Improving radiotherapy services to save more lives

A report summarising the radiotherapy community's views on the future of the radiotherapy service in England

August 2013

CANCER RESEARCH UK

Cancer Research UK[1]

Every year around 300,000 people are diagnosed with cancer in the UK and more than 150,000 people die from cancer. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. Together with our partners and supporters, our vision is to bring forward the day when all cancers are cured. We support research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses. In 2012/13 we spent £351 million on research. The charity's pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. We receive no government funding for our research. www.cancerresearchuk.org

August 2013

CREDITS AND ACKNOWLEDGEMENTS

We are very grateful to the speakers at the Roadshow events:
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Nick Slevin, Chair of the Radiotherapy Clinical Reference Group

We are grateful to those who supported the organisation of the Roadshow events:
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We wish to thank everyone who attended the Roadshows for their contributions to the discussions outlined below.

DISCLAIMER: The following document is a summary of the views expressed by attendees of the Radiotherapy Roadshow events. None of the views expressed necessarily represent those of any specific individual or of Cancer Research UK.

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I. INTRODUCTION

Radiotherapy is a highly effective way of treating cancer. Experts suggest that four in ten people whose cancer is cured have received radiotherapy and that radiotherapy is second only to surgery in its effectiveness in treating cancer.

Cancer Research UK believes that all patients that need radiotherapy should have access to world-class radiotherapy services. This means a service which can provide patients with swift access to the latest radiotherapy treatments within an acceptable distance of their home. And a service which embraces research and can turn findings from research into clinical practice as soon as possible. Currently, the proportion of cancer patients who receive radiotherapy in the UK is below internationally accepted recommendations[2,3] and there has been slow progress in rolling out new technologies.

Historically, commissioning for radiotherapy services in England has varied across the country. From April 2013, changes to the NHS mean that radiotherapy is now commissioned as a specialised service by NHS England. National standards for the service are now set out in agreed service specifications produced by the Radiotherapy Clinical Reference Group (CRG)[4]. Following a lengthy development process, a national tariff for radiotherapy has also been introduced.

In light of these changes Cancer Research UK, in collaboration with the Radiotherapy CRG and the National Cancer Action Team, held a series of 'Radiotherapy Roadshow' events between January and March 2013. These Roadshows provided an opportunity to hear from radiotherapy staff, commissioners and other local decision-makers, on the challenges and opportunities facing radiotherapy in England.

Figure 1: Location of the Roadshows: Manchester, Birmingham, Oxford and London. (Pins note location of all radiotherapy centres across England)

Across the service these changes have been generally welcomed. However, there are understandably concerns about how these new arrangements will work in practice and what impact they will have on the day-to-day running of radiotherapy departments across the country.

The Roadshows aimed to:

- Raise awareness of the importance of radiotherapy and improvements that must be made to the service
- Provide a background and hear thoughts on new commissioning arrangements for radiotherapy

- **Encourage commitment** to supporting improvements in local radiotherapy services.

The Roadshows visited each of the four NHS England regions and had a very encouraging attendance, particularly in a time of substantial change for the NHS. In total 107 people attended the events, representing the various professions within the radiotherapy service (see Figures 2 and 3, as well as the Annex to this report).

This report provides a summary of the Roadshows and draws on the findings from discussions that took place.

Figure 2: Professional representation

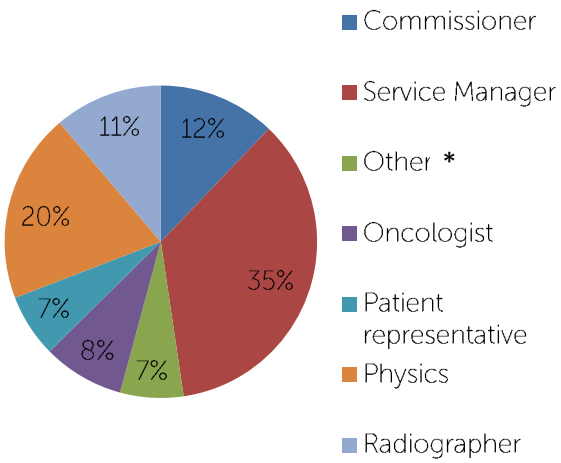
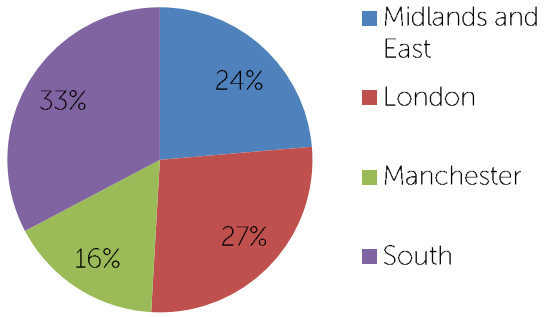


Figure 3: Regional representation



*'other' includes representatives from national bodies such as the Society and College of Radiographers, and the National Cancer Action team, a Trust finance manager and a Trust Chief Executive.

II. PRESENTATIONS

A number of presentations were given at the beginning of each Roadshow event. These provided background and context to inform discussions on the day. A summary of each appears below.

