



Humber, Coast and Vale Cancer Alliance

Cancer in the Long Term Plan for the NHS

Feedback from Stakeholders – September 2018

Background:

Cancer Alliances across the Country were asked by NHS England (NHSE) in August 2018, to support the development of a new plan for the next ten years. This followed the government's announcement of a new financial settlement for the NHS. This was an opportunity for us to gather a wide range of views across the Humber, Coast and Vale Cancer Alliance from our stakeholders. These views sought to understand what our stakeholders considered to be the priorities for improving cancer care outcomes and care over the next five to ten years. The feedback from our stakeholders is contained in this paper submitted to NHSE to form part the development of the Long Term Plan for cancer.

Methodology

An on-line survey was developed with the seven question areas that NHSE had identified. Humber, Coast and Vale Cancer Alliance gave our stakeholders an opportunity at the end of the survey to tell us anything else that they would like us to share with NHSE and this is included in this paper – please see Appendix 1.

We wanted the survey to be anonymous but sought to understand who had responded and we therefore, asked our respondents to identify which sector they were from ie commissioner, patient, provider.

The survey was sent to a wide range of stakeholders which included our Cancer System Board, Work-stream Boards, Voluntary and Community Sector organisations, Communications and Engagement leads within the Cancer Alliance's partner organisations and it was also placed on the Cancer page of the Health & Care Partnership website. The stakeholders were then asked to share the survey across their networks.

The survey was available to be completed from mid-August to early September in order for a summary report to be sent to NHS England to inform the Long Term Plan.

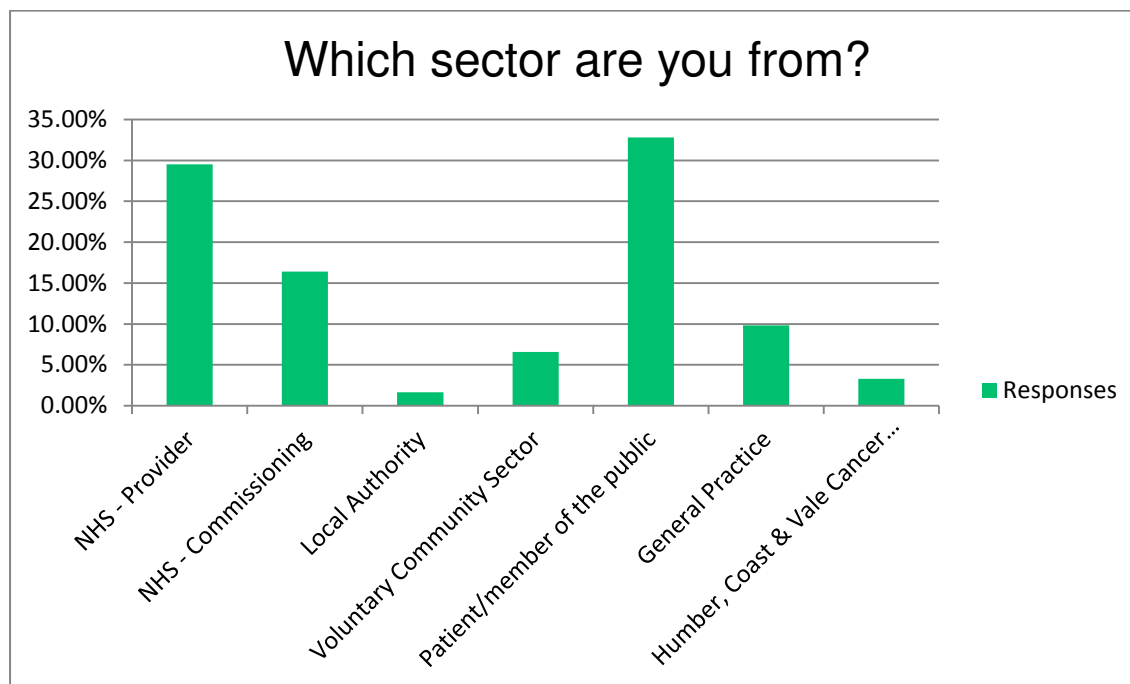
Whilst the timescale for seeking feedback was short, the Humber, Coast and Vale Cancer Alliance stakeholders took time to respond and gave in-depth qualitative feedback to all questions. Sixty six respondents, with a collective 2,000 plus individual lines of qualitative feedback across the eight questions was received from our stakeholders. The 66 respondents covered a number of sectors as detailed in Table 1, with patients and the public making up a third of responses.



