

THE ROYAL COLLEGE OF RADIOLOGISTS

Response to:

NHS England - Modernising Radiotherapy Services in England - developing proposals for future service models

The Royal College of Radiologists (RCR) has consulted widely with its Fellows and members on the proposed reorganisation of radiotherapy services in England. In general response has been positive.

General comments

Here are our general comments:

- The RCR welcomes closer working between radiotherapy services to provide greater resilience in times of unexpected absence as this can only improve patient experience. Improved connectivity can facilitate independent peer review of radiotherapy planning not only in terms of volume definition but also in terms of plan quality. This will be beneficial for patient outcomes. We recognise there is little direct evidence of the impact of patient numbers in terms of quality outcomes in radiotherapy. However, we generally accept the principle that patients will benefit from being managed by a team with sufficient experience to understand the particular challenges of that anatomical body site, both in terms of radiotherapy planning, but also management of treatment induced side effects. In this regard we feel that specifying numbers in a particular tumour site should be used as a guide rather than an absolute indication. For example, lymphoma is an uncommon cancer with each body site being in turn less common. However, knowledge and experience of pelvic radiotherapy e.g. from treating prostate cancer should be looked on as transferable within a centre.
- The RCR would welcome more explicit information around governance arrangements for the proposed provider clusters. Whilst it is essential for responsibility to be clearly delineated, it is also essential to produce a governance framework which protects the non-lead provider hospitals within a cluster.
- Peer review of radical plans should be mandated as a tool to improve consistency and quality but sufficient time needs to be made available for this in consultant job plans. There is an opportunity to link the re-design of radiotherapy services with a clear expectation of clinical peer review of volume definition for radiotherapy planning. The Royal College of Radiologists currently has a working party producing a guideline entitled *Radiotherapy target definition and peer review – RCR guidance* which should be linked to the proposals.
- An explicit statement that no current provider of radiotherapy services will be closed would be welcome.

- Where changes in patient flows are anticipated it would be important to clarify how loss of tariff revenue is going to be communicated to Chief Executives of Trusts. Although collaboration and cooperation underpin the working of many oncologists on the ground, the current model of reimbursement of activity favours competition between Trusts. Some commentary on how this will be addressed and managed, especially given the current severe straits of NHS finances, would be informative.
- For the model to work as envisaged by the discussion document, significant improvement in IT connectivity between Trusts is required. Without this investment up front, the potential gains for patients or those delivering a radiotherapy service, cannot be realised. This connectivity does not just encompass treatment planning systems but also RIS/PACs and pathology systems. Given current difficulties around data sharing between Trusts these problems must be fully addressed and a solution implemented prior to service reorganisation or the new model is destined to fail.
- The RCR remains concerned about the lack of input from patient groups to these proposals. As the service reorganisation is outlined, a small but significant number of patients will have to travel long distances to access therapy, often over a 4 – 6 week period. What has been done to include their views in the proposed model? Given the straitened financial circumstances of the NHS, what actions are being taken to ensure that those patients who would have to travel, would receive sufficient support not only in financial matters but also social care, as many act as unpaid carers for spouses or dependants.
- In summary the RCR broadly supports the rationale underpinning these proposals but significant questions around essential IT infrastructure, support for implementation, governance and patient input need to be addressed.

Responses to Questions

Question 1a: Do you support the proposal to create networked services?

- Generally supportive.
- A clear and rapid patient pathway with some shared care for the 5-10% of rare cancers would no doubt be of benefit, but do we need a network for all cancers to achieve this?

Question 1b: What comments and/or ideas do you have about how networked services could be organised?

- There is a need to work collaboratively and recognize that site specific excellence within a network may rest with the Lead Provider.
- There needs to be a network understanding of where the expertise is in various sites and techniques, and this should be formally identified, acknowledged and continued development facilitated. Regular review of all pathways needs to occur so that services continue to develop and improved patient outcomes are supported.

Question 2: What comments and/or ideas do you have about how the proposals could work in practice?

- Physics support and centralised QA for trials would be very helpful.
- Ideally treat patients locally wherever possible – planning can be done remotely. Review of plans in the Centre where the biggest experience and expertise lies (which may not be the lead provider) would upskill the local team and improve plan quality.
- Clinician peer review of radical plans (both volume definition but also plan evaluation) needs to be explicitly supported. Achieving this will require dedicated time in consultants job plans. Linking the re-design of radiotherapy services with a clear expectation of clinical peer review of radiotherapy volume definition will significantly improve the quality and consistency of radiotherapy but also provide the lever with which to achieve this rapidly.

Question 3a: Please explain whether you feel that the case numbers presented within the clinical and service model reflect clinical best practice?

- We generally accept the principle that patients will benefit from being managed by a team that has sufficient experience to understand the particular challenges of that anatomical body site, both in terms of radiotherapy planning, but also management of treatment induced side effects. In this regard we feel that specifying numbers in a particular tumour site should be used as a guide rather than an absolute indication. For example, lymphoma is an uncommon cancer with each body site being in turn less common. However, knowledge and experience of pelvic radiotherapy e.g. from treating prostate cancer should be viewed (and encouraged) as transferable within a centre. Central review of radical planning in smaller centres can then be linked to ability to supervise the local treatment, reducing the impact of travel on patients and the resources of the local health economy.

Question 3b: Can you think of anything else that should be considered that may impact on the case numbers proposed?

- National consideration should be given to anatomical site specific teams with 'specialist supporting staff' e.g 'upper aero-digestive' teams should include a speech and language therapist, dietician and skin care expert – and would support patients with head and neck cancer, lymphoma of the head and neck region and oesophageal cancer.

Question 4a: What equality and/or health inequality issues may arise as a result of the proposals, as they currently stand?

- We know that there are patients who will refuse treatment, or opt for an inferior treatment rather than travel – how will this be compensated for? Has there been any estimate of the societal cost (direct transport costs and carer costs) to balance the potential for cost minimization from the perspective of the radiotherapy provider only
- Members and Fellows have expressed concern that these proposals will create a two tier system, with the lead provider possessing the financial and technical advantage, leading to preferential recruitment of all staff groups to that centre. In

turn this will result in a worsening of recruitment and retention issues in non-lead providers and a poorer service for the population served by those centres.

Question 4b: What steps could be taken to avoid any equality and/or health inequality issues?

- Ensure governance arrangements for the lead provider are organised specifically to ensure that disinvestment in non-lead provider Trusts does not occur.
- Invest in local provision of supporting specialist staff to enable local treatments in a innovative fashion across anatomical body areas rather than traditional tumour types.

Question 5: Is there anything else that we need to take into account when developing the service specification?

- Ensure robust patient representation on the engagement, the consultation and the implementation of change.
- A central rolling programme of machine hardware and software replacement for radiotherapy equipment which should not be subject to the increasing financial competition from the pressure of unplanned/emergency care and local deficits in social care funding
- The major benefits of the proposed reorganisation are in the networked sharing of good practice, standardised protocols, physics quality assurance and a co-ordinated approach to clinical research trial. There is a real concern among members and Fellows that this will be lost due to financial restraints – how does NHS England propose to protect this most useful part of the proposal?

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