0.43%0.26%0.41%0.43%0.	Larynx	0.41%	0.50%	0.48%	0.46%	0.46%	0.42%	0.41%	0.50%	0.47%	0.44%	0.42%	0.34%	0.41%	0.50%	0.45%	0.38%	0.29%	0.11%	0.40%	0.49%	0.42%	0.29%	0.08%	-0.28%
Under0.34%0.34%0.52%0.59%0.59%0.73%1.15%0.34%0.43%0.52%0.69%1.07%0.42%0.42%0.50%0.57%0.84%0.43%	Liver	0.44%	0.47%	0.42%	0.28%	0.14%	0.04%	0.44%	0.47%	0.41%	0.26%	0.10%	-0.04%	0.44%	0.46%	0.39%	0.20%	-0.02%	-0.26%	0.43%	0.45%	0.36%	0.11%	-0.22%	-0.63%
Oesophages0.86%0.81%0.80%0.65%0.29%0.06%0.86%0.79%0.63%0.21%0.70%0.70%0.70%0.75%0.12%0.45%0.75% <td>Lung</td> <td>1.92%</td> <td>1.74%</td> <td>1.47%</td> <td>1.02%</td> <td>0.55%</td> <td>0.03%</td> <td>1.92%</td> <td>1.74%</td> <td>1.46%</td> <td>1.00%</td> <td>0.50%</td> <td>-0.04%</td> <td>1.92%</td> <td>1.73%</td> <td>1.44%</td> <td>0.94%</td> <td>0.38%</td> <td>-0.26%</td> <td>1.91%</td> <td>1.72%</td> <td>1.40%</td> <td>0.84%</td> <td>0.17%</td> <td>-0.63%</td>	Lung	1.92%	1.74%	1.47%	1.02%	0.55%	0.03%	1.92%	1.74%	1.46%	1.00%	0.50%	-0.04%	1.92%	1.73%	1.44%	0.94%	0.38%	-0.26%	1.91%	1.72%	1.40%	0.84%	0.17%	-0.63%
And Oral cavity0.34%0.41%0.40%0.35%0.29%0.16%0.34%0.40%0.33%0.25%0.08%0.33%0.40%0.38%0.28%0.18%0.14%0.33%0.39%	Melanoma of skin	0.34%	0.43%	0.52%	0.59%	0.73%	1.15%	0.34%	0.43%	0.52%	0.57%	0.69%	1.07%	0.34%	0.42%	0.50%	0.52%	0.57%	0.84%	0.34%	0.41%	0.46%	0.43%	0.37%	0.46%
Or open arrows0.13°0.15°0.16°0.11°0.07°0.02°0.13°0.15°0.16°0.16°0.10°0.02°0.10°0.13°0.13°0.11°0.11°0.11°0.10°	Oesophagus	0.86%	0.81%	0.80%	0.65%	0.29%	-0.06%	0.86%	0.81%	0.79%	0.63%	0.24%	-0.13%	0.86%	0.80%	0.77%	0.57%	0.12%	-0.35%	0.85%	0.79%	0.74%	0.47%	-0.08%	-0.72%
And the problem of t	Oral cavity	0.34%	0.41%	0.40%	0.35%	0.29%	0.16%	0.34%	0.40%	0.40%	0.33%	0.25%	0.08%	0.33%	0.40%	0.38%	0.28%	0.13%	-0.14%	0.33%	0.39%	0.34%	0.19%	-0.08%	-0.51%
Pancreas0.31%0.27%0.28%0.13%0.04%0.04%0.04%0.30%0.27%0.27%0.11%0.00%0.11%0.30%0.25%0.12%0.34%0.36%0.25%0.27%0.31%0.31%0.31%0.31%0.31%0.30%0.25%0.31%0.30%0.30%0.25%0.31%0.30%0.25%0.31%0.30%0.25%0.31%0.31%0.30%0.25%0.31%<	Oropharynx	0.13%	0.15%	0.16%	0.11%	0.07%	-0.02%	0.13%	0.15%	0.16%	0.10%	0.02%	-0.09%	0.13%	0.15%	0.14%	0.04%	-0.10%	-0.31%	0.12%	0.14%	0.10%	-0.05%	-0.30%	-0.68%
Prostate0.19%0.19%0.09%0.02%0.02%0.04%0.19%0.19%0.08%0.08%0.10%0.19%0.19%0.10%<	Ovary	0.44%	0.77%	0.87%	0.73%	0.49%	0.24%	0.44%	0.77%	0.86%	0.71%	0.45%	0.16%	0.44%	0.76%	0.84%	0.65%	0.32%	-0.06%	0.43%	0.75%	0.81%	0.55%	0.12%	-0.44%
