

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, the response has been positive in terms of improving quality of radiotherapy services nationally. However there are some important concerns with the proposal as it currently stands.

Main issues:

- The RCR remains concerned about the lack of evidenced input from patient groups to these proposals. As the service reorganisation outlines, 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?
- The RCR is concerned that requiring patients to travel for better services threatens both the quality of their experience and outcomes. Patients should be able to book appointments in advance, so they can have a timed slot which facilitates organising travel. Given the straitened financial circumstances of the NHS, what actions are being taken to ensure that those patients, who will now have to travel, will receive sufficient support not only in direct financial terms but also in caring support – as many act as unpaid carers for spouses or dependants? Suggesting that this will be wholly delivered by charity funding may not provide uniform access across the whole population.
- The RCR remains concerned about the potential impact on healthcare inequality. Patients in low socioeconomic groups will be most negatively affected as they may choose not to have the best possible treatment in favour of a local service, for convenience, especially if financial support for travel and / or accommodation is not present locally. Research published in the BMJ found that 77% of the included studies showed evidence of an association between worse health outcomes the further a patient lived from the healthcare facilities they needed to attend. This was evident at all levels of geography—local level, interurban and intercountry level. A distance decay effect cannot be ruled out, and distance/travel time should be a consideration when configuring the locations of healthcare facilities and treatment options for patients.¹
- The RCR is concerned that under current NHS reorganisation, the responsibility for delivering the whole cancer pathway lies with a number of bodies: STPs, Cancer Alliances, Vanguards and the proposed radiotherapy networks. None of these bodies are aligned. Their ability to produce a comprehensive funding and workforce strategy – a key part of the reorganisation - is not fully elucidated. The risk is that these functions will not be delivered in a meaningful fashion.
- The RCR is concerned that there is no indication of how the radiotherapy networks will be sustainably funded.
- For the model to work as envisaged in the published proposals, significant improvement in IT connectivity between Trusts is required. There is mention that local solutions will need

¹ Kelly C, Hulme C, Farragher T, et al Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review BMJ Open 2016;6:e013059. doi: 10.1136/bmjopen-2016-013059

to be sought by the network boards. This is not logical given the small number of providers and the urgent national need for IT connectivity from the outset of the reorganisation. For cost effectiveness, a national IT solution should be sought for the reorganisation to be effectively implemented. The funding promised for radiotherapy service improvements has been badged for both software upgrades and IT infrastructure. The RCR would welcome clarity around how IT connectivity on a national scale will be achieved. Without investment up front, the potential gains for patients and those delivering a radiotherapy service cannot be realised. This connectivity does not just encompass treatment planning systems but also RIS/PACs, pathology and EPR systems. Given current restrictions around data sharing between Trusts, these problems must be fully addressed, and a solution implemented prior to service reorganisation or the new model will not work

- In summary, the RCR broadly supports the rationale underpinning these proposals but significant questions around supporting patients to travel, essential IT infrastructure, and support for network implementation including sustainability and governance and patient input need to be addressed.

Responses to Questions

Question 1 & 2: To what extent do you support or oppose this proposal? Please provide comment in support of your answer.

The RCR supports the principles underpinning this proposal, as it is clear that there needs to be a sufficient concentration of patients with rare cancers to maintain sufficient expertise to treat them safely and effectively. Additionally, it is unlikely that services for rare cancers are cost-effective unless they are centralised.

The RCR feels that an important part of this consultation revolves around the debate between having local services and asking patients to travel for better services. The RCR strongly believes that as many services as possible should be carried out locally. The RCR has concerns that patient travel times may detract from patient experience and outcome, and has evidence that patients will often choose a local service over a superior treatment if the distance is much further, with demographics often determining the patient's decision. An RCR audit found that patients were declining travel for treatment to a limited number of centres commissioned, reducing access and potentially negatively impacting on patient outcomes².

Question 3 & 4: To what extent do you think our description of the impacts is accurate? Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?

The RCR finds the descriptions of the impacts to be partially accurate. The improved outcomes impact (B2.4) is described effectively; however, there is insufficient recognition of the need for patients to travel to specialised centres and the challenges that this may cause to the patients, such as the personal organisation required in terms of distance from home/transport/accommodation costs/backfill of caring responsibilities. Placing the burden of this on charitable funding will lead to uneven access to such support by patients.

2.14 The Royal College of Radiologists' publication: *The timely delivery of radical radiotherapy: standards and guidelines for the management of unscheduled treatment interruptions* recommends "that during machine breakdowns, patients in "category 1" should be have no

² J. McAleese, S. Baluch, K. Drinkwater, P. Bassett, G.G. Hanna. The Elderly are less likely to Receive Recommended Radical Radiotherapy for Non-small Cell Lung Cancer. *Clinical Oncology*, Volume 29, Issue 9, 593 - 600

uncompensated gaps as this reduces tumour control'³. This document is undergoing a review at present and the updated version is expected to be published autumn 2018. There may be some movement of tumour categories e.g. anal cancer is likely to be classified as category 1. Can the reference to the guideline indicate that latest published version is to be used?

