

## **Comprehensive Spending Review (CSR) Submission**

**from The Royal College of Radiologists**

### **Joint statement from the RCR, SCoR and IPEM**

The Royal College of Radiologists (RCR), Society and College of Radiographers (SCoR) and the Institute of Physics in Engineering and Medicine (IPEM) between us represent over 46,000 members, whose professional skills underpin the medical specialties of clinical radiology and clinical oncology to detect, diagnose and treat disease and injury. Together we work in multi-disciplinary teams on the frontline to carry out and report on patient scans (approximately 44.5m scans every year in England alone<sup>1</sup>), monitor disease progression, and apply our combined knowledge and training to give life-saving and palliative radiotherapy to patients with cancer. In diagnostic imaging alone, millions of patients in the UK rely on our expertise to diagnose their conditions quickly and safely, and we play a pivotal role in many onward clinical pathways. In short, without us, the health outcomes of patients risk being severely impacted through inefficient and delayed treatment.

As a collective voice we are calling on this government to take urgent action as part of the Comprehensive Spending Review and seize the opportunity to rapidly boost the UK's cancer - fighting and scanning capacity by investing courageously in our medical specialties and the workforce behind them. Specifically we would like to see:

- Robust funding in additional training places and overseas recruitment to address the current and forecast workforce shortages in each of the three professions;
- Replacement of equipment and machines which are more than 10 years old to secure fast, safe and uninterrupted patient treatment;
- Recognition of the essential role played by modern information technology (IT) and digital infrastructure in supporting service delivery, and the need to commit to further investment if funding in the workforce and equipment is to be optimised.

To facilitate deeper understanding of the context in which we each operate, please read our separately endorsed submissions, which set out further information on our organisation-specific spend requirements and data.

### **Introduction**

The Royal College of Radiologists (RCR) represents the medical specialties of clinical radiology and clinical oncology. Clinical radiology is the use of medical imaging techniques to investigate, diagnose, treat and monitor diseases and injuries; interventional radiology – a subspecialty of radiology - refers to minimally invasive, image-guided medical treatments; and clinical oncology relates to any type of cancer treatment that is not surgery, including radiotherapy and systemic therapies such as chemotherapy.

This submission comes at a unique and unparalleled moment for healthcare in the UK. COVID-19 has impacted all aspects of healthcare, resulting in huge backlogs in both diagnosis and treatment. It will take years, if not decades, for the NHS to fully recover. Yet, at the same time, the crisis has also encouraged new, innovative and efficient ways of working. It is essential that this Comprehensive Spending Review provides adequate funding to support the health service through recovery and enable the implementation of new pathways and working models. It must also take into account the needs and wellbeing of the workforce in the aftermath of the crisis and beyond. The

majority of costings outlined below are based on data collected before the crisis and relate to pre-existing issues, including workforce shortages, aging equipment and inadequate IT infrastructure. However, this should in no way detract from the need to invest in the specific programmes and measures necessary to manage COVID-19 and its wide-reaching implications for healthcare.

## Clinical oncology

Over half the people in the UK born after 1960 will have cancer at some point in their lives.<sup>2</sup> Clinical oncologists deliver all types of non-surgical cancer treatment apart from surgery, and are the only medical specialty qualified to deliver radiotherapy.

Radiotherapy is a common and effective treatment for cancer, with nearly half of cancer patients having radiotherapy at some point.<sup>3</sup> Radiotherapy is highly effective in treating cancer - around 40% of patients who are cured of their cancer receive radiotherapy as part of, or the whole of, their treatment.<sup>4</sup> Therefore, to improve cancer survival rates and provide greater support to those living with and beyond cancer, the Treasury must:

### 1. Fund increases in the oncology workforce

There is a current shortfall of 207 consultant clinical oncologists (19%) and this is forecast to rise to 444 (32%) by 2024.<sup>5</sup>

A fully staffed and adequately funded cancer workforce will:<sup>6</sup>

- Improve patient outcomes and experience
- Release capacity for clinicians to dedicate to service improvement and research
- Decrease waiting times for treatment
- Improve staff wellbeing, retention and productivity
- Enable more efficient use of the workforce's skills and experience

To address workforce shortages, we need investment in additional training places and overseas recruitment. We calculate that to address the shortfalls in consultant clinical oncologists predicted by 2024 will require a total of approximately **£232.8m**, comprised of **£210.1m** to boost training places and **£22.8m** to support overseas recruitment. Realistically, to accommodate this number of trainees, this cost would need to be spread over a period of a decade or more.