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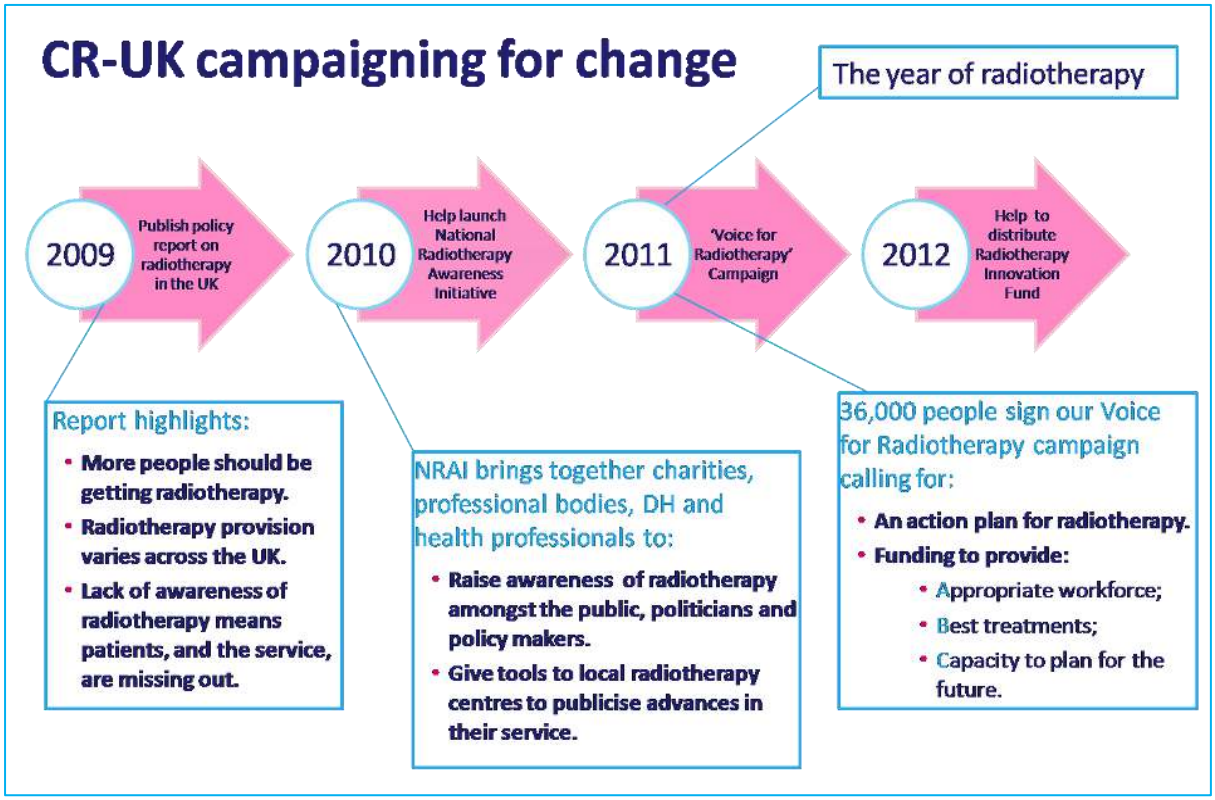
a. Cancer Research UK activity in radiotherapy

Presented by Hilary Tovey, Senior Policy Manager, Cancer Research UK

Cancer Research UK (CR-UK) champions improvements to the radiotherapy service. For the past five years CR-UK has been working to promote the importance of radiotherapy to politicians, policy makers and patients, to ensure that radiotherapy gets the priority it deserves.



Over this time, CR-UK has repeatedly heard from the service that the biggest barriers to real progress in radiotherapy are the lack of a co-ordinated, national tariff for radiotherapy – particularly one which rewards and promotes more advanced radiotherapy – and a variable approach to commissioning radiotherapy services.

In November 2012 the Department of Health published a report *Radiotherapy Services in England 2012,* which highlighted that significant improvements were needed in certain areas to bring the radiotherapy service in England in line with accepted standards. Around the same time, the Prime Minister announced a commitment that, from April 2013, all patients will get access to clinically appropriate, cost effective, radiotherapy which their doctor recommends. Accompanying this commitment, the Prime Minister launched the £23 million Radiotherapy

Innovation Fund, which provided a huge boost to the services' ability to provide more advanced radiotherapy to patients[5].

The introduction of specialised commissioning and a national tariff for radiotherapy should help address the barriers to improvement in the service, but questions still remain over how they will work in practice. The NHS has been through significant change. The Radiotherapy Innovation Fund, which CRUK helped to deliver, has made an important difference to radiotherapy services and their ability to deliver more advanced radiotherapy to patients in England. It is hoped that the radiotherapy service will build on the success of the Fund and benefit from recent changes to commissioning, as well as from renewed political attention.

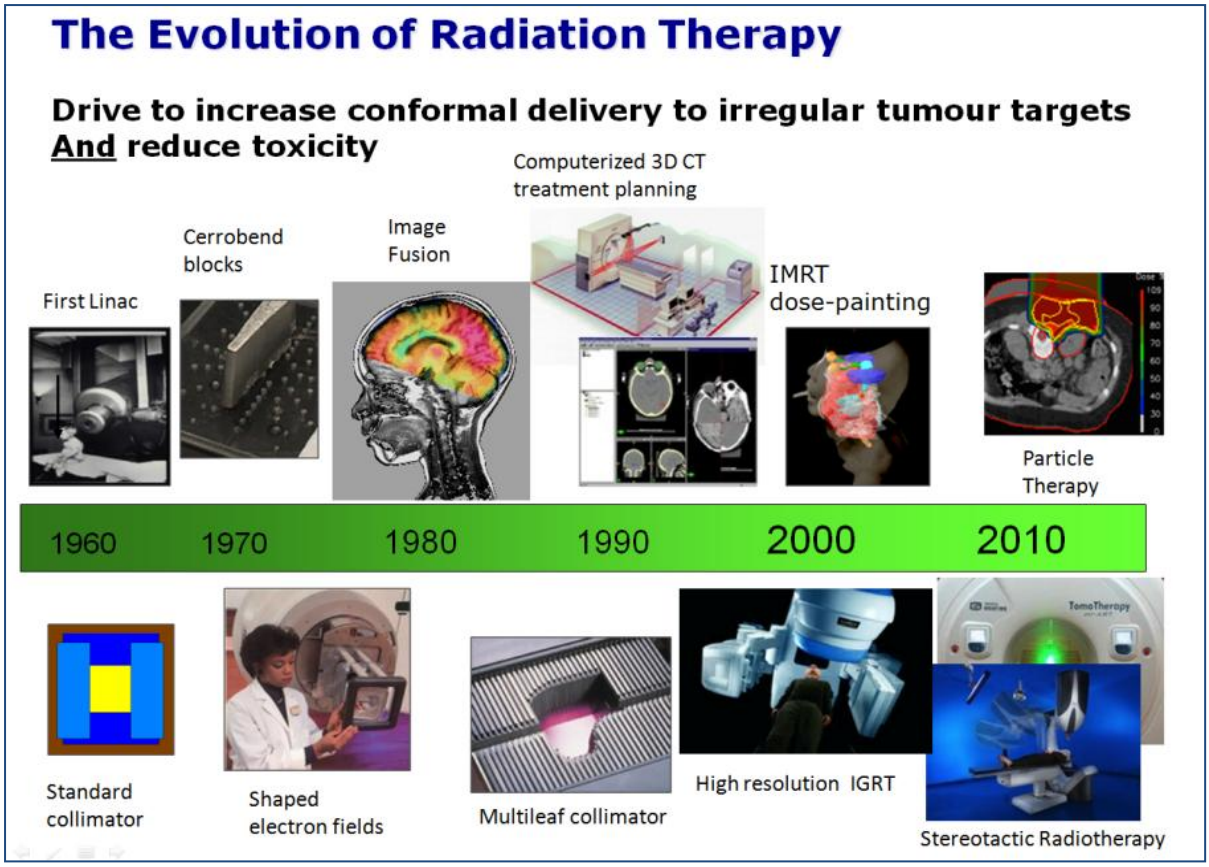
It is vital that the Prime Minister's commitment that all patients should expect to get access to the best, cost effective, radiotherapy which their doctor recommends becomes a reality.

b. The importance of radiotherapy in cancer treatment
   Presented by Dr Adrian Crellin, former Co-Chair of the National Radiotherapy Implementation Group, Department of Health National Clinical Lead Proton Beam Therapy

Radiotherapy plays an indispensable role in modern cancer care. 4 in 10 cancer patients whose cancer is ultimately cured undergo some form of radiotherapy treatment[6]. It is frequently used in conjunction with surgery, chemotherapy or biological therapies which would not be effective alone.