The responses have been analysed, and for the purpose of this paper have been reported collectively. Given the number of responses to the survey and the depth of the qualitative feedback, Humber, Coast and Vale Cancer Alliance will further analyse the feedback for its ongoing work and is providing NHSE with themes to their questions with a small sample of feedback from these questions, incorporated.

Table 1: Which sector are you from?

Answer Choices	Responses	
NHS – Provider	29.51%	18
NHS – Commissioning	16.39%	10
Local Authority	1.64%	1
Voluntary Community Sector	6.56%	4
Patient/member of the public	32.79%	20
General Practice	9.84%	6
Humber, Coast & Vale Cancer Alliance Programme Team	3.28%	2
Other (please specify)		17
Skipped Q		5



The 17 respondents who replied ‘other’ to this question describe themselves within the following categories:

- Retired Health professionals –commissioning, surgeon, nursing
- Employees in the NHS and cancer patients
- Patient and Carer
- Patients and family members lost to cancer
- Patient and Participation Group member



Question 1:

What are your top three priorities for improving cancer outcomes and care over the next five and ten years

Through a review and coding process, the responses found that the following were the top three priorities cited in the survey, however there was a significant proportion of respondents who also included Workforce (recruitment, retention, training) and Living with and Beyond (focus on recovery, more support following treatment) in their feedback.

1. Diagnostics – speed of access to, and speed of reporting
2. Treatment – speed of access to treatment following diagnosis–(rapid pathways)
3. Public Health - prevention/screening/awareness

Comments (sample):

“early detection and prompt appointments histology returns quick”

“Ensuring that the public know what symptoms to be aware of”

“Remove any stigma of approaching a clinician to check if it is actually cancer or otherwise”

“Speed up treatment and make after care more frequent and prolonged”

“Improve waiting times for diagnosis and treatment”

“Rapid access to diagnosis and treatment”

“Staffing levels appropriate to allow staff to care properly for patients”

“investigations within 2 weeks completed. eg scans”

“improve scan reporting more speedily”

“Greater access to first diagnostic services - likely to be primary care related”

“Faster treatment following diagnosis”



Question 2

What more can be done to ensure that more cancers are prevented?

The 66 respondents all gave a number of answers to this question with the majority of responses falling into the following categories which were labelled 1 to 5. Category 1 and 2 was the category where the majority of respondents cited Public Health and Screening to prevent cancer. Screening was given its own category to Public Health as this featured highly in the responses with Earlier Diagnosis (Primary Care) being the third area. Smoking and smoking cessation were frequently mentioned in this section.

1. Public Health
 - a. More awareness campaigns
 - b. Smoking cessation – more campaigns/education for people and professionals
 - c. Improving lifestyle choices
2. Screening
 - a. More screening for men
 - b. Reduce and extend screening ages i.e. start at an earlier and continue
 - c. Better screening for those known to be at risk
3. Earlier Diagnosis (Primary Care)
 - a. GPs having time to listen and refer
 - b. Education for GPs to better refer
4. Research
 - a. Research in to a blood test for screening
 - b. Improve research into stem cell

Comments (sample):

“In deprived inner cities like Hull there need to be a stronger public health message. We have well-being advisers in GP practices but know that people access these facilities when health has already deteriorated. Well-being advisers should have a presence in pubs and public places which the more hard to reach members of the public access. We need more subsidised access to exercise trainers. E.g. There are free gym equipment pieces in local parks but people need advice to know how to develop a fitness programme which utilises these items effectively and how to progress”.

“Better health promotion - proactive engagement with the public. More innovation and better ideas to improve health i.e. Couch 25K classes, Slimming World, walking Public education about risk factors”

“Access to screening tests at times that don't require people to take time off work”



“More information to the public, where cancer prevention is known. Public health campaigns in schools and the work place”.

Question 3

What more can be done to ensure that more cancers are diagnosed early and quickly?

The 66 respondents each gave more than one response to this question with over 300 answers which have been categorised in to three main themes. Access to, and waiting times to, GP and Secondary Care also featured in some respondents' feedback and included availability of GP appointments.

