

QUESTIONNAIRE

Please insert your name, organisation and telephone number:

Name: Professor John Toy

Organisation: Cancer Research UK

Telephone number: 020 7061 6114

Short responses would be very welcome.

Broad direction of travel

1. Cancer charities and professional groups whose views have been sought to date have indicated that higher priority should be given to extending the scope of the current targets (i.e. to encompass more patients with cancer) rather than to compress the targets themselves (i.e. to set shorter targets than 14, 31 and 62 days respectively).

Questions

Q1: Do you agree with this broad direction of travel? If not, why not?

Cancer Research UK strongly agrees with this broad direction of travel.

Waiting times for breast and bowel problems

2. We know that it can be very difficult for GPs to differentiate between patients who do or do not have cancer, based on history and physical examination alone. In practice only around one third of all newly diagnosed cancer patients are coming through the urgent referral route, with one third being referred routinely (i.e. non-urgently) and one third coming through other routes (e.g. accident and emergency; screening and consultant to consultant referrals).
3. The proportion of patients being referred non-urgently varies from cancer to cancer. Particular concerns have been expressed about the high numbers of patients who are subsequently found to have breast and bowel cancer who are referred non-urgently and the anxiety for patients that this can cause.
4. It has therefore been recommended that all patients who are referred to breast clinics should be considered as "urgent" and be seen within two weeks.
5. It was also originally proposed during the 2005 election campaign that all patients referred to a colorectal clinic should be considered as "urgent" and seen within two weeks. Views from experts in this area however have suggested that four to six weeks would be feasible and it is therefore recommended that all patients who are referred to colorectal clinics should be considered as "urgent" and seen within four to six weeks with the aim of reducing this to two weeks over time.
6. Discussions with experts suggest that reducing waits for non urgent referrals for breast and bowel problems should be achievable provided a number of steps are undertaken. These include:

- ❖ Better support for decision making by GPs on the need for investigations and/or referral
- ❖ Better direct access to investigations from primary care (e.g. to flexible sigmoidoscopy for some patients with rectal bleeding)
- ❖ Increased capacity in secondary care (e.g. through the training of breast or colorectal practitioners)
- ❖ Reducing follow up, especially for patients with benign conditions

Questions

Q2 : Do you agree that all patients with breast problems who are referred to a breast clinic should be seen within two weeks? If not, why not?

We agree.

Q3 : Should the same (2 weeks) apply to all patients with bowel problems? If not, would either four or six weeks be appropriate? Please give reasons.

The 2 week wait target should apply to bowel cancer patients immediately. If this is not possible, the shorter wait should be introduced as soon as possible thereafter.

Q4 : Should this standard apply to patients being referred to any other clinics eg. urology, gynaecology etc? If so, which patient groups and why?

Cancer Research UK believes that the 2 week target should be applied to all patients with a suspicious chest x-ray. Nearly 34,000 patients died from lung cancer in 2002 and we feel that these patients should be able to benefit from rapid access to care and treatment.

Q5: Have the right steps (see para 6) to achieve the possible new standards been identified? If not, what other steps might be taken?

We believe the steps are appropriate but would like to see this approach made generic for all cancers.

31 days: exploring the options

7. At present, the 31 day target only applies to patients receiving their first treatment for cancer. In practice many patients receive two or three different treatments for cancer (e.g. surgery followed by radiotherapy followed by chemotherapy), but the second and third treatments are not covered by the current target. In addition patients may need treatment at the time of a relapse of cancer, but this is not covered by the current target.
8. We have heard both from patient groups and clinicians that there is a strong case for extending the scope of the 31 day target to cover all treatments for cancer. We have also been told that for second and subsequent treatments the relevant interval is between the patient being "ready for treatment" and treatment. This is because the decision to treat may be made before the first treatment, when the patient is clearly not ready for the second treatment.

Questions

Q7: Do you agree that all treatments should be covered by a 31 day standard?
If not, why not?

We do consider that the 31 day target should apply to all treatments.

However, an understanding of when a patient is medically 'ready for treatment' should be acknowledged within this target.

Q8: Do you envisage any areas (e.g. by cancer type or treatment type) where this may cause particular problems? If so, which areas?

In some cases certain types of treatment, such as radiotherapy following surgery and/org chemotherapy, may be planned well in advance of the 31 day standard in the full knowledge that it would be difficult to deliver within that timescale.

Patient involvement in the development of their treatment plan should provide a mechanism for these decisions to be agreed.

Q9: Do you agree that the starting point for 31 days should be based on the patient being "ready for treatment"?

We agree. The treatment plan should be agreed and the patient involved in making the decision about when they are ready for treatment.

62 days: exploring the options

9. The 62 day target currently only applies to patients referred urgently for suspected cancer by a GP. We have heard from a range of stakeholders that a 62 day standard could benefit more patients if:

- ❖ Patients detected through national screening programmes were formally to enter a 62 day pathway from the time at which the screening result indicates a substantial risk of the patient having cancer (e.g. an abnormal mammogram)
- ❖ Hospital specialists were given the right to deem that a patient should be considered 'urgent' and thus transfer to a 62 day pathway when they suspect cancer. This might, for example, occur
 - When the referral letter is reviewed
 - When a patient has a suspicious imaging investigation
 - At the time of clinical examination
 - At the time of an endoscopy

Questions

Q10: Do you agree that screen detected cases should be managed on a 62 day pathway? If not, why not?

Yes, we absolutely agree.

Q11: Do you agree that hospital specialists should be given the right to deem that a patient should be managed as 'urgent' on a 62 day pathway? If not, why not?

A specialist doctor's opinion is the most appropriate way to trigger a patient's urgent cancer care pathway.

Q12: Are there any other ways in which the coverage of the 62 day standard should be broadened?

Referral from accident and emergency departments for suspected cancer patients should fall within the 62 day standard.

Is there any other information concerning the proposed options that you would like to tell us?

Please see the attached letter

Do you want your responses to be treated as confidential? Please tick one of the following boxes:

No