Advanced radiotherapy and patient outcomes

Over recent years, techniques have evolved to offer more advanced forms of radiotherapy that minimise unpleasant side-effects, and can more accurately target cancer tissue while preserving healthy surrounding tissues.



Access to advanced radiotherapy – for example Intensity Modulated Radiotherapy (IMRT), Image Guided Radiotherapy (IGRT) and Stereotactic Ablative Radiotherapy (SABR)[7] – plays an important role in achieving a number of goals within the NHS outcomes framework, including preventing premature mortality, enhancing quality of life, helping people to recover from episodes of ill health, and decreasing the chance of avoidable harm[8].

The integration of imaging into radiotherapy planning and treatment, as well as the ability to 'shape' doses of radiation to tumours, has meant that new techniques can adapt when tumours change in shape or location. This is particularly helpful in treating cancers in organs which move frequently, such as the lung, where it has traditionally been difficult to deliver a targeted dose of radiation. Complex techniques, such as proton beam therapy[9], have also helped people with very rare cancers. Additionally, radiotherapy is used to relieve symptoms such as pain and bleeding, as well as to preserve functions such as swallowing and breathing.

Planning for the future

Being able to plan for the future in commissioning radiotherapy services is crucial. Cancer incidences are increasing yearly: the number of cancer cases in the UK is projected to climb from around 298,000 in 2007 to around 432,000 by 2030[10]. Demographic factors such as ageing and lifestyle shifts, as well as the introduction of more effective technologies and efforts to diagnose cancer earlier will increase demand for radiotherapy treatment.

Access to high-quality radiotherapy treatments must be able to reflect rising demand in the years to come. This will depend on high levels of awareness around the importance of

radiotherapy amongst the public and clinicians, improved delivery and coverage of services, as well as investment in facilities and the radiotherapy workforce.

Given increases in demand and the fact that radiotherapy is a relatively cost-effective treatment [11] there is a clear business case for focusing efforts on improving the service and planning for the future.

c. Recent changes to radiotherapy commissioning and the national tariff
Presented by Professor Nick Slevin, Chair of the NHS England Radiotherapy Clinical Reference Group

The NHS reforms mean that, from April 2013, the way that radiotherapy services are commissioned and paid for has changed. These services used to be commissioned regionally, leading to some variation, but they are now commissioned nationally by NHS England. The Radiotherapy Clinical Reference Group (CRG) was established to set the national standards for the radiotherapy service. In addition, a national tariff for the radiotherapy service has been introduced.

The Radiotherapy Clinical Reference Group

CRGs are the main source of clinical advice on specialised commissioning for NHS England. CRGs have a key role in defining and reviewing the scope of specialised services. The Radiotherapy CRG is one of 74 that have been established to provide clinical leadership for a particular service.

As well as the development of the service specifications, the Radiotherapy CRG is responsible for developing commissioning policies and thinking more long-term about what the service should look like in the future – for example, driving the use of more advanced radiotherapy techniques and the incorporation of innovation and research into clinical practice.

CRGs are made up of 15-25 individuals:

- A Clinical Chair
- A clinician from each of the senate areas, plus 2 from London (14 in total)
- Patients/carers
- Up to 4 professional organisations
- An 'Accountable Commissioner'

National commissioning of radiotherapy services

Radiotherapy services are now commissioned as a specialised service at the national level by NHS England, administered by 10 local area teams. Service specifications for radiotherapy have been developed by the Radiotherapy CRG. These set out the minimum standard that radiotherapy providers should be delivering and form the basis of the standard contract for these services[12]. It is expected that this specification will be fully implemented in October 2013. The move to a national approach to the commissioning of these services is expected to reduce the variation in access and quality of services that was seen previously.

National tariff

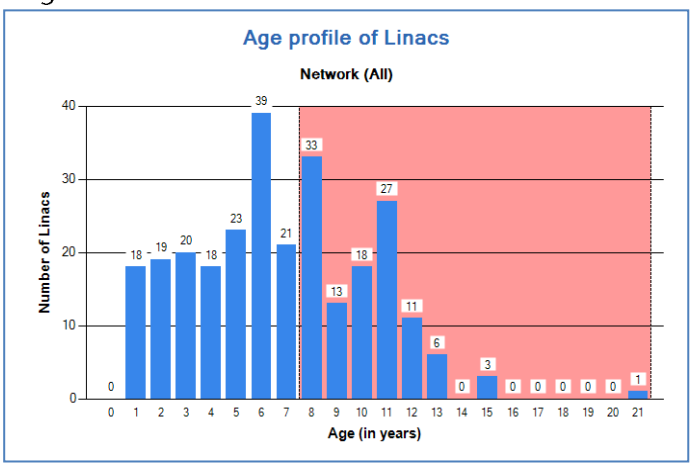
Historically, radiotherapy services have been paid for using locally agreed tariffs or via block contracts. This created variation in the costs that providers received in return for the services they delivered. A new national tariff for external beam radiotherapy was introduced for 2013/14 to move towards standardised pricing for radiotherapy services.

Due to the potential challenge in moving from local to national prices for some radiotherapy providers, the service is currently in a transition period. All providers are likely to be expected to move to full national tariff in 2014/15.

d. Challenges and opportunities – how are we doing nationally and locally?
Presented by Russell Hart, Radiotherapy Service Manager, Nottingham University Hospitals NHS Trust

The *Radiotherapy Services in England 2012*[13] report highlighted the challenges and opportunities now facing service providers and commissioners. It is now possible to compare providers using publicly available data, and therefore providers have a responsibility to ensure that the data they provide is as accurate as is possible.

Figure 4[14]



The regional basis of the Roadshows allowed a comparison of local providers in terms of demand, capacity, productivity and uptake of advanced techniques. A key metric proving to be a great challenge to providers is the use of treatment machines (linacs) that are more than ten years old, the recommended replacement age[15].