- 1 Screening
 - a. Lung screening
 - b. GP screening
- 2 Diagnostics
 - a. Improve access
 - b. Multi-disciplinary centres/rapid diagnostic centres
 - c. One-stop centres/clinics
- 3 Public Health
 - a. Health Promotion /Awareness of signs and symptoms
 - b. Education for staff
 - c. Education for patients/public

Comments (sample):

“Improve access to GP services. Having to phone in repeatedly for an appointment "on the day" only to be told that only emergency appointments are available means that people can be put off attending until symptoms are advanced. There should be a system for non-urgent appointments”

“Take all measures to reduce barriers to earlier help seeking by the public”

“increasing public awareness of the signs and symptoms of cancer”

“easier access to GP”

“promote the benefits of screening & earlier diagnosis”

“Introduce lung screening as per the evidence base”

“Rapid access pathways”

“Enhanced/targeted screening i.e. Lung”



“People shouldn't be afraid of getting checked out. Perhaps allow people to photograph dodgy moles etc. and get an opinion quickly if it needs further assessment. Make more GP's aware that breast does occur in young women”.

“Use a standardised targeted approach to identify individuals at high risk of lung cancer for low dose CT scans to achieve earlier diagnosis”

“Invest in research to support prevention & earlier diagnosis of cancer e.g. develop non-invasive tests for earlier diagnosis of cancer”

“Ensure all GPs have direct access to key diagnostic tests”

“Establish services that support the diagnosis of cancers that tend to have non-specific symptoms, for example Multidisciplinary Diagnostic Centres (MDCs) or Rapid Diagnostic and Assessment Centre”

“Straight to test based on patient concerns”.

Question 4

What can be done to ensure that people maintain a good quality of life during and after treatment?

Sixty four respondents suggested a number of answers to this question and the answers were themed into four categories:

- 1 Access to support
 - a. psychological
 - b. financial
 - c. family
 - d. support groups
- 2 Patient Centred Care
 - a. Time and location of treatment, diagnostics and other Services
 - b. Living beyond cancer
- 3 Access to resources
 - a. Nursing time
 - b. Information
 - c. Education

Comments (sample)

“Treatment at home, Shorter waiting times, Allocated staff and follow up support”

“Free parking and transport. Treatment to fit in around “everyday” life “

“Greater awareness and assistance with the psychological and physical side effects of a cancer diagnosis and treatment.”



“More research and education is required to aid understanding of the devastating impact of fatigue on quality of life”

“introduction to the living with and beyond cancer teams for every patient. This service should be part of a patients pathway after treatment with long term support, focus on the recovery and health and wellbeing. More health and wellbeing groups for patients and families to attend to attend as the patients that attend these session do better in recovery. Patient living with cancer long term also benefit from this service as they have on going support and can access sessions and groups as and when needed. Facilities to run Living with and beyond effectively would benefit all”

“More care in the community”

“Good co-ordination between inpatient and community services, better use of community facilities for outpatient clinics i.e Hornsea Cottage Hospital”

“Good support both from the hospital and in the community”

“People have to have confidence in the team looking after them, including experienced support staff to help and advice through the early phases of treatment, but to have a regular person to be their contact over the long term to talk over problems, and their solution. Such a person can encourage the patient to be as normal as possible, but be there any time for the unforeseen problem”

“Better home care, more domestic family support”

“Support the living with and beyond cancer campaigns”

“Support improved cancer care reviews by GPs”

“Promote Cancer Champions”

Question 5

What can be done to ensure that people with cancer have a good experience of care?

Responses to this question were themed in to four categories with Communication and Information being the most frequently cited answer followed by Staff, Local services, Hospice and Patient and User Input

1. Communication and Information
 - a. Better explanation from health professionals
 - b. Timely communication and information
2. Staff
 - a. Training, Skills, Numbers
 - b. Investment in staff
3. Local Services
 - a. Local services and access
 - b. Reduction in travel times/early starts/late finishes after treatment



4. Patient and User Input
 - a. Seeking views
 - b. Involvement of patients in co-design/commissioning services

Comments (sample)

“Ensure that people are fully informed about treatment and care options
Listen to the individual and their family - tailor the care to what they want/need not what clinicians think they want/need. Clear, easily understandable information. Care provided at a time / venue that fits with the individual wherever possible.
Ensure the majority can be provided locally and does not involve long journeys with early starts and late finishes to the treatment days”
Improve holistic care and reviews

“Develop EPaCCS for end of life care”

“Ensure information from MDT's is dissipated well to primary care”

“good communication, timely communication, constant communication”

“Ensure access to tumour site specific CNS (and teams)”.