Stomach0.9000.8900.8900.8020.6700.9000.9000.8900.400 <t< td=""><td>Pancreas</td><td>0.31%</td><td>0.27%</td><td>0.28%</td><td>0.13%</td><td>0.04%</td><td>-0.04%</td><td>0.30%</td><td>0.27%</td><td>0.27%</td><td>0.11%</td><td>0.00%</td><td>-0.11%</td><td>0.30%</td><td>0.26%</td><td>0.25%</td><td>0.05%</td><td>-0.12%</td><td>-0.34%</td><td>0.30%</td><td>0.25%</td><td>0.22%</td><td>-0.04%</td><td>-0.32%</td><td>-0.71%</td></t<>	Pancreas	0.31%	0.27%	0.28%	0.13%	0.04%	-0.04%	0.30%	0.27%	0.27%	0.11%	0.00%	-0.11%	0.30%	0.26%	0.25%	0.05%	-0.12%	-0.34%	0.30%	0.25%	0.22%	-0.04%	-0.32%	-0.71%
Testis       0.09       0.05%       0.11%       0.04%       0.05%       0.14%       0.09%       0.05%       0.10%       0.05%       0.01%       0.05%       0.01%       0.01%       0.05%       0.01% <th< td=""><td>Prostate</td><td>0.19%</td><td>0.19%</td><td>0.09%</td><td>-0.02%</td><td>-0.04%</td><td>-0.04%</td><td>0.19%</td><td>0.19%</td><td>0.08%</td><td>-0.04%</td><td>-0.08%</td><td>-0.11%</td><td>0.19%</td><td>0.18%</td><td>0.06%</td><td>-0.09%</td><td>-0.20%</td><td>-0.34%</td><td>0.18%</td><td>0.17%</td><td>0.03%</td><td>-0.18%</td><td>-0.40%</td><td>-0.71%</td></th<>	Prostate	0.19%	0.19%	0.09%	-0.02%	-0.04%	-0.04%	0.19%	0.19%	0.08%	-0.04%	-0.08%	-0.11%	0.19%	0.18%	0.06%	-0.09%	-0.20%	-0.34%	0.18%	0.17%	0.03%	-0.18%	-0.40%	-0.71%
Thyroid 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0% 0.0	Stomach	0.90%	0.89%	0.82%	0.67%	0.50%	0.02%	0.90%	0.89%	0.81%	0.65%	0.46%	-0.05%	0.90%	0.88%	0.79%	0.59%	0.33%	-0.27%	0.89%	0.87%	0.76%	0.49%	0.12%	-0.65%
	Testis	0.09%	0.05%	0.11%	0.04%	0.05%	0.14%	0.09%	0.05%	0.10%	0.02%	0.01%	0.06%	0.08%	0.04%	0.08%	-0.04%	-0.11%	-0.16%	0.08%	0.03%	0.05%	-0.13%	-0.31%	-0.53%
Uterus 0.18% 0.38% 0.43% 0.58% 0.74% 0.75% 0.18% 0.38% 0.42% 0.57% 0.70% 0.68% 0.18% 0.42% 0.57% 0.70% 0.68% 0.18% 0.18% 0.37% 0.40% 0.51% 0.58% 0.44% 0.17% 0.36% 0.37% 0.42% 0.37% 0.40%	Thyroid	0.00%	0.02%	0.04%	-0.01%	0.05%	-0.07%	0.00%	0.02%	0.04%	-0.03%	0.01%	-0.15%	0.00%	0.01%	0.02%	-0.08%	-0.11%	-0.37%	-0.01%	0.00%	-0.02%	-0.17%	-0.31%	-0.74%
	Uterus	0.18%	0.38%	0.43%	0.58%	0.74%	0.75%	0.18%	0.38%	0.42%	0.57%	0.70%	0.68%	0.18%	0.37%	0.40%	0.51%	0.58%	0.44%	0.17%	0.36%	0.37%	0.42%	0.37%	0.06%