Radiotherapy infrastructure

Whilst the new tariff will reward volume and case-mix adjusted activity, the capital required to replace equipment and expand capacity remains an issue for NHS Trusts at a time when many are struggling to maintain timely equipment replacement programmes. The use of equipment older than 10 years old is specifically excluded in the national service specification. To replace old linacs, and to provide capacity to deal with rising demand, the service needs around 250 new linacs by 2016.

Workforce issues

In *Radiotherapy Services in England 2012*, it is demonstrated that workforce demands are a key challenge for the service and this problem could increase in the coming years. It is believed that the following increases in workforce are required:

- Therapeutic Radiographers: 39%
- Clinical Scientists and Technologists: 31%
- Clinical Oncologists: 16%

The forthcoming proton beam therapy services will place additional demands on the radiotherapy workforce as staff will potentially be drawn from existing NHS services. The recent growth of additional non-NHS providers has also drawn workforce from existing NHS services. The Roadshows also brought to light the apparent lack of the adoption of the four tier professional structure[16] within the radiographic workforce.

e. The patient and carer perspective

A number of patients and their family members were present at the Roadshows and were able to provide their perspective on radiotherapy treatment. Accounts of their experiences appear below.

Curative radiotherapy

I will never forget the day I went for the mammogram and ultrasound, when I was told 'it looks like something that shouldn't be there'. I wanted the hospital to throw all they could at it so I would see my daughters grow up.

I had 6.5 cm of disease and two lymph nodes were affected. I underwent chemotherapy and two lumpectomies before full mastectomy. This was followed by three weeks of daily radiotherapy treatment at the wonderful Mount Vernon Hospital.

People have some funny ideas about radiotherapy, and see it as something sinister or scary. My treatment was actually a complete breeze - certainly after chemo. People need access to radiotherapy so they can spend more time alive with their friends and families, and we must all campaign to make sure people get it when they need it most. It's really clever stuff, and it works.

Elizabeth Bailey, Cancer Research UK Campaigns Ambassador and breast cancer survivor

Radiotherapy for palliative care

My husband Philip was 52 when he was diagnosed with prostate cancer. After over 4 years of treatment in October 2009 he had run out of options - palliative care was what was left.

An MRI scan later revealed brain metastases at the base of his skull. He was treated with 4 daily fractions of radiotherapy, which improved his quality of life significantly so that he didn't need any further in-patient stays.

We were later informed that lesions on Philip's spine meant he needed more radiotherapy. The first fraction was delivered later that day with others the following week. Without rapid access to radiotherapy Philip would have become paralysed.

Although he only lived for a short time afterwards, radiotherapy treatment helped him to maintain a limited level of mobility and so I could care for him relatively easily. He was 6 ft 1 - trying to care for him if he had been unable to walk at all would have created significant challenges.

Providing rapid access to radiotherapy for palliative care purposes is vital – it can give patients near the end of their lives a reasonable quality of life by controlling symptoms and allowing the patient to be in their own home, as well as improving the wellbeing of carers.

Sue Duncombe, whose husband Philip died of prostate cancer in 2009. She is a Cancer Research UK Campaigns Ambassador

III. DISCUSSION SESSIONS

Participants were divided into groups and asked to reflect on the opportunities and challenges presented by recent changes to commissioning structures and the introduction of the national tariff. Participants were also asked to reflect on what they thought the new commissioners would need to know about their service. A summary of these discussions are set out below.

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a. Implementation of national commissioning

Participants agreed that the success of the new system will rely on a good relationship between NHS Trusts, commissioners and radiotherapy departments where services are provided, based on understanding each other's needs. It was clear that there is a lack of clarity across the community about how the new commissioning structures will work in practice.

There was optimism about changes in commissioning for radiotherapy - it will hopefully be better to work with specialised commissioners. However, commissioners will need to consider the whole service when seeking to improve patient pathways. Participants felt that there needs to be national leadership and help with commissioning, procurement, and business cases.

In general the introduction of new commissioning arrangements was seen as an opportunity to make the case for radiotherapy services to new commissioners. One set of participants described the situation as a 'blank slate' to take radiotherapy services forward. The new tariff and service specification make it clearer what commissioners expect from radiotherapy departments and this should lay the groundwork for a better relationship.

However, departments need to know who to talk to in the new system. In addition, new commissioners who may not have a background in radiotherapy will need support to understand the service. There needs to be an evidence base for the cost effectiveness of radiotherapy so that commissioners can make informed choices. Participants believed that commissioners must also ensure cancer remains a priority in the new structure, and part of this will be maintaining equity of access to advanced radiotherapy services.

Regional strategic planning was also considered to be a positive move. However, regional links between departments need to be improved to ensure equality for patients across different regions.

b. The introduction of the national tariff

The introduction of a tariff was generally welcomed by participants. It was thought the national tariff could improve relationships between radiotherapy departments and commissioners, as the payment structure for services will become clearer.

High quality radiotherapy will, in some cases for the first time, bring additional funding into NHS Trusts. It was noted that some NHS Trusts may lose out with the move to a national tariff. However, there was optimism that the tariff will help to increase provision of more advanced radiotherapy treatments.

It was hoped that the tariff will improve overall quality and provide greater clarity of expectations, which should in turn support conversations about how to promote and develop radiotherapy services both within NHS Trusts and among commissioners.

The importance of getting the tariff right was stressed. In the broadest sense this should be 'national, equitable and transparent'.

Concern about the tariff focused on whether income will be sufficient to cover radiotherapy services now and in the future. Key areas of concern for participants included:

- *How will investment in radiotherapy services, which will be needed to keep up with patient demand, be supported by the tariff system?*

Participants questioned whether the total running costs of departments are properly estimated within the tariff. Upfront costs for new equipment need to be addressed: one suggestion was using the tariff to incentivise capital investment.

The three-year time lag taken to develop the tariff was a concern, as it is felt real costs will be underestimated.

- *Will the tariff be flexible enough to adapt to newer treatments as they come to be accepted as best practice?*

Participants thought that the tariff was already out of date. While stereotactic ablative radiotherapy (SABR) is included within the service specification, this treatment is not included in the tariff. As well as providing for advanced radiotherapy, it was stressed that the tariff needs to keep up to date with emerging techniques so that departments have an incentive to provide new and innovative services.

Disappointment was expressed that the new system does not make a distinction between IMRT and complex conformal radiotherapy. There was also concern that the tariff has not kept pace with IGRT guidelines and now it is difficult to get the tariff changed.

Concerns were also raised that non-radiotherapy services within radiotherapy departments are not included in the tariff. Psycho-social support is an important part of the patient pathway. However, as this is not provided for directly through the tariff, some were worried that this area in particular will be vulnerable to cuts.