“Ensure patient are provided with as much information as they want and need”

“Ensure staff are well supported to provide an excellent service - with a plentiful, well trained work force with time to deliver the care needed”

“Improve waiting times for diagnostics and treatment to reduce anxiety”

“don't cancel patient's appointments”

“ask them what their experience is like”

“can they receive a one-stop shop for treatment”

“Find out what is important to them”

“Speak in plain English”

“Timely access rather than arbitrary targets”

“Evening and weekend and services - acknowledge that people work during the day and want to access services at other times”

“Utilise apps and other ways to involve people”

“Increase personalisation of care - roll out PHBs to cancer patients”?



Question 6

How can we recruit, train and retrain the workforce to deliver the changes we need and the priorities you have shared?

Sixty five responses to this question were themed in to four categories of

1. Pay and Conditions
 - a. Incentive schemes to attract staff
 - b. Remove disincentives to working >50
 - c. Listen and engage staff
 - d. Engage staff in developing services
 - e. Increased access to development roles / succession planning
2. Training
 - a. Apprenticeships
 - b. Bursaries and traineeships/no university/training costs
 - c. Increase training places for specialty staff
3. Working with others
 - a. Schools – starting early and maintaining links and commitment
 - b. Voluntary Sector

Comments (sample)

“More pay. Better working conditions, Decent banding levels, Incentives, Career progression”

”Be realistic about the workforce required to deliver a responsive service that meets nationally recognised standards and patient needs. Plan/commission based on need and expected demand – not affordability. Recognise that the ageing population will place increasing demands on the system due to higher incidence, treatment of recurrence and second and subsequent primaries“

“Network and share expertise (digitisation) – esp. radiology & pathology – to support wide access to specialist expertise for all patients/mdts”.

“Appoint to a geography (sub regional) – not an institution. And support flexible working to retain experience and expertise”

“Get into schools, colleges and have incentives to retain the future staff, create good foundations where a team is provided and cared for throughout their career - look at other places and times where it does work and did work well”

“Advertise. Use ex patients to share experiences during training. I'm a nurse and cancer patient. I would love to work as part of the team but I can't say I've noticed any adverts for staff”

“Increase funding for nationally accredited higher education modules. Increased access to developmental roles for succession planning. End of Life Academies”



“Engage the staff in developing services - listen to them”

“The cancer networks and cancer leads help. Making cancer care successful, publishing improvements. Making Marie Curie and other groups part of the success teams. Training staff across all sectors”

“Start with programmes in schools but also look to improve overall image of area to attract people to move”

“Bursaries. Apprenticeships. Increase radiographer. More investment in VCS who can help with awareness raising”

Question 7

How can we address variation and inequality to ensure everyone has access to the best diagnostic services, treatment and care?

The 64 respondent’s feedback went across many categories, with many responses giving feedback which was individual and specific and didn’t easily fall into a defined category; themes were hard to identify, for this reason. The following categories were identified and comments were placed into these areas, where this was appropriate. There was contrasting feedback to this question with a number of respondents reporting that they would like to have Centres of Excellence in a particular area instead of lots of services in a number of areas. Other respondents suggested more local services close to the patient’s own area/home, to reduce travelling.

The comments section from Question 7 will provide useful understanding to the feedback and the difficulty in categorising the feedback.

1. Best/Sharing Practice
 - a. Adopt/seek
 - b. Seek best practice – where is it working well
2. Centres of Excellence
 - a. Specialist equipment used 6/7 days
 - b. Standards led by Centres of Excellence and rolled **out**
3. Investment
 - a. Services
 - b. Staff
 - c. equipment
4. Standards/National Standards
 - a. Standards are identified across the country/improvements across all cancer services
 - b. Standards led by Centres of Excellence and rolled out
 - c. Standard procedures – followed by all



5. Local Services

- a. Close to patients home
- b. Transport for patients

Comments (sample)

“Having specialist centres works ie Breast Centres, but ensuring links with other general units, and providing feedback loops. Having good links in radiography and also labs”.

