

EDITORIAL

Cancer Waiting Times: the Clinical Perspective

The Lead Clinicians, the West of Scotland Managed Clinical Networks for Adult Cancers

Correspondence to

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The outline framework for the 2008 update of the Scottish Cancer Strategy *Better Cancer Care*¹ has recently been circulated to Cancer Managed Clinical Networks (MCNs) for comment. This framework confirms that new waiting time targets 'more meaningful to more patients and capable of being delivered'¹ are to be considered. This then, is an opportune time to revisit the Cancer Waiting Times Initiative in the hope that we can help to shape the development of more clinically meaningful targets.

The Scottish Executive report *Cancer in Scotland: Action for Change*² introduced cancer waiting times to Scotland and defined the target to be achieved by 2005; 'the maximum wait from urgent referral to treatment of all cancers will be two months'.² It is against this target that performance is currently measured.

The waiting time represents the interval in days between urgent referral and either the time to start treatment or the decision to monitor the patient without treatment. At present these targets apply only to those patients who receive urgent referral from a general practitioner (GP) and those patients referred acutely to hospital (including self-referrals) as either surgical or medical emergencies. The targets then, do not currently apply to other referrals such as non urgent GP referrals, patients already under review, those identified at screening or diagnosed as an incidental finding.

The investment and effort to meet the waiting times target and measure performance has involved both the expansion of clinical services and the expansion of data collection. Between 2001 and 2007, more than £250 million has been invested in cancer services across Scotland. Although it is difficult to estimate how much of this has been directed towards improving cancer waiting times, tangible improvements in service have been achieved in the form of:

- Three hundred additional staff including doctors, nurses and other healthcare professionals involved in the delivery of cancer care across Scotland.
- Improved imaging facilities including state of the art dedicated magnetic resonance imaging (MRI) scanners in each of Scotland's five specialist cancer centres.
- The introduction of cancer 'trackers', staff who are responsible for tracing and expediting all urgent cancer referrals through the system from referral, to diagnostic services, to investigations (such as x-rays, computed tomography/magnetic resonance imaging scans, endoscopy) to the start of treatment.²

From the clinical perspective these achievements are recognised and welcomed. The initiative has also shown that the concerted, collaborative effort of clinicians and managers

can deliver real improvements in particular aspects of service, but at what cost? There are four major issues of concern that have resulted from the waiting times initiative.

- 1 Is it reasonable to apply a single common target to all types of cancer?
- 2 Is it reasonable to concentrate only on those patients with urgent referral?
- 3 Is it reasonable to consider both curative and palliative treatments together?
- 4 Is it reasonable to pursue the collection of waiting times data at the expense of the clinical audit of treatment and patient outcome?

1 A Single Common Target

The term 'cancer' covers a wide range of conditions with variable presentations, variable rates of biological progression and varying complexities of diagnosis and treatment. There are those which may progress to patient detriment within this 62-day target and those that will not. For patients with squamous carcinoma of lung and a potential doubling time of less than two weeks, a 62-day target is clearly inappropriate.

Even within any one diagnostic group, significant clinical differences can exist to influence the interval between diagnosis and the start of treatment. Within this volume of the *Scottish Medical Journal*, Savage et al⁴ show that for lymphoma patients, those with Diffuse Large B Cell (DLBC) Non Hodgkin Lymphoma (NHL) are significantly more likely to start treatment within 62 days than patients with either Hodgkin Lymphoma (HL) or Follicular NHL. The inclusive waiting time for all lymphomas fails to recognise differences between these lymphomas in terms of their degree of malignancy, curability and need for urgent treatment.

2 Urgent and Non Urgent Cancer Referrals

The 62-day target only applies to those patients that receive urgent referral. In clinical practice however we recognise that cancer is seldom a non-complex illness. Symptoms are often not specific for cancer with considerable overlap between benign and malignant disease. Cancer patients frequently do not follow a simple unbranching path from the development of new symptoms (ie lump, haemoptysis etc), to GP consultation, to urgent hospital referral, to diagnosis and treatment. Analysis of the waiting times submissions in Scotland for the 'Big Three' cancers, reported for the third quarter of 2007, illustrates how difficult it can be to recognise the need for urgent referral. This data shows that only 44% (n=439) of new patients with breast cancer (n=1007), 55% (n=417) of new patients with colorectal

cancer (n=753) and 70% (n=643) of new patients with lung cancer (n=922) received urgent referral. Those units that fast track urgent referrals do so at the expense of the many cancer patients that do not receive urgent referral.