Clinical oncologists work in multidisciplinary teams. Therefore, to realise real benefits for patients, funding to grow the numbers of medical oncologists, therapeutic radiographers, specialist nurses and other associated medical professionals will also be essential. For more detail, please see the submissions from the SCoR and IPEM, as well as other cancer charities and those involved in cancer care. Funding should also cover other associated costs, including training infrastructure, trainer time, leadership roles and administrative support.

### 2. Invest in radiotherapy equipment

There is a need for significant investment in radiotherapy equipment. Funding equipment for radiotherapy delivery will:

- Improve access to state-of-the-art treatment to ensure that patients benefit from the most advanced technologies with the highest chances of cure and lowest levels of side effects
- Ensure there is no reduction in radiation dose, minimising long term side effects for patients
- Reduce waiting times for patients and improve patient experience of treatment
- Reduce regional variation in patient care.

Capital expenditure for a UK-wide rolling radiotherapy equipment replacement programme, including computed tomography (CT) and magnetic resonance imaging (MRI) planning machines, would cost

approximately **£87.3m per annum**, plus an initial investment of **£300m** to replace linear accelerators (LINACs) over 10 years old – although it should be noted that some trusts and health boards will continue to lease rather than purchase equipment outright, and others may be able to secure discounts during procurement. The breakdown of our calculations is as follows:

For LINACs, which are used to deliver radiotherapy:

- A LINAC costs approximately £2m (including software and installation)
- We estimate that there are 340 LINACs in the UK<sup>7</sup>
- LINACs need replacing every ten years
- £2m x 340 LINACS/10 years = **£68m per annum**
- A one-off payment to replace all LINACs over 10 years old would also be necessary. According to calculations from the All-Party Parliamentary Group for Radiotherapy this would cost **£300m**.

For CT machines and software for planning radiotherapy:

- There are an average of two CT planning machines per cancer centre, and a total of 62 cancer centres in the UK
- These need to be replaced every ten years. The cost of a CT scanner is approximately £900,000
- Radiotherapy planning software is required for each treatment course. The cost of a rolling replacement of upgrades, including planning licences, would be approximately £0.5m per annum
- $(62 \text{ centres} \times 2 \text{ CTs} \times £900,000) / 10 \text{ years} = £11,160,000 \text{ per annum}$
- $£11,160,000 \text{ CT costs} + £500,000 \text{ software costs} = £11,660,000 / 10 \text{ years} = \mathbf{£11.7m \text{ per annum}}$ .

The RCR recommends that each cancer centre has a dedicated MRI machine for radiotherapy planning:

- The cost of an MRI scanner is approximately £1,000,000. These need to be replaced every ten years
- 62 cancer centres
- $(62 \text{ centres} \times £1,000,000) / 10 \text{ years} = \mathbf{£6.2m \text{ per annum}}$ .

Brachytherapy is a subset of radiotherapy. It requires the concurrent use of ultrasound to guide the placement of applicators inserted into the anaesthetised patient.

- We estimate that there are 40 brachytherapy machines across UK cancer centres<sup>7</sup>
- A brachytherapy machine costs £300,000 and an ultrasound machine costs £50,000
- Both sets of equipment need to be replaced every 10 years
- Therefore a rolling replacement of brachytherapy machines would cost **£1.4m per annum**.

All equipment upgrades need to be supplemented with funds to cover installation costs (which can be as much as the equipment itself) and maintenance costs. Equipment upgrades must be accompanied by any necessary upgrades in software, as well as the IT hardware needed to run it. Without these associated investments, clinicians' will be unable to provide up-to-date radiotherapy treatment – for example, the RCR is aware of recent anecdotal examples whereby upgraded radiotherapy software was unable to run on the trust's outdated computer systems.

### 3. Invest in radiotherapy operational delivery networks

In January 2019, NHS England published their final service specifications for the creation of 11 operational delivery networks (ODNs).<sup>8</sup> These networks are mobilising well, and have been able to

access small packages of initial funding through NHS channels. However, if they are to deliver real benefits to patients then they will require ongoing managerial and clinical input, as well as shared systems and software. Similar investment will be required to support the current networking arrangements in cancer centres across Scotland, Wales and Northern Ireland.