“Have specialist hospitals around the UK State of the art scanners and access to the latest pathology tests are expensive and require more staffing. NHSE/ STP leads should be developing links with large local employers in each STP patch to provide sponsorship which will improve hospital’s ability to meet the cancer targets. Better IT infrastructure and availability of analysts to inform clinicians where in the region there are shortest waiting times or best facilities for the tests required. Patients who are able to travel can then access care regionally for biopsies; diagnostic tests; treatment and care. To avoid postcode lotteries, there may need to be corporate sponsorship to assist with shuttle bus type transport between regional cancer centres”

“As stated earlier, it is important to identify the hard to access populations and link with representatives of these groups to learn how to enhance access to services for these groups”

“Adopt best case practice and scenarios in all areas, ensuring that all treatment centres work in the same way and also ensuring that any improvements in one area are then adopted by all other centres”

“manage cancer services on a national basis, in a prescriptive manner, specify by tumour site, pathway for each type of contract and contract with acute trusts directly to deliver this and use a process to monitor delivery and outcomes”

“Increased funding in areas with more disease burdon e.g. the North”

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“it is important to identify the hard to access populations and link with representatives of these groups to learn how to enhance access to services for these groups. Initial



consultation should be as near to home as possible, outreach clinics or local hospitals, Initial tests, if not already done by the GP, may be done locally depending on the site of the cancer. If Specialist radiological investigation or more invasive procedures are required they should be done at a site with the best equipment, being used 6/7 days a week, staffed and overseen by a team of experienced people at all times”

“There is little point in having expensive equipment standing idle for the majority of normal working time and used by staff who only perform the investigations intermittently”.

“Patients should have all their investigations done in a concentrated time period, to avoid repeated, tiring, costly, and anxiety provoking visits. It can be done with a little planning”

Conclusion

Acknowledging the timeframe open to collect and collate responses, the growing maturity of engagement across the Cancer Alliance, we are very pleased that 66 respondents took time to complete the survey in great detail. With over 2,000 comments within the feedback across all sectors who responded, we are delighted with the reach of this survey and the feedback contained in it. Whilst, Humber, Coast and Vale Cancer Alliance have provided NHSE with a number of broad themes identified within the feedback and comments from respondents, we plan to further utilise the feedback in future areas of work in the planning/improvement of services and to additionally understand what our stakeholders are saying and what is important to them.

We are pleased to see that over a third of our respondents are patients and members of the public (there were a number of patient responses who were included in the member of staff categories too which has increased the number of patients overall, responding).

A key finding across all the feedback was the requirement to listen to patients and understand, across every level and each stage of all pathways, how they believe the service was for them, how it could be improved and how the negative experiences can be turned into positives.

A further and very pertinent part of the feedback has been around targetting population health management and inequalities, not focusing on targets and missing the point, or the person involved in the pathway.

Public Health was a major theme running throughout all questions and responses, from awareness campaigns and health education/promotion, to supporting those that



we describe as hard to reach to access to GP appointments, screening and early diagnosis. Investment in diagnostics and improving this part of the patient pathway was a key theme across the feedback from all respondents. The recognition that the demand on diagnostics and the capacity to deliver this in a timely way is seen as one of our main priorities identified in this survey and also a priority for our Cancer Alliance.

The Humber, Coast and Vale Cancer Alliance looks forward to being involved, and further influencing the Long Term .

Those involved in the submission of this document were:

Jane Hawkard, Chief Executive, East Riding CCG and SRO for Humber, Coast and Vale Cancer Alliance.

Kay Gamble, Communications and Engagement Lead, Humber, Coast and Vale Cancer Alliance

Stuart Baugh, Clinical Lead, Humber, Coast and Vale Cancer Alliance

John Hancock, Programme Lead, Humber, Coast and Vale Cancer Alliance



Appendix 1

Additional feedback from respondents

Humber, Coast and Vale Cancer Alliance gave our stakeholders an opportunity at the end of the survey to tell us anything else that they would like us to share with NHSE and to be included in our feedback report.

The following are the comments that have been received and have not been categorised. Feedback was received from 43 respondents.

Radiotherapy needs more resources - use the all party working party thing as a start!

It would be better if every area could easily communicate with other areas, gp, hospitals etc sometimes there is a lot of time wasted chasing information that isn't available between 'sites' . And not coming down to a funding thing eg gp can't do a certain blood test for the hospital because it comes out of their budget not the hospitals.