#### Supplementary Table 8: Life-years lost per patient referred from 2-, 4-, and 6-month delay (by age group).

Nosocomial infection rate: 0.5% per investigatory referral.

Red indicates values above median and blue values below the median

			2 month	delay					4 month	delay					6 month	delay		
	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+	30-39	40-49	50-59	60-69	70-79	80+
Bladder	0.69	0.52	0.37	0.22	0.10	0.01	1.49	1.13	0.82	0.48	0.21	0.02	2.34	1.80	1.32	0.77	0.32	0.02
Brain	0.03	0.03	0.03	0.02	0.01	0.00	0.08	0.07	0.07	0.04	0.02	0.01	0.13	0.12	0.10	0.06	0.03	0.01
Breast	0.07	0.04	0.02	0.01	0.01	0.00	0.15	0.08	0.04	0.02	0.02	0.01	0.24	0.13	0.07	0.04	0.04	0.02
Cervix	0.04	0.05	0.05	0.03	0.01	0.00	0.10	0.12	0.12	0.08	0.03	0.00	0.17	0.21	0.20	0.12	0.04	0.00
Colorectal	0.04	0.04	0.03	0.02	0.01	0.00	0.11	0.10	0.07	0.04	0.03	0.01	0.19	0.16	0.12	0.08	0.06	0.02
Kidney	0.19	0.19	0.19	0.16	0.10	0.03	0.44	0.46	0.45	0.36	0.22	0.06	0.78	0.79	0.77	0.60	0.37	0.09
Larynx	0.05	0.05	0.04	0.02	0.01	0.01	0.12	0.12	0.08	0.06	0.03	0.02	0.19	0.19	0.14	0.09	0.06	0.03
Liver	0.09	0.07	0.05	0.02	0.01	0.00	0.16	0.14	0.09	0.04	0.01	0.00	0.21	0.18	0.12	0.06	0.02	0.00
Lung	0.28	0.25	0.18	0.09	0.03	0.00	0.59	0.48	0.32	0.16	0.06	0.00	0.90	0.65	0.42	0.20	0.07	0.00
Melanoma of skin	0.04	0.04	0.03	0.03	0.02	0.02	0.09	0.09	0.08	0.07	0.05	0.04	0.16	0.16	0.15	0.12	0.09	0.07
Oesophagus	0.17	0.13	0.10	0.06	0.02	0.00	0.31	0.24	0.18	0.10	0.03	0.00	0.41	0.30	0.23	0.13	0.03	0.00
Oral cavity	0.04	0.05	0.04	0.02	0.01	0.00	0.10	0.10	0.08	0.05	0.02	0.01	0.16	0.15	0.11	0.07	0.04	0.01
Oropharynx	0.02	0.02	0.01	0.01	0.00	0.00	0.04	0.04	0.03	0.01	0.00	0.00	0.06	0.06	0.05	0.02	0.01	0.00
Ovary	0.05	0.08	0.08	0.05	0.02	0.00	0.12	0.18	0.16	0.10	0.04	0.01	0.21	0.29	0.25	0.14	0.06	0.02
Pancreas	0.07	0.05	0.04	0.01	0.00	0.00	0.12	0.09	0.07	0.02	0.00	0.00	0.14	0.10	0.08	0.03	0.01	0.00
Prostate	0.02	0.02	0.01	0.00	0.00	0.00	0.06	0.04	0.01	0.00	0.00	0.00	0.09	0.07	0.02	0.00	0.00	0.00
Stomach	0.15	0.12	0.09	0.05	0.02	0.00	0.30	0.24	0.17	0.10	0.05	0.00	0.42	0.33	0.23	0.13	0.06	0.00
Testis	0.01	0.00	0.01	0.00	0.00	0.00	0.02	0.01	0.02	0.00	0.00	0.00	0.04	0.02	0.03	0.01	0.01	0.01
Thyroid	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.01	0.01	0.00	0.01	0.00
Uterus	0.02	0.03	0.03	0.03	0.02	0.01	0.05	0.08	0.07	0.07	0.05	0.03	0.08	0.14	0.12	0.12	0.09	0.05

#### Supplementary Table 9: Multivariate sensitivity analysis.

Lives lost and life-years lost per year from 2 month delay, by variation in Fatality HRs, COVID-19 annual population infection rate, COVID-19 per day nosocomial infection rate, and ""cancer multiplier"" for COVID-19 case fatality rate.