To ensure these networks of cancer expertise continue to progress, they will require a dedicated ODN support fund of **£21m** per annum over the next five years. This would enable strong clinical leadership, the implementation of quality improvement and research networks, and audit and data collection. It would also cover the purchase and implementation of a national software solution for sharing information on radiotherapy plans. This would make clinician peer review significantly easier and would provide quality assurance of radiotherapy on a national basis.

## **Clinical and interventional radiology**

Clinical radiologists use medical imaging techniques to investigate, diagnose, treat and monitor diseases and injuries. Interventional radiologists use image-guided techniques to carry out minimally-invasive procedures, improving patient experience, reducing hospital stays and – vitally - reducing risk of exposure to COVID-19.

Imaging is central to the diagnosis and treatment of many NHS patients - for example, 2 in 5 patients attending A&E receive an imaging examination.<sup>9</sup> In the case of major trauma (the most common cause of death for those under 40),<sup>10</sup> three-quarters of these critically unwell patients receive a CT imaging examination. As such, ensuring that imaging services are adequately funded and resourced is essential for guaranteeing the best possible care for a huge proportion of NHS patients.

To improve outcomes in clinical and interventional radiology, the Treasury must:

### 1. Fund increases in the clinical radiology workforce

There is a current shortfall of 1,876 consultant clinical radiologists (33%), and this is forecast to rise to 3,331 consultant clinical radiologists (43%) by 2024.<sup>11</sup>

A fully staffed and adequately funded imaging workforce will:

- Support ambitions for earlier diagnosis for conditions such as cancer, improving patient experience, outcomes and survival rates
- Prevent unnecessary delays in diagnosis and minimise the risk of missed diagnosis
- Free up time for clinicians to undertake service improvements and research
- Improve staff wellbeing, retention and productivity
- Reduce outsourcing (teleradiology), insourcing and locum costs (which totalled £193million in 2019)
- Enable trusts and health boards to provide effective and sustainable 24-hour interventional radiology services, delivering lifesaving emergency treatment for patients.

To address these shortages, we need investment in additional training places and overseas recruitment. We calculate that to address the shortfalls in consultant clinical radiologists predicted by 2024 will require approximately **£1.5bn** - comprised of **£1.2bn** to boost training places (including an increase in year 6 interventional radiology training places, outlined in more detail below) and **£251m** to support overseas recruitment. Realistically, to accommodate this number of trainees, this cost would need to be spread over a period of a decade or more.

See below for additional costings for the interventional radiology workforce.

Radiologists work in multidisciplinary teams. Therefore, to fully realise benefits for patients, funding to grow the numbers of diagnostic radiographers, sonographers, medical physicists and other associated medical professionals is also essential. For more detail, please see the submissions from

the SCoR and IPEM. Funding should also cover other associated costs, including training infrastructure, trainer time, leadership roles and administrative support.

## 2. Invest in imaging equipment

There is a need for significant investment in equipment for diagnostic imaging. Imaging equipment that is more than ten years old can be considered obsolete or inadequate for conducting certain procedures and must be replaced;<sup>12</sup> yet previous industry surveys have shown one in ten CT scanners<sup>13</sup> and nearly a third of MR scanners in UK hospitals exceed this threshold and hence pose a risk to patients.<sup>14</sup> The UK has fewer scanners than the majority of comparable OECD countries:<sup>15</sup> the latest available OECD data shows the UK has 9.5 CT scanners per million population while France has 18.24 and Germany has 35.1. Similarly, for MRI scanners per million population, the UK has 7.23 MR scanners, France has 15.4, and Germany has 34.7. The £200m committed by the Prime Minister last year to fund new scanners<sup>16</sup> is insufficient to replace all outdated equipment, let alone bring the UK equipment base in to line with other comparable countries.

Adequate funding equipment for diagnostic imaging will:

- Reduce waiting times for patients and ensure that patients benefit from the safest and most advanced medical technology
- Support ambitions for early diagnosis by improving access to diagnostics
- Reduce regional variation in patient care
- Minimise exposure to radiation during scanning
- Bring the UK into line with other comparable countries in terms of access to diagnostic equipment
- Ensure capacity to be able to meet periods of higher demand or restricted equipment use – such as during the COVID-19 pandemic
- Reduce downtime and repair costs associated with the use of obsolete equipment
- Improve the quality of images acquired.

