Modernising Radiotherapy Services in England – developing proposals for future service models

Engagement Report

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations and Information	**Specialised Commissioning**
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:		7338
Document Purpose	Report	
Document Name	Modernising Radiotherapy Services in England – developing proposals for future service models	
Author	Sara Geater	
Publication Date	17 October 2017	
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, NHS Trust Board Chairs, Directors of Finance, Allied Health Professionals, GPs, Emergency Care Leads, NHS Trust CEs	
Additional Circulation List	NHS England Regional Directors, NHS England Directors of Commissioning Operations, Communications Leads	
Description	In October 2016, NHS England published an engagement guide - Modernising Radiotherapy Services in England. This set out proposals for new clinical and service models to drive improvements in the way radiotherapy services are delivered for the future. An engagement exercise ran for 8 weeks and NHS England received 271 online responses including those from professional organisations and charities. This report summarises the themes which emerged via the engagement responses	
Cross Reference		
Superseded Docs (if applicable)	n/a	
Action Required	n/a	
Timing / Deadlines (if applicable)	**n/a**	
Contact Details for further information	Specialised commissioning Skipton House 80 London Road London SE1 6LH england.scengagement@nhs.net www.england.nhs.uk/commissioning/spec-services/npc-crg/group-b/b01/	

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Contents

1. Background to the engagement process

1. NHS England took responsibility for commissioning radiotherapy services in April 2013.

2. In 2014, NHS England and Cancer Research UK together set out a vision for the future of radiotherapy services (**A Vision for Radiotherapy, 2014 - 2024**) (https://www.cancerresearchuk.org/sites/default/files/policyfeb2014radiotherapy_vision2014-2024_final.pdf) which would enable people across England to receive, and have access to, modern and innovative radiotherapy, which has been shown to be clinically and cost effective. Implementation of this vision would provide patients with substantially improved outcomes, higher cure rates and fewer side effects from their treatment.

3. This ambition for modern, innovative radiotherapy services was echoed in the independent Cancer Taskforce report (2015), (https://www.england.nhs.uk/wp-content/uploads/2016/05/cancer-strategy.pdf) specifically highlighting the need to tackle variation in the quality of services provided.

4. In December 2015, NHS England approved the commencement of a service review in radiotherapy with the aim of securing improvements to services and delivery of the ambitions set out in the Vision for Radiotherapy document.

5. On 28th October 2016, NHS England published an engagement guide - Modernising Radiotherapy Services in England – developing proposals for future which outlined a number of proposals for change. The over-arching objective of our proposals for new clinical and service models is to drive improvements in the way radiotherapy services are delivered for the future.

6. We want to ensure sustainable, high-quality, safe and efficient services. We also want to improve access for patients, enabling them to receive care as close to their homes as possible, where clinically appropriate.

7. At the same time, we want to make sure that those with more complex, and rarer cancers, have access to the very latest treatments and technologies, as well as to clinical trials, and are treated by experienced subspecialist teams which may not be available at their local hospital.

8. The proposals described networked services as:

- Covering a population of 3-6 million;
- Delivering services according to a proposed Clinical Model incorporating minimum number requirements (Appendix B);
- Aligning to a Cancer Alliance(s);
- Operating a single, unified radiotherapy physics workforce; and
- Led by a specialist regional provider of radiotherapy, i.e., each network would be able to deliver the full range of radiotherapy treatments from within the network.

9. An Engagement Guide was published explaining the proposed changes and outlined a series of questions for stakeholders to consider in line with the proposed changes. Responses to the engagement could be submitted via an online portal. The engagement was publicised via the NHS England website and through internal and external communication briefs.

10. In addition four workshops in total were also held for stakeholders, one in each of the four regions in England as well as a webinar event. In total 250 participants joined the events and the feedback from the engagement events is included as part of this report.

11. The engagement exercise ran for 8 weeks until 23rd December 2016 and NHS England received 271 on-line responses including those from Professional Organisations and Charities.

12. At the time of engagement, we committed to publication of a report summarising the themes which had emerged via the engagement responses and enables NHS England to demonstrate that it has listened to, and heard, the views of stakeholders

1.1 Responses received

13. NHS England received responses through a number of different routes: (i) direct correspondence; (ii) a webinar (iii) 4 regional public engagement events; and (iv) the engagement portal, the latter two generating the largest volume of responses.

14. Over 250 individuals attended the regional events and a total of 271 engagement responses were received through the portal, all of which were anonymous.

15. In addition, a number of detailed responses were also received from a variety of stakeholders, specifically:

   - 3 NHS organisations
   - Clinicians.
   - Medical and Professional associations including; The Radiotherapy Board (comprising Society and College of Radiographers, Institute of Physics and Engineering Medicine and the Clinical Oncology arm of the Royal College of Radiologists, Cancer Research UK and the Royal College of Radiologists.
   - One Private Healthcare provider

16. All of these detailed responses, though not received through the consultation portal, have been taken into account in the production of the engagement report and the key themes raised by these responders are included within section 2.1.