- *Who will be monitoring implementation - and how will the variability in the way that tariff codes are interpreted across the country be addressed?*

Some felt that there was still a disconnect between how activity is delivered and how it is measured. Different departments have different ways of interpreting tariff codes. For example, there are various different interpretations of what constitutes 'adaptive radiotherapy' in different situations and departments were still getting to grips with the best way to capture an accurate picture of IGRT, meaning that it is difficult to code this in the new tariff. It was thought that this could lead to departments being inadequately funded for the services they are providing. There was uncertainty around who will be responsible for monitoring and reviewing this.

It was also acknowledged that, although the tariff will act as an incentive for some, existing favourable arrangements developed over time in some areas mean that departments in these areas will lose out.

- *How will the new funding structure support and drive innovation and research?*

Radiotherapy is a cutting edge treatment. Although moving to a national commissioning system was considered to be beneficial for radiotherapy departments, negotiating with local commissioners previously provided an opportunity to innovate. There were concerns that the new, more structured approach to commissioning may lack the flexibility previously seen in the system which enabled departments to start to slowly adopt new treatments as their clinical benefit start to emerge. This is particularly important given the iterative nature of innovation in radiotherapy.

There was also concern that the proposed funding structures will make it difficult for radiotherapy departments to support research without losing money. An example of this is undertaking trials that are testing hypofractionation - regimens comprising smaller numbers of fractions are currently disincentivised by the tariff. In addition, while clinical trial activity provides some income for NHS Trusts, this tends to be volatile and so cannot be depended on for future planning.

c. Staffing

Workforce issues were raised throughout the Roadshow events. Some of the key discussion points raised by participants are below.

- *Opportunities should be taken to exploit the currently high levels of excitement and engagement of radiotherapy staff.*

In general, the radiotherapy community has been well engaged with national policy development and its implementation. The National Radiotherapy Implementation Group (NRIG) and the national radiotherapy programme (delivered by the National Cancer Action Team (NCAT)) played an important role in bringing the community together.

Participants believed there was excitement within the workforce regarding the introduction of a new commissioning structure, leading to a renewed momentum and high expectations. Recent Government investment and commitment to radiotherapy through the Radiotherapy Innovation Fund and the accompanying Prime Ministerial guarantee have provided an additional boost to radiotherapy departments across the country. Maintaining this momentum was thought to be important, especially as NRIG and NCAT would no longer exist after April 2013.

- *Long term planning for the future workforce should be a priority to ensure that services are adequate.*

Workforce presents a huge challenge for radiotherapy services. There was concern about the current and future staffing levels. It was thought that measures to address this will need to be supported by a national strategy and leadership. Co-ordination of services could improve local staffing issues that are currently affected by remote planning.

There was a question about who would champion the need to address staffing issues in the future. National bodies, such as the Royal College of Radiologists, have a role in supporting providers in this regard. But some thought it would be a challenge to ensure the Radiotherapy CRG focuses on the service as a whole, and not just on delivery of the service specifications.

It was noted that the tariff could act as a driver for addressing workforce issues. NHS Trusts will lose out on money if departments cannot meet national standards - this should be used as a lever for departments to make the case for additional staffing.

- *Training programmes need to be designed to attract and retain the radiotherapy workforce of the future.*

Participants believed that one of reasons for the shortage of physicists in the service is that university recruitment is not meeting requirements.

The current national training scheme for radiographers has also faltered. Attrition rates from training are particularly high in this group, especially in the first year of training. To address this, radiographers must be aware of both the technical and caring aspects of their role, which

must be included in training. There needs to be an increased awareness of radiography as a career choice and university education must provide relevant skills for working in the sector.

Recent improvements such as encouraging postgraduate entry into radiotherapy, protected time for technical development, and the introduction of the four-tier system as an incentive for staff to plan their career progression, were cited as opportunities which could be better exploited in the current system. The recently developed Consultant Radiographer role was noted as one example of increased opportunities for professional leadership[17]. Additionally, the development of the Bristol Masters level programme in Brachytherapy[18] was noted as an example of how more specialised training programmes are now being made available.

There were questions about whether funding might be made available to cover tuition fees to encourage people to train as radiographers, or whether there are opportunities to exploit international recruitment programmes.

- *Providing radiotherapy services out of hours will put pressure on departments.*

While it is accepted that there is a need for radiotherapy to keep up with the trend for services to be provided out-of-hours and to adopt a seven day working week, the pressure that this will put on staff and resourcing in an already stretched workforce should be considered.

- *Radiotherapy posts need better protection from efficiency drives.*

Participants believed that initiatives to improve radiotherapy services should focus on staff as well as on equipment. Although staff shortages are recognised, there is currently no clear way to increase staff levels. It was reported that often when staff are promoted there is a fight to keep former positions open.

d. Driving progress in advanced radiotherapy

The challenge of funding was also highlighted in terms of the need to plan for the introduction of advanced radiotherapy. As radiotherapy techniques are improving and becoming more complex, additional capacity will be needed to support this. The target of treating 24% of patients with IMRT was not considered ambitious, but departments are already struggling to pay for it. While some systems, such as volumetric modulated arc therapy VMAT, have reduced delivery times there have been increases at other points in the pathway so the overall time has not decreased.

Staff are aware of pressures within NHS Trusts on capital expenditure. However, if targets are to be met, resources must be improved. Linacs without IGRT capacity, for example, will need to be replaced even before machines are over ten years old. The Radiotherapy Innovation Fund was seen as a 'stepping stone' to improving infrastructure. In particular there were positive comments about the potential for the NHS supply chain to support joined-up purchasing.

e. Finding the missing patients

Access to radiotherapy across the country currently lies below the desired 52% of all cancer patients. However, while the service can aim to increase capacity to get more patients

through the service faster, it was considered that not enough people are being referred for treatment in the first place. Participants believed that the whole patient pathway should be aligned to ensure patients who could benefit from radiotherapy are being referred. Potential barriers included late presentation, palliative versus radical proportions, early presentations leading to surgery only, and diagnostic bottlenecks.

It was suggested that there may be an opportunity for NHS England to take a more holistic look at cancer pathways and how they can ensure the right patients are being referred for radiotherapy.

f. A focus on data collection

The increased focus on collecting and reporting performance data was welcomed. However, it was noted that there will be a challenge in ensuring that all data is up-to-date and that services collect the same information. Standardised specifications and data collection methods were expected to help with this.