The NHS Long Term Plan included the commitment that investment in new equipment, including CR and MRI scanners, would be negotiated in this Spending Review in order to deliver faster and safer tests.<sup>17</sup> We estimate that within the next three years 251 CT machines and 167 MRI machines will exceed the 10-year age limit and will need to be replaced. The cost of replacing these machines will be approximately **£392.5m**, based on a cost of £900,000 for a CT machine and £1,000,000 for an MRI machine - although it should be noted that some trusts and health boards will continue to lease rather than purchase equipment outright, and others may be able to secure discounts during procurement.

If the UK wants to improve its number of CT and MRI machines per capita, and consequently improve patient wait times and outcomes, these costs will be even higher. The Health Foundation calculates that to bring the UK up to the average number of MRI and CT scanners among EU15 and G7 countries would require approximately **£1.5bn** in extra capital spending.<sup>18</sup> Indeed, this likely underestimates the total cost, since it does not include additional infrastructure costs such as space in hospitals. It should be noted that the UK data is from 2014, compared with 2016 for the other countries in question.

All equipment upgrades need to be supplemented with funds to cover installation costs (which can be as much as the equipment itself), maintenance costs and regular software updates.

Further capital expenditure is also required for reporting workstations. There is a shortage of Picture Archiving and Communication Systems (PACS) workstations – the standard method for viewing all medical images - meaning that radiologists are sometimes unable to find space for reporting, resulting in unnecessary delays. If, as we recommend, the number of radiology trainees is increased, then this equipment shortage will be exacerbated further. To address this shortage, we recommend investment in an extra 2,000 PACS workstations. This would cost approximately **£10m**

(based on an estimated cost of £5,000 per workstation), and replacement should be on a seven-year cycle.

In addition to the costs outlined above, investment in additional mobile equipment to support mobile lung screening and centres requiring temporary uplift in capacity, for example, during the COVID-19 pandemic, is essential.

### 3. Invest in interventional radiology

Interventional radiology (IR) is a subspecialty of clinical radiology. Interventional radiologists use image-guided techniques to carry out minimally-invasive - and often life-saving – procedures, including treatments for stroke and haemorrhages. An effective IR service can:

- Offer a faster, safer and more cost-effective alternative to traditional surgery
- Improve patient outcomes
- Improve patient recovery times compared with traditional surgery, reducing the length of hospital stays
- Save patients' lives during medical emergencies such as stroke and haemorrhages
- Enable trusts and health boards to provide 24-hour interventional radiology services, delivering lifesaving emergency treatment for patients.

As with clinical radiology, there is a significant shortage of interventional radiologists – an additional 386 consultant interventional radiologists (37%) are currently needed in the UK to meet IR guidelines for patient safety.<sup>19</sup> Interventional radiologists require an extra year of training after completing their clinical radiology training; we calculate that to address forecast shortfalls in IR would require an additional 562 training places, at a cost of **£42.7m**. Realistically, to accommodate this number of trainees, this cost would need to be spread over a period of a decade or more.

In addition, IR services need:

- Access to day-case beds, ideally in a dedicated IR unit. We would suggest an average of 4 day-case beds per unit, equating to approximately 800 beds across 200 additional sites.
- Investment in IR suites for delivering treatment. We estimate that to maximise productivity and throughput there should be one IR suite for every two interventional radiologists.
- Additional nursing and clerical staff to reflect the increase in IR work and support 24/7 activity. For a robust and safe service, each unit requires a minimum of 6 IR's, 6 nursing staff, 6 radiographers and 2 clerical staff.
- Greater investment in interventional neuroradiology, including ensuring that services have the workforce and equipment necessary to deliver 24/7 mechanical thrombectomy treatment.\*
- Educational and training budgets for maintenance of competencies.

