Engagement on proposed revisions to Clinical Reference Groups in specialised commissioning
Deadline 10th March

Response from The Royal College of Radiologists

1. Do you have any comments on the proposed revisions set out in section 2 of the engagement guide around the resourcing of CRGs, the remuneration of members or the number of members in each CRG?

   The RCR has been represented on CRGs since their inception. A weakness of the CRGs has been the severe lack of resource and infrastructure. The formalisation of the CRG chair appointment and remuneration as well as the proposed additional infrastructure support and funding are therefore very welcome.

   However, the proposed reduction in the number of "senate" clinical members from 14 to 4 regional CRG clinical members and the reduction proposed in the number of patients or carers would reduce the range of expert clinical and service user advice available and the strength of advocacy. This will create particular difficulties as and when subgroups or working parties are required to address specific issues. Increasing pressure on clinical time as well as annual and other leave could result in poor attendance at some meetings with consequent restricted clinical advice.

   The remit of the CRGs is based on having adequate representation from relevant regions, and the planned reduction would not provide adequate breadth of coverage from across England.

2. Do you have any comments on the proposed revisions set out in sections 3 – 8 of the engagement guide relating to the numbers and remit of the CRGs within each National Programme of Care?

   The radiotherapy CRG has been an effective body and the opinion of the RCR is that the remit of this Group should include stereotactic radiosurgery (SRS), stereotactic radiotherapy (SRS) and molecular radiotherapy as well as its established role in having a remit for external beam radiotherapy and brachytherapy.

   Currently radiology patient services are covered by 3 CRGs:

   - Specialised Imaging
   - PET-CT
   - Interventional Radiology.

   The RCR considers that these 3 CRGs should continue given that there are over 45 million radiology investigations and treatments each year with vast impact on patient treatment decisions and outcomes as well as optimal use of NHS resources.

PET-CT is proposed to be covered by a working group within Cancer Diagnostics. However over 10% of PET-CT currently is for patients who have diseases other than cancer, e.g. dementia. These non cancer indications and patient numbers are increasing.

The Phase 2 PET-CT procurement has a direct expenditure implication of £1 billion over 10 years and far more in respect of downstream treatment decisions, e.g. change of chemotherapy, dementia drug treatment/nursing care.

Interventional Radiology is used not only for patients with vascular disease, but also with renal disease, cancer, infection, thoracic disease etc. It should have a CRG in its own right.

Specialised Imaging CRG needs to continue not only because of the millions of Ultrasound CT and MRI scans done every year in England, but because of the vastly increasing images generated per patient (thousands), and the need to develop informatics for data mining, structured reporting, accurate disease progression measurement, etc. MRI and CT are further developing from just providing anatomical information to complex functional information, e.g. which would determine which patients with stroke would benefit from thrombectomy, or which patients should have liver biopsy, etc.

Imaging is absolutely central to the modern management of most serious conditions including cancer. A recent report commissioned by Cancer Research UK to inform the cancer strategy found a severe capacity gap in imaging which will have to be addressed if the ambition of better outcomes for cancer patients is to be achieved. At the same time, the availability of interventional radiology services on a 24/7 basis, as demanded by the Keogh standards, remains a major challenge in many parts of the country The proposed reduction in the number of imaging-related CRGs will reduce the ability of NHS England to plan additional imaging capacity and address the known deficiencies in interventional radiology cover.

3. Are there any other changes or revisions that NHS England should consider to the role, function or membership of CRGs?

The range and depth of expert clinical advice can be strengthened by enhanced representation from the Medical Royal Colleges and other relevant professional organisation.

The current chemotherapy CRG does not have formal RCR representation even though clinical oncologists supervise the majority of chemotherapy activity in the UK. The RCR would strongly recommend formal representation from the RCR on the chemotherapy CRG.

Within the next three years proton therapy will be available at two centres in England. One of the most important patient groups will be children with cancer. Because of the importance of family-focussed patient pathways the RCR would recommend

interaction between the children's/young adults and radiotherapy CRGs to ensure appropriate commissioning of the entire pathway.

4. Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the proposed revisions that we have described?

   The CRGs need to ensure that any representation takes into account the need to consider equitable access to treatment for deprived and rural populations. They also need to consider how to address the relevant 'protected characteristics' that are essential in defining equality, as there is evidence to suggest that patients from some of the groups falling into the category of 'protected characteristics' have unequal access to cancer care in the UK.

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