Too many women late 30s and 40s seem to be suffering with late diagnosis of Breast cancer and it needs to stop screening age should be lowered and if this is too expensive then at least they should all be offered the choice to have mammogram or mri privately but at a reduced rate for say age 32 and over ? Most people I know would contribute to a cost for screening if they thought they could get it for peace of mind. Smears are offered every 3 years at any age why is breast screening not ???

Nurses do an amazing job and they need to be rewarded more for the care, time patience.

Currently care is spread throughout most general hospitals with varying standards of care. This must be streamlined so clinicians with the desire and knowledge focus purely on specific cancers, see and treat a minimum number of patients and monitor the outcomes, like with high end cardiology services.



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We should focus on shifting to outcome rather than process measures to drive the improvement we need to see in UK cancer services. That does not mean we shouldn't offer timely access to services. We know that waiting for diagnostics appointments or consultation with known concerning symptoms is an extremely anxious time and all efforts should be made to keep such waiting times to a minimum

We should continue to try to better understand the differences in population health and service structures that underpin the significant differences in outcomes between England/the UK and other countries health systems.

Timelier more accessible data/information on outcome and variation will drive change

Innovation and Research are key to driving progress across all stages of the cancer pathway and investment should be maximised and protected.. Increasing awareness of and more equitable recruitment to cancer trials will accelerate the rate at which new treatments and technologies can be developed and adopted by into the NHS.

My care in Hull was fantastic. Mr Kneeshaw is an amazing surgeon.

As cancer treatments become more sophisticated and successful, there has to be a societal debate on the ethics of where we also draw the line in terms of what treatments we continue to offer to whom. There is a concern that clinicians do not have the courage to know when to stop offering treatment. Such ethical debates require more robust evidence to inform our understanding of the economic impact and longer term impact on quality of life and hence requires greater funding for longitudinal studies which look at the wider impact in terms of development of other comorbidities, care needs, ability to remain in employment etc., following treatment i.e. at minimum to be longer than one year.

Working for the living with and beyond team, I focus on recovery and the health and wellbeing as well as clinical assessment. The patients that have access to support groups, course, healthy eating and excise do a lot better with moving forward after treatment with the knowledge they have support from staff and other cancer survivors. This should be part of a patient's pathway, exercise may not be for everyone but we also have other courses they can



access which still has very good outcomes with recovery. The living with and beyond cancer teams could still do so much more with more staff and facilities to run services. This would have a better impact on patients' lives and also a better outcome.

these answers are due to my own experience being told we have a shortage of histologists did not help me when waiting for my results

The treatment that I have received at the Hull and East Yorkshire hospitals has been exceptional, but I am always concerned / frightened of what might be happening between check-ups, scans etc. I'd feel happier and more secure if things happened quicker, more often and I received assurance as one always feels that it's returning until one receives results and assurance.

balance supply of appropriate specialists from popular places to work and live to those places where staffing numbers are too low for the numbers presenting

Remember pathology needs investment too.

As a cancer patient there is quite a lot I have noticed. Firstly I had previous gynaecological problems with constant bleeding. I was told I had endometrial hyperplasia. I was discharged from the gynaecology service. I had not stopped bleeding. 2 years later I represented to GP, I had further investigations and was found to have Endometrial cancer. On reading the literature it stated women with endometrial hyperplasia should be closely followed up....I was not.

Secondly. If you do not want women to know they have cancer ensure the follow up letter does not have the code Gyne/Onco written on the bottom left hand side of the letter.

Thirdly. Although I understand the consultants work as a team it isn't very nice that on 4 consultations with the gynaecology team I saw 4 different consultants. It does nothing to reassure the patient and does not build up trust.

Fourthly. Although follow up is explained at no point has anyone explained what the likelihood of reoccurrence is not



what signs and symptoms I need to be looking out for. At present I have no idea when I will be classed as cancer free.

I am a nurse and have looked up these details but I don't think it should be left for the patient to 'Google' for information or facts and figures. It would be easy to get misinformation when patients are left to their own research.