### 4. Invest in imaging networks

Interconnected radiology networks offer a valuable and efficient method for pooling scan reporting capacity, allowing access to expert opinion in times of annual and sick leave and helping to cover the radiologist vacancies across the country. Existing networks have already demonstrated their utility, with undeniable benefits for patient care as well as significant savings for the NHS. East Midlands network EMRAD estimates that it will save its seven partner trusts £3m over the next decade through their collective negotiation of a contract.<sup>20</sup>

The creation of new imaging networks was confirmed as a priority for NHS England in the Long Term Plan,<sup>17</sup> and there are ongoing calls for this to be replicated in the devolved nations.<sup>21,22</sup>

NHS England has established a strategy for establishing 18 networks by 2023,<sup>20</sup> and baseline local provision is still being mapped. Some trusts may be at a more advanced stage of interconnectivity

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\* Mechanical thrombectomy is an effective treatment for stroke that can save lives and reduce permanent brain damage.

and have access to the committed funding and staff time needed to procure and oversee image-sharing platforms, but others will not. For illustration, set up costs alone (not including rolling licensing costs) for one advanced regional network in England were more than £6m.<sup>23</sup> In line with this, a dedicated fund of approximately **£150m** should be ring-fenced to support the creation and IT alignment of emerging English networks, as well as the creation and ongoing support of similar models in the devolved nations.

The Quality Standard for Imaging<sup>24</sup> (QSI) has been developed to underpin and evaluate high quality, patient orientated imaging services. It articulates the quality expectations of good imaging, interventional radiology and teleradiology services. As NHS England works to establish imaging networks, the QSI offers a quality benchmark against which emerging networks can converge to deliver improved and transformed patient access to imaging services. Supporting networks to meet the QSI would enable quality in delivery, encourage service improvement and reduce regional variation experienced by patients. We estimate that the cost for a network to meet the QSI would be £500,000. Therefore, the cost of supporting all 18 networks meeting this standard would be **£9m**.

#### 5. Invest in rapid and community-based scanning services

In recent years we have seen a growing emphasis on community-based testing through models such as Rapid Diagnostic Centres (RDCs) and Community Diagnostic Hubs (CDHs). RDCs have been established as bolt-on hospital clinics, whilst CDHs would be established at new sites that are logistically positioned to serve local communities and link in with trusts/health boards – meaning that CDHs would require dedicated equipment and healthcare staff. Both models would require IT connectivity with local hospitals to enable image and information sharing.

The RDC and CDH models are designed to:

- Speed up diagnoses for patients with suspected cancer and other serious conditions
- Improve early access to testing across a range of services, including imaging, endoscopy and cardiology
- Relieve pressure on acute hospital intake.

Community-based diagnostics, including RDCs and CDHs, will also be particularly important as the NHS responds to the impacts of COVID-19, since they can act as “COVID-secure” sites, thereby increasing diagnostic capacity away from acute settings.

RDCs have already been trialled across the UK, with one Welsh pilot demonstrating that these dedicated diagnostic clinics pick up three times more cancer than via normal pathways.<sup>25</sup> The NHS LTP is committed to RDC development<sup>17</sup> and English Cancer Alliances are now tasked with developing local RDC models.<sup>26</sup>

Although RDC and CDH composition will be driven by local systems and needs, there is no doubt that these new services will require huge amounts of resourcing, including premises creation/conversion, equipment installation and running costs and staff provision.

For trusts, health boards and Cancer Alliances to implement them across the UK, the Treasury must support RDCs and CDHs with funds for imaging equipment. A basic imaging bundle for a new RDC/CHD would cost approximately £2.2m:

- One MRI machine: £1,000,000
- One CT machine: £900,000
- One X-ray scanner: £160,000
- Two ultrasound scanners: £100,000 each

Therefore, assuming that there would be one CDH or RDC for each of the 167 UK trusts/ health boards, the total cost for imaging equipment would be **£378m**.

#### 6. Fund iRefer for the NHS

iRefer<sup>27</sup> is a reference tool that provides up-to-date guidance on selecting the most appropriate imaging investigation for a range of clinical problems. It promotes evidence-based imaging and facilitates appropriate referrals to radiology departments. iRefer benefits both clinicians and patients' by:

- Ensuring that the most appropriate imaging test is conducted at the right time, supporting rapid diagnosis
- Eliminating unhelpful or repeat investigations
- Ensuring that resources are used efficiently and effectively to avoid waste and promote a sustainable service
- Promoting uniform and best care for patients
- Protecting patients by avoiding unnecessary ionising radiation.

Excluding VAT, national access to iRefer guidelines could be provided at a cost of:

- **£330,000** for a website-only subscription;
- **£29,032,500** for the full clinical decision support system (five-year subscription, paid annually); or
- **£23,808,547** for the full clinical decision support system (five-year subscription paid up front).

## Further considerations

### 1. Investment in modern IT and digital infrastructure

To underpin all the asks outlined above and support service improvement across the NHS as a whole, investment in modern information technology (IT) and digital infrastructure will be essential.

