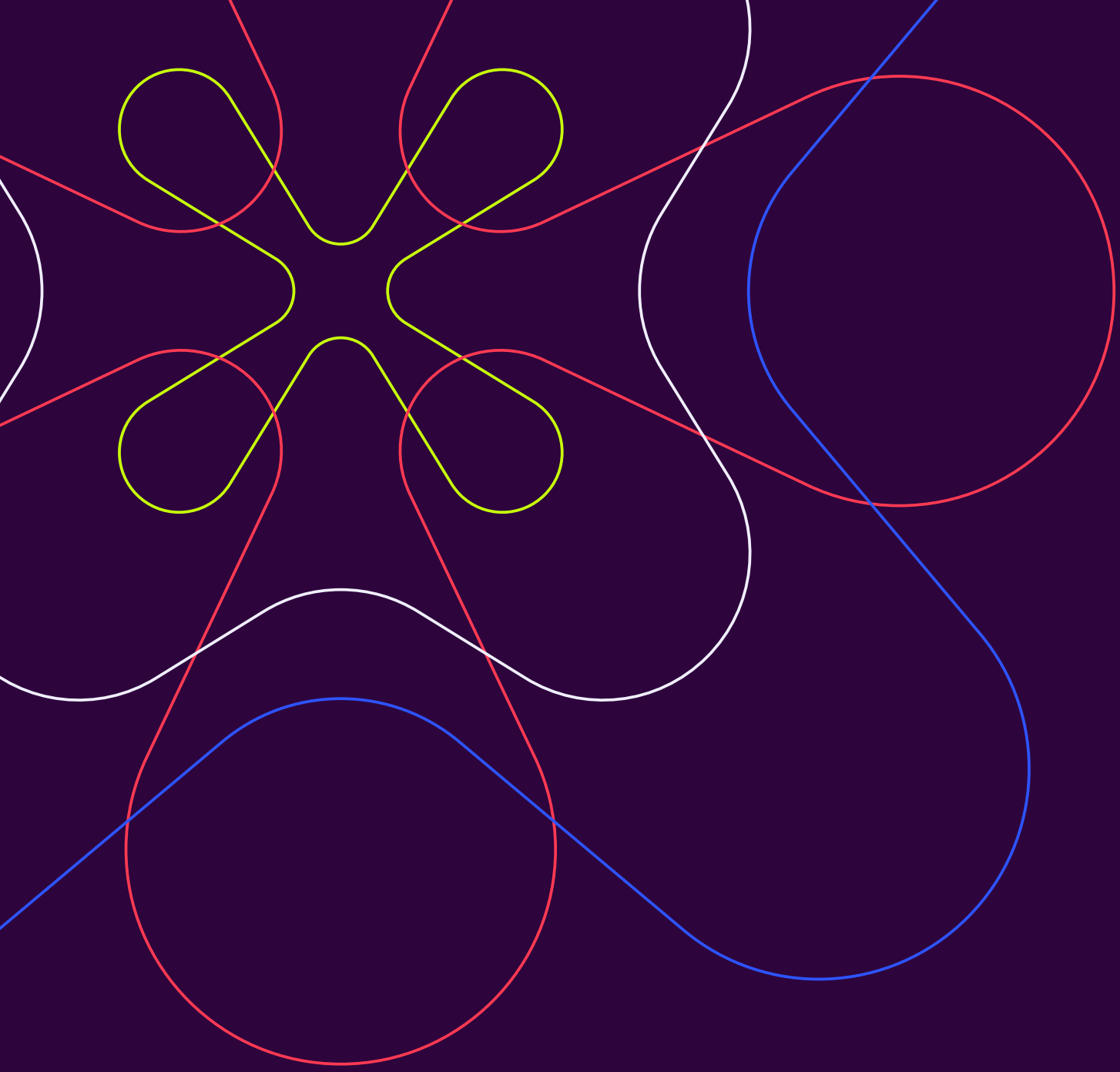

Supportive Oncology: the need for formal, funded services

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The NHS should prioritise integrating Supportive Oncology services into cancer departments, to improve patient experience and outcomes and to alleviate pressure on cancer services. This should include dedicated funding streams to ensure equitable access, and workforce development to address staffing shortages. Embedding Supportive Oncology in NHS standards will save money by reducing the use of secondary care, while enhancing quality of life and lengthening survival for patients.

These measures should be a key feature of the Government's 10-year health plan and cancer plan, moving patients out of hospital and into the community, and are essential to prepare the NHS for the projected rise in cancer cases to over 5 million by 2040.

Policy Recommendations

1. **National leadership:** Supportive Oncology should be a key feature of the Government's National Cancer Plan. This should include a roadmap for how SO will be implemented equitably across all cancer centres.
2. **Integration into care pathways:** The NHS should develop a service specification for Supportive Oncology and a framework for 'What Good Looks Like'. Provision of this service should be mandated in the NHS Contract.
3. **Funding:** The NHS should provide ring-fenced, fixed term funding for all cancer centres to develop a supportive oncology service.
4. **Workforce development:** The NHS should expand the number of clinical fellowships in Supportive Oncology, with an even geographical spread. To grow the pool of applicants, we need to increase the number of oncologists and palliative care consultants by increasing training places.
5. **Measurement and accountability:** The NHS should develop metrics to measure the take up and impact of Supportive Oncology.

Background

Cancer is one of the greatest health challenge the UK faces. Over the years, cancer treatments have advanced significantly and become much more effective. Patients are now living for longer, either having had their cancer successfully treated or living with non-curable cancer. On average, patients live almost six times longer after their cancer diagnosis than 40 years ago.