Despite improvements over the past three years of the Radiotherapy Dataset, participants thought that more work should be done to ensure that the coding and reporting of data is as accurate as it could be. The National Clinical Analysis and Specialised Applications Team (NATCANSAT) was recognised as is a rich source of data and there was a recommendation that this data should be integrated into new arrangements to measure performance, such as the quality dashboard.

Participants believed that there should be a consistent mechanism for information gathering as this is currently unclear. In the new quality dashboard, quality metrics are being measured but not the quality of service. These things should be considered when targets are being set and data collection methods are decided.

g. The increased role of competition

Commissioners need to take care when encouraging competition between departments. Collection of data and comparison of departments are needed to ensure they are meeting standards, but it was stressed that this should not then be used to 'threaten' them. This could change the way departments interact with each other, for example the readiness to share information and innovations. Some thought that departments should be given the chance to improve their services before competition is encouraged, as quality and equity are the drivers behind commissioning decisions. This relationship will depend on good quality data being collected as this is the information commissioning groups will base decisions on.

Participants acknowledged that there was already a degree of competition within NHS Trusts, for example departments 'competing' to treat patients. There was also competition on the research front as research universities tend to bid for funds for drug research rather than for radiotherapy.

IV. CONCLUSIONS AND KEY MESSAGES

Discussions throughout the Roadshows were generally positive about the move to specialised national commissioning of radiotherapy services and the introduction of a national tariff. These changes are seen as an opportunity to promote and develop radiotherapy services across the country. However, concerns were raised about how some parts of the new system, such as the national tariff, will work in practice and how innovation would be promoted.

The Radiotherapy Innovation Fund has provided a boost for radiotherapy services in delivering more advanced radiotherapy. But challenges in renewing existing equipment, buying new equipment and building an appropriate radiotherapy workforce continue to exist. During this time of change, services need to work hard to maintain the status quo while also improving services to deliver more innovative techniques and meet increasing demand.

Radiotherapy cures cancer, is cutting edge and cost effective. The NHS reforms, and associated changes to the way that radiotherapy services are now commissioned, is a substantial shift for the service. While the radiotherapy community has been fairly well engaged with national policy development and its implementation, it was clear that the Roadshows provided a welcome opportunity for participants to voice their opinions and start an open discussion about the evolution of the radiotherapy service.

Looking to the future, there were several **key messages** from the radiotherapy community on how to take the best advantage of the recent changes, and to ensure that radiotherapy services in England continue to improve:

Specialised commissioning and the national tariff

1. There is a continuing need for NHS England and the Radiotherapy CRG to communicate effectively, to commissioners, departments and NHS Trusts, how the new commissioning structures work and how the radiotherapy community can engage in its further development.
2. The move to specialised commissioning and a political spotlight on radiotherapy has created enthusiasm and engagement in the community about the future of the service which must be maintained. To aid this, the Radiotherapy CRG should publish its work programme and allow the radiotherapy community to feed into its development.
3. A mechanism should be established where staff from across the radiotherapy community can troubleshoot and raise specific problems regarding the new commissioning arrangements.
4. Work should be done to ensure that innovation and research is encouraged by the new mechanisms for commissioning and payment of radiotherapy services.
5. The radiotherapy community would welcome clarification on the role of individual members of the Radiotherapy CRG in representing and feeding back to the service in their nominated area.
6. There remains a challenge in NHS Trusts to provide for new and updated equipment, such as linacs. It was suggested that the tariff could be used to reward capital investment.

7. The success of the new commissioning structures relies on good relationships between NHS Trusts, local and national commissioners, and departments. Commissioning staff in local area teams should get to know their local radiotherapy service and support them in making the case for service development within their NHS Trust. The CRG should also play a role in supporting and developing these relationships.

Workforce issues

8. A national strategy to address radiotherapy workforce issues should be developed with input from all relevant professional bodies and organisations.

Improving access to radiotherapy

9. There is still a concern that not enough cancer patients are being referred to radiotherapy services. A holistic look at the cancer pathway should be undertaken by NHS England to ensure that all appropriate patients are being referred.

Data collection and competition

10. The increased focus on data collection on performance is welcomed. However, clarity around a standardised mechanism for data collection is needed. Consideration should also be given to the impact of increased data collection on service resources.
11. Commissioners should ensure that interactions between departments, for example sharing data and innovations, are not compromised with the increased focus on competition in the new system.

V. REFLECTIONS FROM THE RADIOTHERAPY COMMUNITY

Following the workshop participants were asked:

"UPON REFLECTION, WHAT DO YOU THINK THE BIGGEST IMPACT OF **SPECIALISED COMMISSIONING** WILL BE ON YOUR AREA?"

The majority responded that it was **too soon to tell** – but there were a few interesting responses...

a. National specialised commissioning

"In theory it should **improve access** and **service quality**. In reality I remain concerned about the **structure of the new commissioning groups** and how this will impact specialised services."

"There will (hopefully) be **better coordination of effort** so that purchases can be made strategically"

"Hopefully it will help in ensuring that departments keep up to date with technical advancements so that **patients receive the most appropriate treatment**"

"There are concerns about the **knowledge of radiotherapy** that people commissioning services will have. We need to have someone to go to and know that they understand the service"