The NHS' aging IT base is well-documented and a consistent source of lost time and productivity for clinicians. Earlier this year the Department of Health and Social Care committed to reducing staff login times<sup>28</sup> – however, hundreds of thousands of NHS computers continue to run on obsolete hardware and software<sup>29,30</sup>, are unable to receive information from other trusts and health boards and do not have integrated electronic patients records systems. These limitations and inefficiencies are a waste of time and money, and fundamentally inhibit doctors' ability to care for their patients.

The RCR has long advocated for a more advanced and interconnected IT infrastructure. Investment in this area would result in significant benefits for patients, doctors and the wider NHS, including:

- Improved information sharing within and between trusts and health boards to improve care for patients
- Better virtual interactions between patients and clinicians
- Reduced waiting times for patients and avoiding unnecessary repeat appointments
- More effective use of clinicians' time and skills
- Improved networking and peer support to reduce variation in care and raise standards
- Supporting remote working, reducing work stress and improving staff wellbeing

The CSR must commit to greater healthcare capital expenditure in this area, with incentives and initiatives to enable trusts and health boards to rapidly modernise their IT. If not, any investment in workforce, equipment and software will all be undermined.

### 2. Investment in artificial intelligence

Artificial intelligence (AI), if properly funded and regulated, will yield significant benefits for both imaging and cancer care. Alongside broad usage across NHS operations, such as supporting and streamlining patient pathways and appointment bookings, AI solutions have the potential to revolutionise clinicians' workflow, automate low-skilled, time-consuming tasks and provide new insights into patient care and population health.



The Department of Health and Social care and partners have repeatedly committed to ongoing funding for AI, including a recent announcement of a £250m AI Lab to support and accelerate public-private products and trials.<sup>31</sup> Funded projects across our specialties include programmes to detect breast cancer, lung nodules and fetal abnormalities on scans, predict patient responses to cancer treatments and help with radiotherapy planning.

Imaging and cancer AI will need to be rigorously evaluated and tested before being actively deployed across NHS systems outside of trial settings. On top of rolling national grants to support commercial project development, dedicated NHS funding must be earmarked to support the expansion of staff time and clinician job plans to cover AI testing and innovation. Commissioning and regulatory reforms will also be essential.

### 3. Prioritise staff wellbeing

A growing body of evidence shows that medical careers are associated with higher rates of psychological distress and psychiatric morbidity when compared with other professions.<sup>32</sup> The NHS and UK governments have long recognised workforce issues in healthcare and the implications of these for staff morale and patient safety. The 2009 Boorman Report<sup>33</sup> on NHS staff maps the link between the well-being of practitioners and detrimental organisational performance measures. Similarly, following the Mid Staffordshire NHS Trust inquiry, the Francis report<sup>34</sup> in 2013 highlighted the link between over-stretched staff and the resultant adverse effect on patient care. However, although measures have been taken to address these concerns, they have largely tackled the symptoms of the problem, not the root causes; as such, issues persist.

This importance of this issue is increasingly being recognised: in 2018 the NHS announced the national NHS Practitioner Health Programme for a mental health support scheme,<sup>35</sup> and the NHS Long Term Plan<sup>17</sup> also contained a renewed focus on mental health of staff. The NHS People Plan<sup>36</sup>, published earlier this year, outlines behaviours and actions that staff can expect from NHS leaders and colleagues to improve the experience of working in the NHS for everyone. A continued focus on staff wellbeing, building on these publications and initiatives, will be essential to improve staff morale, productivity and retention in the NHS. It will also be a vital consideration as the health service recovers from the impacts of COVID-19. The Treasury must ensure that all measures necessary to support and improve staff wellbeing, included those outlined in the People Plan, are adequately supported and funded.

## **Conclusion**

The investments outlined in this paper, while substantial, will have large and long-term benefits for the health of the population.

The prominence and incidence of cancer is rising consistently, and over half of people in the UK born after 1960 will have cancer at some point in their lives.<sup>2</sup> Funding for the priority areas detailed above will help to ensure that people with cancer get the treatment they need and deserve.

Diagnostic imaging is central to the care of a significant proportion of patients; without the investments we have outlined, imaging services will suffer and the impacts will be felt across the NHS and by millions of patients.

We would be happy to discuss the content of this paper in more detail, and to answer any questions you may have.

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