Increased Fatality HR for High Baseline Fatality HR Fatality HR -2CI Fatality HR +2CI Progressiveness LOW 0.0030 LOW LOW LOW 0.0030 0.0025 0.0035 Progressiveness/Per Day Transition Rate MOD MOD MOD MOD 0.0056 0.0056 0.0047 0.0065 HIGH 0.0056 HIGH 0.0047 HIGH 0.0065 HIGH 0.0105 Lives Lost Life-Years lost Lives Lost Life-Years Lives Lost Life-Years Lives Lost Life-Years lost IMPACT OF 2 MONTH DELAY (year) (year) (year) lost (year) (year) lost (year) (year) (year) **Cancer Multiplier: 2-fold Population infection rate: 0.05** Nosocomial rate: 10% 2,909 53,203 2,426 44,313 62,227 72,170 3,398 3,788 2,932 Nosocomial rate: 5% 53,492 2,445 44,554 3,425 62,562 3,818 72,568 Nosocomial rate: 2% 2,949 53,707 2,460 44,734 3,445 62,812 3,840 72,877 Nosocomial rate: 1% 2,956 53,787 2,465 44,801 3,452 62,905 3,849 72,994 **Population infection rate: 0.2** Nosocomial rate: 10% 2,853 52,565 2,379 43,780 3,332 61,482 3,721 71,361 Nosocomial rate: 5% 2,875 52,847 2,398 44,016 3,359 61,810 3,750 71,751 Nosocomial rate: 2% 2,892 53,057 2,412 44,192 3,378 62,055 3,772 72,053 Nosocomial rate: 1% 2,417 44,257 3,385 3,780 72,168 2,898 53,136 62,146 **Population infection rate: 0.5** Nosocomial rate: 10% 2,740 51,288 2,285 42,714 3,201 59,992 3,587 69,741 42.939 Nosocomial rate: 5% 2,762 51,558 2.303 3.226 60.305 3,614 70.115 Nosocomial rate: 2% 2,777 51,759 2,316 43,108 3,244 60,540 3,635 70,406 Nosocomial rate: 1% 2,783 51,834 2,321 43,171 3,251 60,627 3,643 70,517 Cancer Multiplier: 5-fold **Population infection rate: 0.05** Nosocomial rate: 10% 52.884 2.881 2,402 44.046 3.365 61.854 3.754 71,765 Nosocomial rate: 5% 2,904 53,169 2,422 44,285 3,392 62,186 3,784 72,159 Nosocomial rate: 2% 2,921 53,382 2,436 44,463 3,412 62,434 3,806 72,465 Nosocomial rate: 1% 2,927 53,461 2,441 44,529 3,419 62,526 3,814 72,581 **Population infection rate: 0.2** Nosocomial rate: 10% 2.740 51.288 2.285 42,714 3.201 59.992 3.587 69.741 Nosocomial rate: 5% 2,762 51,558 2,303 42,939 3,226 60,305 3,614 70,115 Nosocomial rate: 2% 2,777 51,759 2,316 43,108 3,244 60,540 3,635 70,406 Nosocomial rate: 1% 2,783 51,834 2,321 43,171 3,251 60,627 3,643 70,517 **Population infection rate: 0.5** Nosocomial rate: 10% 2,459 48,096 2.050 40.049 2.873 56.266 3.252 65.692 Nosocomial rate: 5% 2,477 48,334 2,066 40,249 2,894 56,544 3,276 66,028 Nosocomial rate: 2% 2,491 48,513 2,077 40,398 2,910 56,751 3,294 66,289 Nosocomial rate: 1% 2,496 48,579 2,081 40,454 2,915 56,829 3,301 66,389

Highlighted in dark grey are the lives lost and life years lost per year from 2 month delay at default parameter estimates.