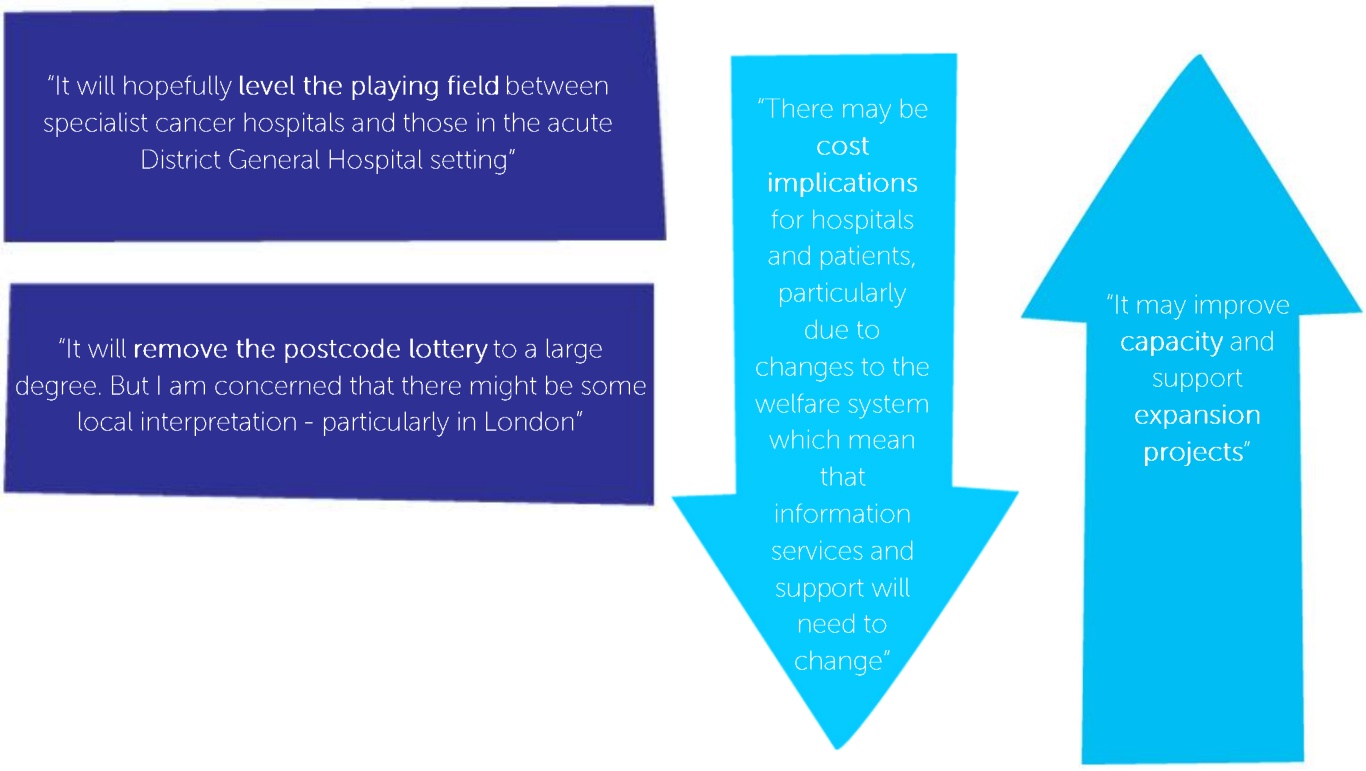
"I hope that the National Commissioning Board* may bring a **more consistent approach** to commissioning radiotherapy and tackle some of the long standing **local challenges**"

"When commissioners fully understand the issues surrounding the provision of radiotherapy services they will be better placed to **avoid being unduly influenced by political agendas** that do not have patient care at their core"

*now known as NHS England

b. The national tariff

c. Improving services and patient access



ANNEX – ATTENDEE LIST FOR ALL FOUR ROADSHOW EVENTS

Abiodun	Adeyemi	Head of Radiotherapy Physics	Royal Berkshire NHS
Ken	Aldred	Chair of User Partnership Group Essex Cancer Network	Essex Cancer Network
Alison	Ambler	Radiotherapy Services Manager	The Harley Street Clinic
John	Arnfield	Lead Practitioner in Portal Imaging, Radiotherapy	University Hospitals Birmingham NHS Foundation Trust
Andrew	Asquith	Divisional Director of Operations	University Hospital Southampton NHS
Elizabeth	Bailey	Cancer Research UK Campaigns Ambassador	
Helen	Baker	Planned Care Services Manager	NHS Oxfordshire and Buckinghamshire
Elizabeth	Barber	Qa Manager, Radiotherapy	Royal Free London NHS Foundation Trust
Jane	Barrett	Chair, Radiotherapy Cross Cutting Group	Thames Valley Cancer Network
Andrew	Bates	Consultant Clinical Oncology	Southampton General Hospital
Charlotte	Beardmore	Professional and Education Manager	The Society and College of Radiographers
Tony	Bedford	Head of Radiotherapy Physics	Plymouth Hospitals NHS Trust
Linda	Bedford	Macmillan Lead AHP	Peninsula Cancer Network
Deborah	Bennett	Deputy Radiotherapy Service Manager	Newcastle Upon Tyne Hospitals NHS Foundation Trust
Claire	Birch	Head of Radiotherapy Physics	University Hospitals Southampton NHS Foundation Trust
Caroline	Brammer	Clinical Oncology Director	Royal Wolverhampton Hospitals
Chris	Brew-Graves	Operations Manager	The Clinical Trials Group of the Dept of Surgery, UCL
Geri	Briggs	Quality Manager, Berkshire Cancer Centre	Royal Berkshire NHS Trust
Paul	Bromley	Regional Officer	Society and College of Radiographers
Cheryl	Buchanan	Directorate Finance Manager	Newcastle Upon Tyne Hospitals NHS Foundation Trust
Tim	Burdsey	Pathway Manager	London Cancer
Kieren	Caldwell	Lead for Radiotherapy	

		Cancer	
Andrew	Cannell	Chief Executive	The Clatterbridge Cancer Centre NHS Foundation Trust
Helen	Clements	Radiotherapy Services Manager	Rosemere Cancer Centre
Ian	Coles	Head of Radiation, Physics and Radiobiology	Imperial Healthcare NHS Trust
Tim	Cooper	Associate Director - Radiotherapy	National Cancer Action Team
Adrian	Crellin	Former Co-Chair of the National Radiotherapy Implementation Group; Department of Health National Clinical Lead Proton Beam Therapy	St James's University Hospital
Jon	Currington	Acting Head of Strategy and Planning	Midlands and East Specialising Commissioning Group
Sian	Davies	Consultant Clinical Oncologist	North Middlesex University Hospital
Julie	Davies	Lead Radiographer	The Christie NHS Foundation Trust
Jeanette	Dickson	East and North Hertfordshire, Clinical Oncology Director	Mount Vernon Cancer Centre
Derek	D'Souza	Head of Radiotherapy Physics	University College London Hospital
Sue	Duncombe	Cancer Research UK Campaigns Ambassador	
Craig	Edwards	Deputy Head of Radiotherapy Physics	University Hospital North Staffordshire
Gill	Elkins	Radiation Therapy Manager	University Hospitals Coventry and Warwickshire NHS Trust
Paul	Evans	Head of Radiotherapy Physics	The Shrewbury and Telford Hospital NHS Trust
Kim	Fell	Cancer Director	North Trent Cancer Network
Angela	Francis	Radiotherapy Services Manager	Guys and St.Thomas' NHS Hospital Foundation Trust
Victoria	Grant	Radiotherapy Project Manager	London Cancer
Michael	Graveling	Principal Pre-Treatment Superintendent Northamptonshire Centre for Oncology	Northampton General Hospital NHS Trust
Tony	Greener	Head of Radiotherapy Physics	Guys and St.Thomas' NHS Hospital Foundation Trust
Bob	Hackett	Patient	Essex Cancer Network