2. Engagement feedback

17. The responses received by NHS England from the public engagement exercise can be broadly grouped into five categories:

    i. Provider Board structure, management, governance and accountability;
   ii. Workforce Impact;
  iii. Suggested geographies;
   iv. Improvement measurement (pre and post minimum numbers); and
    v. Impact on patients.

Provider Boards, Governance and Accountability

18. This issue dominated the engagement responses and stakeholder events. Whilst some of the feedback received indicated a lack of clarity or understanding of the proposals, largely the responses identified a number of well-made concerns. These underline the need to refine and clarify the arrangements for both:

a. **Provider collaboration**. There is a need to set out a framework of options for different networks to select from, enabling local tailoring from within a national approach. This will need to delineate between strategic oversight, contractual arrangements and operational delivery arrangements; and

b. **Commissioner involvement and oversight.** There is a need to ensure that the role of both local commissioners and Cancer Alliances is both clear enables a flexible approach, tailored to the local circumstances of different areas.

Workforce Impact

19. The most significant area of feedback relates to the physics workforce. In particular they highlight the importance of the multi-professional nature of the service which therefore requires a broader focus than just considering a uni-professional element of the service.

20. There is clearly a need to explore workable and evolutionary solutions with the professional bodies to include the IT infrastructure and workforce requirements to achieve robust collaboration between all professions and teams across the networked geography. There is also a need to develop a set of principles and approaches that help define the key underpinning elements that support a range of working solutions (partnerships to full integration depending on local circumstances) in order to build resilience in the services within each networked geography.

Suggested geographies

21. In the main, the responses received were supportive of the need for some form of geographical mapping and the proposed configuration for radiotherapy services and networks. Feedback suggested that: (i) cross-

border flows should be taken into account when setting networks; and that (ii) networks should reflect existing patient flows. This may mean that perfect alignment with some of the Cancer Alliance footprints would not be feasible, even where population requirements were met. This stems from the current design principle of networks to include specialist radiotherapy flows. In such circumstances and where networks span more than one Cancer Alliance, some ground rules would be required about lead and supporting Alliances.

Measuring improvement and the impact on patients

22. The last two areas of feedback essentially explore both sides of the same issue, i.e., the scale of disruption to clinical services and patients must be proportionate to the level of benefit for patients. This means that it is important to be able to make the case for change and evidence the impact of the change once made.

23. The CRG has advised that the improvements that are hoped to be achieved include:

- **Improved clinical outcomes for cancer patients.** This would be a contribution to overall system measures, such as 1, 5 and 10 year survival.
- **Increasing access to innovative treatments.** This can be quantified and measured.
- **Increasing the proportion of treatments delivered by experts in the subspecialty area.** This could be measured, subject to an appropriate metric definition and inclusion within the Radiotherapy Quality Dashboard.
- **Minimising adverse events and adverse side effects.** This could be measured through the Quality Surveillance Team.
- **Increasing access to, and participation in, clinical trials to** aid improvements in treatment technique, protocol and survival.
  This could be measured, subject to an appropriate metric definition and inclusion within the Radiotherapy Quality Dashboard.

However, further work is required to be undertaken to develop metrics and agree reporting arrangements.

3. Feedback by question

24. The proposal is to create networked clinical oncology services in England sufficiently sized to align with existing cancer pathways, full range of specialist cancer surgery services and the associated specialist MDT arrangements. It is proposed that a networked service should cover a population of 3-6 million and be aligned with the Cancer Alliance and would be led by a specialist regional provider of radiotherapy. This would mean that some cancer treatments would be concentrated into a fewer number of centres to ensure availability and maintenance of clinical expertise.