# Supplementary Table 10: Surgical intervention (major resections only) and duration of admission (days), by stage.

			ICU (days)	Ward (days)
Cancer Bladder	Stage	Major resection Cystectomy	2	7
Bladder	2	Cystectomy	2	7
Bladder	3	Cystectomy	2	7
Breast (all hormone marker statuses)	1	Wide Local Excision	0	1
Breast (all hormone marker statuses)	2	Wide Local Excision	0	1
Breast (all hormone marker statuses)	3	Wide Local Excision	0	1
Brain (all)	1-3 combined	Neuro Resection	1	3
Brain (malignant)	1-3 combined	Neuro Resection	1	3
Brain (non-malignant)	1-3 combined	Neuro Resection	1	3
Cervix	1-5 combined		0	3
Cervix	2	Open Hysterectomy+/- Bilateral Salpingo-oophrectomy	0	3
	3	Open Hysterectomy+/- Bilateral Salpingo-oophrectomy		3
Cervix		Open Hysterectomy+/- Bilateral Salpingo-oophrectomy	0	
Colorectal	1 2	Open Resection/AP resection	1	5
Colorectal	3	Open Resection/AP resection Open Resection/AP resection	1	5
				-
Kidney	1	Partial Nephrectomy	0	5
Kidney	2	Open Nephrectomy	1	5
Kidney	3	Open Nephrectomy	1	5
Larynx	1	Laryngectomy	1	6
Larynx	2	Laryngectomy	1	6
Larynx	3	Laryngectomy + neck dissection	1	6
Liver	1	Liver resection	1	7
Liver	2	Liver resection	1	7
Liver	3	Liver resection	1	7
Lung	1	Lobectomy	1	7
Lung	2	Lobectomy	1	7
Lung	3	Lobectomy	1	7
Melanoma of skin	1	Simple skin resection	0	1
Melanoma of skin	2	Complex skin resection	0	2
Melanoma of skin	3	Complex skin resection	0	2
Oesophagus	1	Oesophagectomy	2	10
Oesophagus	2	Oesophagectomy	2	10
Oesophagus	3	Oesophagectomy	2	10
Oral cavity	1	Wide local excision	0	3
Oral cavity	2	Wide local excision	0	3
Oral cavity	3	Wide local excision	0	3
Oropharynx	1	Resection	0	3
Oropharynx	2	Resection	0	3
Oropharynx	3	Resection	0	3
Ovary	1	Uni-/Bilateral Salpingo-oophrectomy	0	2
Ovary	2	Uni-/Bilateral Salpingo-oophrectomy	0	2
Ovary	3	Bilateral Salpingo-oophrectomy/Omentectomy/Peritoneal clearance	1	7
Pancreas	1	Pancreatectomy/ Whipples Procedure	2	10
Pancreas	2	Pancreatectomy/ Whipples Procedure	2	10
Pancreas	3	Pancreatectomy/ Whipples Procedure	2	10

Prostate	1	Radical Prostatectomy	1	5
Prostate	2	Radical Prostatectomy	1	5
Prostate	3	Radical Prostatectomy	1	5
Stomach	1	Partial Gastrectomy	2	7
Stomach	2	Gastrectomy	2	9
Stomach	3	Gastrectomy	2	9
Testis	1	Orchidectomy	0	1
Testis	2	Orchidectomy	0	1
Testis	3	Orchidectomy + RPLN dissection	0	3
Thymus	1-3 combined	Thymectomy	0	4
Thyroid	1	Thyroidectomy/lobectomy	0	3
Thyroid	2	Thyroidectomy/lobectomy + clearance	0	3
Thyroid	3	Thyroidectomy/lobectomy + clearance	0	3
Uterus	1	Open Hysterectomy+/- BSO	0	3
Uterus	2	Open Hysterectomy+/- BSO	0	3
Uterus	3	Open Hysterectomy+/- BSO	0	3

# Supplementary Table 11: 'Technical' risk of death per investigatory referral, by tumour type.

Cancer Type	Procedure-related technical risk
Colorectal	0.010%
Lung	0.005%
Bladder	0.005%