Nathan	Hall	South of England Programme Manager for Specialised Cancer & Blood Services	NHS England (From April)
Holly	Hall	Radiotherapy Services Manager	Hampshire Hospitals NHS Foundation Trust
Richard	Harris	Senior Programme Development Lead	Central South Coast Cancer Network
Suzanne	Harrow	Head of Radiotherapy	Imperial College London Healthcare NHS Trust
Erica	Holmes-Attivor	Cancer Research UK Campaigns Ambassador	
Mike	Holubinka	Director of Medical Physics & Clinical Engineering	Portsmouth Hospitals NHS Trust
Allison	Hopkins	Quality Assurance Radiographer	Royal Berkshire NHS Trust
Paula	Horne	RTSN Reading	Royal Berkshire NHS Trust
Clare	Hutton	Operational Lead for Radiotherapy	Hull & East Yorkshire Hospitals NHS Trust
Stephen	Jackson	Head of Radiotherapy	Royal Wolverhampton Hospitals NHS Trust
Sarah	James	Professional Officer	The Society and College of Radiographers
Catherine	Jephcott	Consultant Oncologist	Peterborough City Hospital
Matthew	Johnson	HSS Programme Director for Cancer and Blood	NHS England
Tom	Jordan	Head of Radiotherapy Physics	Royal Surrey County Hospital
Jagdeep	Kudhail	Radiotherapy Service Manager and Professional Lead	Mount Vernon Cancer Centre
Tony	Lawler	Cancer Commissioning Manager	NHS North and East London Commissioning Support Unit
Catherine	Lemon		Mount Vernon Cancer Centre
Paul	Litchfield	Cancer Information and Support Services Manager	University Hospitals Birmingham
Kate	Love	Radiotherapy Service Manager	University Hospitals Bristol NHS Foundation Trust
Sue	MacGregor	Radiotherapy Services Manager	Royal United Hospital, Bath
Fiona	Mackison	Senior Commissioning Manager	South East Specialised Commissioning Group
Spyros	Manolopoulos	Consultant Clinical Scientist	University Hospitals Coventry and Warwickshire NHS Trust

Helen	Mayles	Head of Clinical Radiotherapy Physics	The Clatterbridge Cancer Centre NHS Foundation Trust
Bill	Mcdougall	Network Site Specific Group Member for Radiotherapy	Birmingham Cancer Network
Linda	McFadden	Patient	Essex Cancer Network
Kashmira	Mehta	Radiotherapy Manager	Royal Free London NHS Foundation Trust
Libby	Mills	Principal Radiographer	The Christie NHS Foundation Trust
Tony	Murphy	Patient Representative	National Radiotherapy Awareness Initiative
Seeni	Naidu	Head of Radiotherapy and Medical Physics	Queen's Hospital
Anne	Nauth-Misir	Lead Therapy Radiographer	Barts Health NHS Trust
Carolyn	O'Donovan	Radiotherapy Services Manager	University Hospital North Staffordshire
Julie	Owens	Radiotherapy Manager	St James Institute of Oncology
Joanne	Page	Senior Physicist	Royal Berkshire NHS Trust
Susan	Palmer	Research Network Manager	Thames Valley Cancer Research Network
Tony	Palmer	Head of Radiotherapy Physics	Queen Alexandra Hospital, Portsmouth
Imran	Patel	Team Leader- Oldham Radiotherapy Physics	The Christie NHS Foundation Trust
Shareen	Pavaday	Practice Development and Governance Superintendant	North Middlesex University Hospital NHS Trust
Ian	Pedley		Newcastle upon Tyne Hospitals NHS Foundation Trust
Hazel	Pennington	Radiotherapy Clinical Education Lead	The Christie NHS Foundation Trust
Steve	Perlish	Radiotherapy IT Manager	Portsmouth Haematology and Oncology Centre
Danielle	Power	Clinical Lead for Radiotherapy Services	Imperial College London Healthcare NHS Trust
Andrew	Poynter	Head of Radiotherapy Physics	Peterborough City Hospital
Christine	Richards	Radiotherapy Services Manager	Maidstone and Tunbridge Wells NHS Trust
Jo	Robinson	Contracts and Patients Account Manager	The London Clinic
Ami	Sabharwal	Clinical Oncology Consultant	Oxford University Hospitals NHS Trust

John	Sage	Head of Radiotherapy Physics	University Hospitals of Leicester
Kim	Sanderson	Radiotherapy Services Manager	Portsmouth Haematology and Oncology Centre
Mike	Saunders	PET CT North Contract Manager	NHS North of England
Michael	Scanes	User Involvement Facilitator	Essex Cancer Network
James	Scott	Deputy Divisional Manager-Networked Services	King's College Hospital
Carol	Scott	Speciality Director OHP & Radiotherapy Services Manager	Gloucestershire Oncology Centre
Ricky	Sharma	HEFCE Clinical Senior Lecturer, University of Oxford	Gray Institute for Radiation Oncology and Biology
Kevin	Skilton	Radiotherapy Business Manager	Cambridge University Hospitals NHS Foundation Trust
Nick	Slevin	Chair	Radiotherapy Clinical Reference Group
Julia	Solano	Radiotherapy Services Manager	University College London Hospital
Martin	Stanley	Commissioning Manager	North of England Specialised Commissioning Group
Julie	Stratford	Lead Research Radiographer	The Christie NHS Foundation Trust
Diana	Tait	Dean of Clinical Oncology	The Royal College of Radiologists
Sonia	Tankard	Radiotherapy Manager	Colchester Hospital University NHS
Paula	Taylor	Radiotherapy Manager	Peterborough and Stamford Hospitals NHS Foundation Trust
Maria	Thompson	Radiotherapy Service Manager	University Hospitals Birmingham
Moira	Tomlinson	Senior Manager, Radiation Services	Sheffield Teaching Hospitals NHS Foundation Trust
Stephen	Tozer-Loft	Head of Radiotherapy Physics	Weston Park Hospital, Sheffield
Angela	Turbin	Operational Lead for Radiotherapy	United Lincolnshire Hospitals
Elisabeth	Turner	Radiotherapy Service Manager	Oxford University Hospitals NHS Trust
Marjorie	Walker	Patient Representative	Central South Coast Cancer Network
Julie	Warner	Radiotherapy Services	

		Manager	
Deborah	Waters	Radiotherapy Services Manager	The London Clinic
Camarie	Welgemoed	Breast Specialist Superintendent	Imperial College London Healthcare NHS Trust
Cathy	Williams	Head of Radiotherapy Services	Mount Vernon Cancer Centre
Steve	Williams	QA Lead Practitioner	University Hospitals Birmingham NHS

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