Many cancers present with either non-localising or non-suspicious features. With the bone cancers, published data⁵ shows there is often a delay of six to nine months from the development of the first symptom to specialist referral. This length of delay then, is far more significant than any delay from referral to treatment. This pre-referral delay also applies to upper gastro-intestinal tract (GI) cancers. The Department of Health in England has now issued warning symptoms upon which GPs are advised to make urgent referral.⁶ These warning symptoms however only pick out those patients with advanced metastatic disease. As a result they serve to selectively encourage urgent referral of cases suitable only for palliative treatment to the detriment of those cases with potentially curable cancers.

3 Treatment (Palliative and Curative)

What matters most to any patient with cancer is the outcome of treatment. For some this can be measured as cure rates, for others it may be survival time when the disease is incurable. For all quality of life is important both during and following treatment. Appropriate treatment for a specific cancer however will depend upon a host of factors. The cancer needs to be accurately staged. Thereafter the ever increasing complexity of treatment options demands that a process of agreement on optimal treatment/management be undertaken with careful consideration and input from the multi disciplinary team (MDT). Although this all takes time the patient's interests are best served by expediting the optimal treatment which may sometimes not be the quickest treatment to start.

The waiting times initiative does not separate palliative from curative treatment. The management of lung cancer illustrates this problem. The majority of patients present with advanced cancer and will not receive curative therapy. For a proportion, appropriate management is good palliative care and symptom control which starts at once. In the west of Scotland more than 90% of these cases will have treatment decision and symptom control started within 62 days. A minority of patients however, may be cured by either surgery and/or high dose complex radiation treatment. Staging these patients accurately and preparing them for treatment takes time. An audit performed in 2000 revealed that less than 10% of patients awaiting potentially curative radiotherapy started their treatment within 62 days and that a quarter of these patients progressed while on the waiting list to become incurable.⁷ This audit was repeated in Glasgow in 2007 with exactly the same results.⁸

4 The Cost to Clinical Audit

This is perhaps the crux of our concerns. Effective clinical audit of cancer treatment and outcome is the single most important means by which we can assess the quality of service. It underpins our MCN activity and is fundamental to service improvement, initiatives and quality assurance of service provision. It is recognised as a key method by which all organisations in the National Health Service (NHS) deliver clinical and cost effective care.⁸

Data collection and its analysis are the energy sources for clinical audit, yet the system in place at present involves audit staff in the manual collection of information from a variety of sources such as case records, pathology reports, MDT

meetings, hospital PAS etc. Regional review of cancer audit resources in the west of Scotland has shown that the pressure to submit quarterly waiting times has significantly impacted on the workload of these staff and has adversely affected the clinical audit of treatment and outcome. Audit staff have been forcibly directed away from clinical audit to waiting times. As a result most MCNs struggle to provide meaningful clinical audit or indeed any form of patient follow up. Additional pressures now result from the demands of Government for weekly progress reports on waiting times.

In support of this drive, the Scottish Government has now established a Cancer Performance Support Team as part of a Waiting Times Delivery Directorate. However their demands on audit staff come at a time when some health boards and cancer networks cannot obtain full treatment details of chemotherapy or radiotherapy from the Regional Cancer Centre. The MCNs then have no way of ensuring that the best treatments are being delivered.

Conclusion

There is much to celebrate in the form of the service developments that have resulted from the waiting times initiative. The improvements in staffing, imaging facilities, diagnostic services and equipment provide a solid backbone on which to develop *Better Cancer Care*. The initiative however does not provide the most appropriate measure of cancer care and has serious flaws particularly in the damage it has done to clinical audit of treatment and outcome. The pressures now on audit staff are excessive and there is urgent need to develop systems to electronically capture data in 'real time'. Pressures also result from demands to report waiting times from each previous quarter. These demands are clinically unnecessary and current timelines could be relaxed. An interval of six to nine months would still allow timely monitoring and simultaneous collection of data for both clinical audit and waiting times, without unnecessary duplication of effort.

Now is the time to refocus attention to quality of care and clinical audit rather than waiting times. Clinical audit underpins the activity of each MCN and is the key to service improvement and better cancer care. This must now be the focus of *Better Cancer Care* and thereafter waiting times must be the product of clinical audit, not vice versa.

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