Tumour Group	Criteria for urgent referral/urgent investigation in primary care	Criteria for non urgent referral
Brain and CNS	<ul> <li>Adults with:</li> <li>Progressive, sub-acute loss of central neurological function</li> <li>New onset seizures – focal or interictal focal deficit</li> <li>Rapid personality change or behavioural disturbance / slowness confirmed by witnesses with no reasonable explanation</li> <li>Headache with sinister features suggestive of raised intracranial pressure including nausea, vomiting, drowsiness, pulse-synchronous tinnitus, worse on supine position, awakens sleep, behavioural slowness, cognitive decline</li> <li>Isolated new onset daily headache duration</li> </ul>	
Breast	<ul> <li>Women of any age (particularly age ≥ 30) with the following symptoms</li> <li>Suspicious breast lump</li> <li>Persistent or unexplained lump in axilla</li> <li>Unilateral nipple discharge (blood-stained/serous), retraction, ulceration, distortion, eczema resistant to topical steroids, other changes of concern</li> <li>Skin changes that suggest breast cancer including nodules, ulceration, peau d'orange or dimpling</li> <li>Unilateral non-cyclical breast pain persisting beyond one menstrual cycle (higher suspicion if aged ≥ 30)</li> <li>Previous history of breast cancer plus suspicious symptoms</li> <li>Men aged ≥ 50 and over with a sub-areolar lump</li> </ul>	<ul> <li>The following patients do not usually need urgent referral to a breast clinic - consider a non-urgent referral for the following:</li> <li>Bilateral nipple discharge</li> <li>Sebaceous cysts</li> <li>Bilateral gynaecomastia</li> <li>Bilateral breast pain</li> <li>Asymptomatic patients with a family history of breast cancer. (Please note there may be a special 'family history breast clinic' in your area)</li> </ul>
Gynae	Ovarian Cancer         Carry out tests in primary care (see below) if a woman (especially if aged 45 or over) reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month: <ul> <li>Persistent abdominal distension or 'bloating'</li> <li>Feeling full (early satiety) and/or loss of appetite</li> <li>Pelvic or abdominal pain</li> <li>Increased urinary urgency and/or frequency. (CG122, 2011)</li> </ul>	
	<ul> <li>Endometrial Cancer</li> <li>Women aged 45 and over with unexplained symptoms of vaginal discharge* who: <ul> <li>Are presenting with these symptoms for the first time</li> <li>Have thrombocytosis</li> <li>Report haematuria or</li> <li>Have visible haematuria and <ul> <li>Low haemoglobin level</li> <li>Thrombocytosis</li> <li>High blood glucose levels</li> </ul> </li> </ul></li></ul>	
	Cervix • Appearance of cervix consistent with cervical cancer	
	Vagina         •         Unexplained palpable mass in or at entrance to vagina	
	<ul> <li>Vulva</li> <li>Unexplained vulval lump, ulceration or bleeding</li> </ul>	

# Supplementary Table 12: Criteria for Urgent (2WW) investigatory referral from Primary Care

Head and Neck	<ul> <li>Laryngeal/Pharyngeal Cancer         <ul> <li>Unexplained lump or mass in the neck / throat</li> <li>≥ 40 years old with:                 <ul></ul></li></ul></li></ul>	
	<ul> <li>Salivary Cancer</li> <li>≥ 40 years old with unexplained or persistent parotid orsubmandibular swelling</li> <li>Firm sub-mucosal swelling in the oral cavity</li> </ul>	
	<ul> <li>Ear/Nose/Sinus Cancer</li> <li>Persistent unilateral otalgia</li> <li>Serosanguinous nasal discharge which persists for more than three weeks</li> <li>Unilateral nasal obstruction associated with a purulent discharge</li> <li>Facial palsy / cranial neuropathies</li> <li>Orbital masses</li> <li>Severe facial pain</li> </ul>	
	Thyroid Cancer         • Unexplained solitary thyroid lump         • Ultrasound suggestive of thyroid cancer	
	Oral/Lip Cancer         • ≥ 3 weeks unexplained ulceration in the oral cavity         • Suspicious lump/mass on the lip or in the oral cavity         • A red or red and white patch in the oral cavity suggestive of leukoplakia or erythroleukoplakia         • Tooth mobility not associated with periodontal disease         • Poor healing ≥ 3 weeks post tooth extraction	
Lower GI	<ul> <li>Abnormal lower GI investigations (colonoscopy/flexible sigmoidoscopy) suggestive of cancer</li> <li>Positive FIT (Faecal Immunochemical Test) suggestive of cancer</li> <li>Any age with unexplained rectal or abdominal mass</li> <li>Any age with unexplained anal mass or unexplained anal ulceration</li> <li>≥40 years and over with unexplained weight loss and abdominal pain</li> <li>≤50 years with rectal bleeding and any of the following unexplained symptoms:         <ul> <li>Abdominal pain</li> <li>Change in bowel habit</li> <li>Weight loss</li> <li>Iron deficiency anaemia (attach results)</li> </ul> </li> <li>≥50 years with iron deficiency anaemia</li> <li>≥60 years with changes in their bowel habit</li> </ul>	