2.13 Recommendation of the use of ALERT-B for pelvic toxicity is welcomed. An expectation that every radiotherapy network will identify and provide a late effects service should be an explicit part of the commissioning of radiotherapy. The Clinical Oncology Heads of Service meeting in autumn 2017 discussed pelvis toxicity and some centres indicated that they did not have access to a service to refer patients, once identified as having a problem.

B3.6 needs some careful re-wording. It appears to imply that 'each consultant clinical oncologist will be responsible for treating' a cohort of rare cancers. This suggests that each consultant in each centre will treat common and uncommon cancers. As the RCR understands it, the purpose of the networks is to ensure that fewer consultants treat the uncommon cancers in fewer centres, where they are able to maintain sufficient case-mix and expertise.

B3.8 does not describe how the leadership of radiotherapy networks will be determined in terms of contracting and funding. Unless this is carefully defined, it is unlikely that there will be any significant changes to the existing pathways. Unless some contractual 'teeth' are described (and implemented) then the whole exercise will have little of the desired impact.

Cancer alliances, Vanguard, STPs and radiotherapy networks are not always co-terminus and one provider may cross two alliances. The relationship between cancer alliances and providers is already complex without the addition of radiotherapy networks, and so the RCR would like this additional layer to be carefully and thoroughly considered before being clearly defined in this proposal.

We are also concerned that the networks will not be functional without the IT connectivity to support them. Section A2.5 and 2.15 speaks about the proposed radiotherapy networks seeking local IT solutions, but this is wasteful of effort. There were early requests in the consultation period requesting better access to IT solutions to link networks and radiotherapy facilities. These do not appear to feature in the proposals. It is a significant challenge to attempt to facilitate intra-organisational IT-data-collaboration. The success of the networks will be mainly dependent on fully-functioning IT links, and this will require support and facilitation.

Question 5: Please describe any equality or health inequality impacts which you think we should consider in relation to the proposed service specification, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others??

There is an established link between poverty and cancer which will cause healthcare inequalities. The proposed plan could mean that many patients cannot afford to travel for treatment. Only a small proportion will be eligible for state benefit and travel costs. It is stated in section A2.6 of the service specification that "during the consenting process it will be important for each oncologist to provide information about travel transport and any available accommodation options". If these do not exist this puts a significant strain on the oncologist to justify unequal access to healthcare. Those who are on low income or the self-employed cannot afford to take longer periods of time off work to travel for treatment. Also, some patients have childcare issues or other caring roles of parents/spouses and it is unrealistic to assume they will be able to be away from their home for long periods of time. Based on previous experience of specialised commissioning, for example lung SABR, we know that patients will decline a potentially superior treatment for a less 'complex' treatment delivered locally. The motivated patient with higher level of income and excellent family support is likely to accept such treatments and there is real potential for discrimination along socioeconomic lines. This is particularly relevant as some of the intermediate and rare cancers

³The Royal College of Radiologists *The timely delivery of radical radiotherapy: standards and guidelines for the management of unscheduled treatment interruptions*, Third edition, 2008. London: The Royal College of Radiologists, 2008.

(e.g. head and neck and gynaecological cancers) are predominantly in patients with lower socioeconomic groups and often less social support or young families.

Question 6: Do you have any other comments about the proposals in the service specification?

There is mention of “reduced variation in quality by the introduction of nationally developed treatment protocols” in one part of the consultation document. In another there is mention of each radiotherapy network board agreeing tumour site specific protocols. This is duplication of effort.

For rare cancers there is a coherent argument to centralise services to ensure a necessary accumulation of expertise. For less common cancers there should be an explicit acknowledgement that the expertise developed for management of common cancers might be transferable across anatomical body sites e.g. a centre with expertise in accurately immobilising patients with prostate cancer, planning pelvic malignancies, managing acute radiotherapy toxicities in the pelvis and providing suitable support during follow-up could with very little support manage less common cancers e.g. anal; gynaecological and lymphoma in the pelvis. Well-constructed peer review of volumes and plans could support local delivery of therapy for a wider range of patients. This would require a change in emphasis in service delivery. It also requires appropriately supported IT connectivity. It should be actively and explicitly brought out in the service specification that this is to be encouraged to facilitate local service delivery for the maximum number of patients.

There is very little narrative in the document about the potential need for patients to travel further for treatment of rarer cancers. It is unhelpful to leave out this narrative as it will be one of the main barriers identified to implementing these pathways. In reality we can already send patients to the US for proton beam therapy or across the UK for highly specialised cardiac surgery, but this needs to be described properly in oncological terms. The localism impact on the NHS services is demonstrable in many reconfiguration exercises of the past (e.g. paediatric cardiac surgery as one example) and this needs to be handled very carefully and effectively.

For the radiotherapy network to be effective, the clinical leadership roles must be supported with protected non-clinical time. It is important to specify how the board members time will be funded and whose responsibility this is.

**The Royal College of Radiologists
January 2018**