The population of people with cancer is also evolving. Increasing life-expectancy in general means more people with cancer have multimorbidity or are frail. They may still be able to benefit from modern, less-toxic cancer treatment, but enabling them to remain independent with a good quality of life is increasingly difficult.

These trends mean that the support that patients now need from the NHS is changing, and traditional models of care need to be re-examined in the context of new cancer patient populations.

Supportive Oncology benefits patients and the system, and delivers cost savings

Patient benefits[1]:

- Reduced physical symptoms, including pain.
- Improved quality of life.
- Longer survival, in part by leading to better adherence to and tolerance of treatment.
- Reduced need for emergency interventions.

System benefits:

- Saves money: a recent national analysis of supportive care services in England demonstrated improved symptom burden, and a saving of £8.5m across eight hospitals over a 12-month period, through reduction in secondary care usage in people with treatable but incurable cancer.[2]

- Reduces hospital admissions by over a third (35%) and reduces bed days by 28%, once the patient is in hospital.[1] Once out of hospital, effective Supportive Oncology can keep patients at home for longer. Supportive Oncology directly advances the ambitions of the Government's 10-year health plan by moving care out of hospital into the community.

What is Supportive Oncology?

In Supportive Oncology – an umbrella term for how patients with cancer are supported alongside their anticancer treatment – their broader needs are met by healthcare professionals, including doctors and nurses, specialising in supporting oncology, while oncologists focus specifically on cancer treatments. This can relieve oncologists' workforce pressures by up to 15%, which is incredibly valuable given the limited workforce capacity and rising demand in both oncology and palliative care.[3] [4]

This means managing the physical and psychological impact of cancer and its treatment and applies to all stages of cancer – from initial diagnosis, those living with cancer, those cured but still experiencing the effects of treatment, and in end-of-life care.

In practice, optimal Supportive Oncology requires a highly multidisciplinary approach to patient care and can involve doctors across a range of medical specialties, primary care teams, clinical nurse specialists, physiotherapists, occupational therapists, dietitians, spiritual care providers and psycho-oncologists.

Case Study:

The Christie NHS Foundation Trust – Supportive Oncology Directorate

The Christie Supportive Oncology Directorate is the first in the UK to bring together all "supportive services" in one place. Launched in 2024, its goal is to fully integrate multidisciplinary supportive care into both planned and emergency pathways, as well as outpatient care and follow-up.

The directorate focuses on:

1. Ensuring all patients have equal access to services that improve their experience and quality of life during and after treatment.
2. Reducing waiting times and improving access to clinical expertise.
3. Increasing the input of senior medical staff and allied health professionals in Hotline services, ward, and outpatient provision.
4. Reducing emergency hospital admissions and shortening hospital stays through these efforts.

This model provides comprehensive, seven-day support through an integrated approach aligned with Acute Oncology. Services include attending ward rounds, offering hotline advice and guidance, daily drop-in clinics, and team discussions for complex cases. By supporting "Front Door" services at The Christie, the directorate helps patients avoid hospital admissions when their GP or other secondary care options are only accessible through A&E.

A three-year pilot estimated that almost 600 emergency admissions were avoided as a result of Supportive Oncology – equivalent to a £1.4m saving, or £460,000 a year.[5]

A Supportive Oncology model of care can contain many different services

The ideal supportive oncology service model will depend on local service configuration (eg a standalone cancer centre v smaller DGH with links to an acute trust). We don't advocate for any particular model, but all cancer centres should be enabled and encouraged to provide a SO service that prioritises prompt, equitable access, admission avoidance and community care.

- Enhanced Supportive Care (ESC), is a more established practice in the NHS, focusing primarily on managing the medical side-effects of cancer and its treatment.
- Acute Oncology focuses on the management of cancer emergencies and the acute side effects of therapy, primarily in hospital. Supportive Oncology takes a longer-term, holistic approach to cancer management, part of which includes a focus on preventing admission via Acute Oncology services.
- An SO service would also include palliative care and more specialist services such as late-effects services, cardio-oncology, psycho-oncology and endocrine-oncology.
- Currently, there is a lack of ownership of the coordination of care, which results in palliative care, oncologists and GPs taking on part, but not all, of the role.

Momentum is growing for Supportive Oncology, but there are challenges in uptake

There are some excellent Supportive Oncology services developing, but implementation is patchy. Momentum is growing, and national support would reduce the current postcode lottery. Work is also underway to train dedicated Supportive Oncology fellows; the first four fellowships have been filled. Current challenges include:

- **Regional disparities:** Adoption and implementation of supportive oncology is patchy across the country, which introduces a postcode lottery of care. While it is thought that 22 cancer centres offer an Enhanced Supportive Care service, these have usually developed organically meaning that there will be inconsistencies in the provision of care. Dedicated Supportive Oncology services remain rare.
- **Workforce shortages:** Shortfalls exist in each workforce group involved in Supportive Oncology, including medical and clinical oncologists, acute oncology services, psychological medicine specialists, and palliative care doctors. Doctors are already overworked, limiting their ability to dedicate time to supportive oncology. The first clinical fellowships in Supportive Oncology have recently been recruited to, which should help build future capacity.
- **Funding and resources:** Supportive Oncology is rarely funded as a service in its own right, despite its proven benefits. Funding is not uniform across the country, which exacerbates inequalities in access.
- **Integration:** Siloed ways of working can limit the effectiveness of Supportive Oncology, especially between clinical and non-clinical workforce groups and between primary and secondary care. Outdated IT systems limit integration and prevent a fully patient-centred approach to care.

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The Royal College of Radiologists. Supportive Oncology: the need for formal, funded services: The Royal College of Radiologists, 2025.

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