Lung and Pleural	<ul> <li>Age ≥ 40 years with UNEXPLAINED haemoptysis</li> <li>Abnormal chest x-ray suggestive of lung cancer or mesothelioma (such as a slowly resolving consolidation or pleural effusion)</li> <li>Abnormal CT scan suggestive of lung cancer or mesothelioma</li> <li>Features suggestive of lung cancer metastasis including bone pain, paraneoplastic signs or history of cancer</li> <li>Normal chest x-ray but high suspicion of lung cancer</li> </ul>	
Melanoma	Refer patients with a suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more.         Each major feature scores 2 points. Each minor feature scores 1 point.         Major Features of the legions (scoring 2 points each):         •       Change in size	
	<ul><li>Irregular shape</li><li>Irregular colour</li></ul>	
	Minor Features of the legions (scoring 1 point each): <ul> <li>Largest diameter 7 mm or more</li> <li>Oozing</li> <li>Inflammation</li> <li>Change in sensation</li> </ul>	
Upper GI	Oesophagus/Stomach         • Dysphagia         • Weight loss with any of the following:         • Upper abdominal pain (also consider pancreatic cancer) or reflux ordyspepsia         • Abnormal upper GI endoscopy suggestive of cancer (or high grade dysplasia of oesophagus)         • Upper abdominal mass consistent with stomach cancer         • Suspicious symptoms or signs but no GP direct access to urgent upper GI endoscopy	
	<ul> <li>Pancreas         <ul> <li>People aged 60 and over with weight loss and any of the following:                 <ul></ul></li></ul></li></ul>	
	<ul> <li>Liver/Gall Bladder</li> <li>Upper abdominal mass consistent with an enlarged gall bladder or liver</li> <li>Abnormal abdominal ultrasound scan suggestive of liver/gallbladder cancer</li> <li>Upper abdominal mass consistent with an enlarged liver/gall bladder</li> <li>Suspicious symptoms or signs but no GP direct access to urgent ultrasound scan</li> </ul>	

Urology	Testicular Cancer         Refer men if they have:         •       A solid intra-testicular lump         •       Non-painful enlargement or change in shape or texture of the testis         •       Abnormal ultrasound scan suggestive of testicular cancer	
	<ul> <li>Prostate Cancer</li> <li>Refer men if: <ul> <li>Prostate feels malignant on digital rectal examination</li> <li>PSA levels are above the age-specific reference range. For patients with a slightly elevated PSA, a suspected cancer referral is still recommended.</li> </ul> </li> </ul>	
	Bladder Cancer         • Adults aged ≥45 with:         ○ UNEXPLAINED visible haematuria without urinary tract infection         ○ Visible haematuria that persists or recurs after successful treatment of urinary tract infection         • Adults aged ≥60 with:         ○ UNEXPLAINED non-visible haematuria and either dysuria or a raised white cell count	Blood Cancer GPs should consider non-urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent UNEXPLAINED urinary tract infection. 'Non-visible' or 'trace' haematuria is determined by dipstick urinalysis of a fresh urine sample. Dipstick testing is preferable to microscopy as it is more reliable and not compromised by haemolysis; the test should be repeated twice.
	<ul> <li>Renal Cancer         <ul> <li>Abnormal ultrasound scan suggestive of renal cancer</li> <li>Adults ≥45 with:                  <ul></ul></li></ul></li></ul>	
	<ul> <li>Penile Cancer</li> <li>Penile mass or ulcerated lesion, where a sexually transmitted infection has been excluded as a cause</li> <li>Persistent penile lesion after treatment for a sexually transmitted infection has been completed</li> <li>Unexplained or persistent symptoms affecting the foreskin or glans</li> </ul>	