Much more capacity is needed to deal with larger numbers of patients with vague early symptoms which might be cancer, The rate of diagnosis per 100 patients seen is likely to fall but that is the price of picking up disease earlier at a stage when it can be treated effectively. By the time symptoms are obvious it is likely to be too late for a significant number of patients.

stop the variation in service delivery and give all cancer suffers timely access, diagnosis and treatment
Cancer charities seem to waste money on expensive headquarters and staff. Keep the costs down and keep it local
Free car parking during treatment would be a big help, especially when some people have to travel long distances for treatment incurring large costs

get rid of NICE and enable Doctors to use their expert decisions without their interference

The stress for a cancer patient of having to attend a unit miles from home, is not conducive to recovery, no matter how good the treatment and care

Regional variation in service and standards but stop. Good practice in one area must be passed on. What is developed for use in remote areas could also be used in rural areas that has long travel times.

More trust, respect and use of cottage hospital services. Blood tests etc.

I elected to go to York hospital and found the care extremely good until I had finished my treatment and then I was on my own back in Scarborough because follow up meetings were in York



More time to talk to Drs and specialists.

Understanding of the different types of cancer and the help that is offered.

Ensure that the 2 week target remains, also add a maximum target to begin treatment. Ensure enough investment in Radiotherapy and diagnostic centres

Encourage people to take responsibility for their lives and health, eat sensibly, exercise and seek help as soon as people feel unwell , like checking breasts etc

Changes in diets and reducing processed foods. More freshly cooked foods without preservatives and sugar and salt

Need a national NHS recruitment campaign for radiology staff - with the emphasis on making a difference for patients - competent staff with excellent customer service skills - we could learn from private providers. Improved appointment booking systems - speak to the customer to know when is best for them - this will reduce DNA. One-stop clinics so that all tests can be done on the same day and be great if they could also get results. Improved reporting times - is better for the patient and reduces stress/worry and more efficient for Trusts will help to improve performance and meet NHS Constitutional Targets. Appointments to start on time - patients get cheesed off hanging around. While the 62 day target is important, there is a significant risk that other parts of the cancer pathway will suffer if the focus is restricted to that.

I know in the grand scheme of things 2 weeks is short but it's too long with suspected cancer, work towards making it less have ways of having clinics where people can have a breast clinic type onestop clinics to identify genuine cancer cases and rule out in others and forward to cancer team

I do not understand why, when a Trust or Cancer Alliance isn't hitting the 62 day target money is taken away! Surely they are not reaching their targets so need more support and help not to be penalised!



The demand for cancer treatments is going to completely outstrip our capacity to manage it over the coming years. Urgent action needs to be taken to address diagnostic equipment and staff issues and to bolster the cancer workforce. In itself this will not be enough and there needs to be a change in policy to stop approving and supporting therapies that add little to patients' lives. NICE also need to stop extrapolating the results of clinical trials in selected groups to the population as a whole as outcomes and toxicities will be different. There needs to be funding to support the development of molecular diagnostics across the country.

Most importantly we have to recognise that the system will fail if we try to run it the way we do now. There has to be much more networking of service provision and we have to make the public accept that not all services can be delivered locally. Politicians must stop defending their patch when better solutions to support the wider population, including their patch, exist.

We need better planning and this needs to be long term and stuck to. Nothing will work if NHSE continue to move the goalposts. This is not about delivering figures on a spreadsheet it is about how we provide effective cancer services for our people.

Still using patients as tick box exercise

There needs to be a joined up approach with health, public health, social care, education and local and central government to tackle cancer.

Transformation funding should not be linked to performance , e.g. poor performance against standards = system being penalised. Transformation resources should be linked to innovation and improvement plans

By reducing revenue for Cancer Alliances who are not reaching the 62 day targets is not actually achieving anything, all this does is to diminish the monies that they can spend on the required projects

Amend the standards. Individual spoke Trust will struggle the more tertiary diagnostics and treatments are provided in pathways

Provide a country wide programme for training staff whereby significant numbers are in the pipeline year on year

Ensure technology is used wherever



1. Allocating resources to areas which are already rated as good exacerbates inequality of service provision
2. Referrals from GPs need to increase to improve outcomes further but at present there is no incentive to do so as capacity to deliver 62 day performance can't cope with increased demand. This system target is not supporting improving outcomes for patients in the wider sense and needs a rethink.
Did this for last 5 year programme and little has changes other than management frustrations
I think when targets such as 62 days are not achieved and funding is reduced in significant amounts it makes it difficult to plan and transform services when funding is taken away.