#### Supplementary References

- 1. National Cancer Registration and Analysis Service (NCRAS). 2018, Public Health England.
- 2. And ersson, T.M., et al., *Estimating and modelling cure in population-based cancer studies within the framework of flexible parametric survival models*. BMC Med Res Methodol, 2011. **11**: p. 96.
- 3. National Life Tables (2016-2018). Office for National Statistics (ONS), U.K. .
- 4. Lee, Y.H., et al., *Effect of length of time from diagnosis to treatment on colorectal cancer survival: A population-based study.* PLoS One, 2019. **14**(1): p. e0210465.
- 5. Richards, M.A., et al., Influence of delay on survival in patients with breast cancer: a systematic review. Lancet, 1999. 353(9159): p. 1119-26.
- 6. Mano, R., et al., *The effect of delaying nephrectomy on oncologic outcomes in patients with renal tumors greater than 4cm.* Urologic Oncology: Seminars and Original Investigations, 2016. **34**(5): p. 239.e1-239.e8.
- 7. Smith, E.C., A. Ziogas, and H. Anton-Culver, *Delay in Surgical Treatment and Survival After Breast Cancer Diagnosis in Young Women by Race/Ethnicity*. JAMA Surgery, 2013. **148**(6): p. 516-523.
- 8. Chu, A.T., et al., *Delays in radical cystectomy for muscle-invasive bladder cancer*. Cancer, 2019. **125**(12): p. 2011-2017.
- 9. Sánchez-Ortiz, R.F., et al., An interval longer than 12 weeks between the diagnosis of muscle invasion and cystectomy is associated with worse outcome in bladder carcinoma. The Journal of urology, 2003. **169**(1): p. 110-5; discussion 115.
- 10. May, M., et al., Significance of the time period between diagnosis of muscle invasion and radical cystectomy with regard to the prognosis of transitional cell carcinoma of the urothelium in the bladder. Scandinavian Journal of Urology and Nephrology, 2004. **38**(3): p. 231-235.
- 11. Bleicher, R.J., et al., *Time to Surgery and Breast Cancer Survival in the United States*. JAMA Oncology, 2016. 2(3): p. 330-339.
- 12. Richards, M.A., et al., *The influence on survival of delay in the presentation and treatment of symptomatic breast cancer*. British journal of cancer, 1999. **79**(5-6): p. 858-864.
- 13. Yang, C.-F.J., et al., Impact of Timing of Lobectomy on Survival for Clinical Stage IA Lung Squamous Cell Carcinoma. CHEST, 2017. 152(6): p. 1239-1250.
- 14. Gatto, N.M., et al., *Risk of perforation after colonoscopy and sigmoidoscopy: a population-based study*. J Natl Cancer Inst, 2003. **95**(3): p. 230-6.
- 15. Eapen, G.A., et al., *Complications, consequences, and practice patterns of endobronchial ultrasound-guided transbronchial needle aspiration: Results of the AQuIRE registry*. Chest, 2013. **143**(4): p. 1044-1053.
- 16. Hiraishi, Y., et al., *Hospital Volume and Mortality following Diagnostic Bronchoscopy in Lung Cancer Patients: Data from a National Inpatient Database in Japan.* Respiration, 2019. **97**(3): p. 264-272.
- 17. Botteman, M.F., et al., *The health economics of bladder cancer*. PharmacoEconomics, 2003. **21**(18): p. 1315-1330.
- 18. Gronthoud, F., Rates of Nosomial Infection at an Acute UK Surgical Oncology Centre. 2020.
- 19. Rivett, L., et al., Screening of healthcare workers for SARS-CoV-2 highlights the role of asymptomatic carriage in COVID-19 transmission. Elife, 2020. 9.
- 20. Black, J.R.M., C. Bailey, and C. Swanton, COVID-19: the case for health-care worker screening to prevent hospital transmission. Lancet, 2020.
- 21. Wang, D., et al., Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus-Infected Pneumonia in Wuhan, China. Jama, 2020.
- 22. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. Lancet, 2020.
- 23. The Epidemiological Characteristics of an Outbreak of 2019 Novel Coronavirus Diseases (COVID-19). 2020, China CCDC.
- 24. Docherty, A.B., et al., Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol. medRxiv, 2020.
- 25. Liang, W., et al., Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. Lancet Oncol, 2020. 21(3): p. 335-337.
- 26. Williams, M., et al., Estimating the risk of death from COVID Infection in Adult Cancer Patients. medRxiv, 2020.
- 27. Lai, A., et al., Estimating excess mortality in people with cancer and multimorbidity in the COVID-19 emergency, in Lancet Oncol (in Press). 2020.
- 28. Local data in combination with expert clinical surgical/anaesthetic review (authors): D.L.N., S.J., S.A.B., M.W.