3.1 Summary of responses received through the engagement portal

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

25. The majority of responses received via the engagement portal were supportive of the proposed networks but highlighted the need to better understand how the management and governance arrangements would be established; concern that lead provider organisations could become too dominant over the other trusts and services within networks; and concerns over funding and how funding and contracting would be managed within networks.
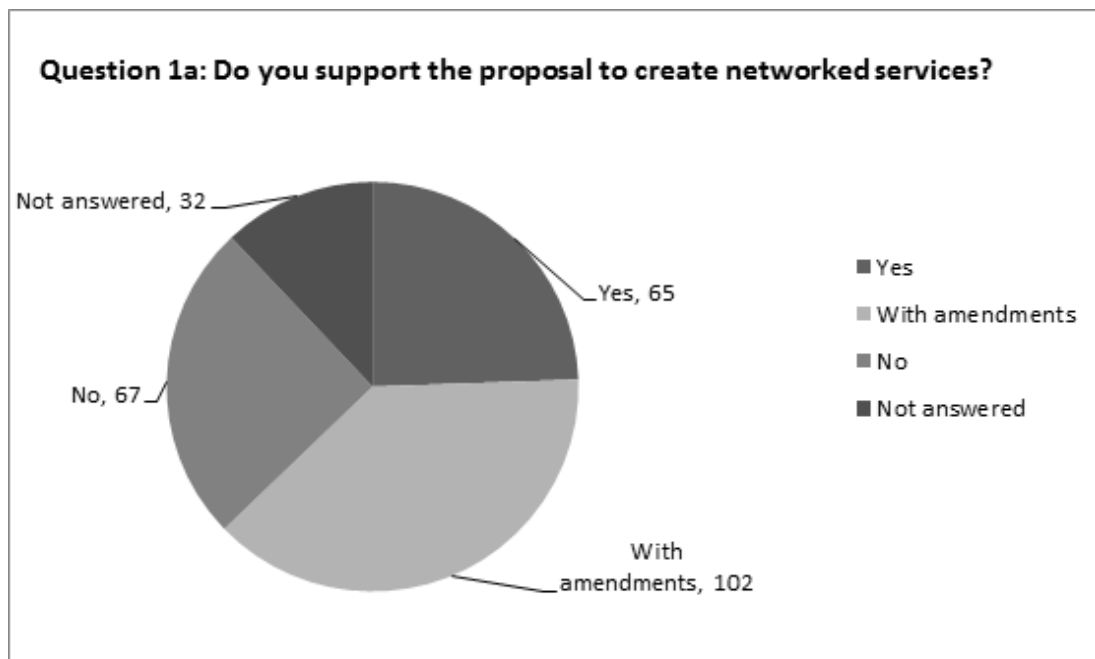
3.1.2 Question 1b: How should networked services could be organised?

26. Responses relating to the organisation of networked services (247) identified the following suggestions and issues:

- Cancer alliances and the potential to include the current Cancer Alliances in the proposed networks in some way (27: 11%)
- The potential dominance of lead provider / disenfranchisement of smaller centres (44: -18%)
- The importance of supporting/ recognising multidisciplinary team working (17: 7%)
- The need for a reliable IT infrastructure (29: 12%) and;
- The potential to have an impact on quality and care standards (78: 32%) of which 53 indicated a positive impact (68% of those referring to quality and

care); 16 (20%) highlighting the proposal would have a negative impact and 9 (12%) not indicating either positive or negative

3.1.3 Question 2: What comments and/ or ideas do you have about how the proposals could work in practice?
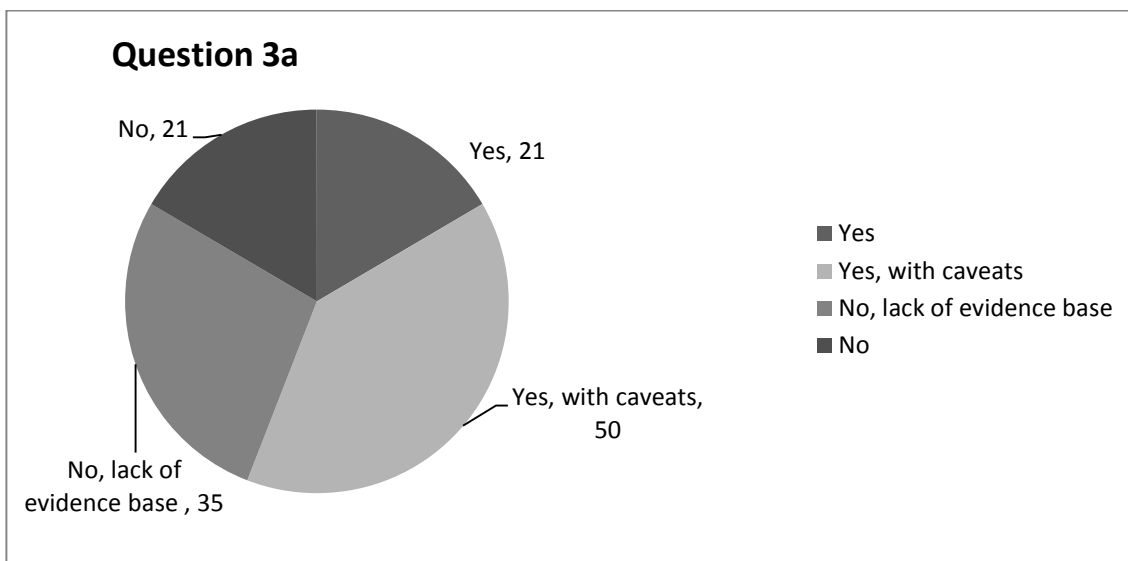
27. 234 responses were received and identified:
- The importance of working to shared protocols within networks (46: 20%)
- The importance of collaboration within networks (31: 13%)
- The potential impact of the proposals on staff training, skills and personal development. (41; 18%). Some responses highlighted positive effects such as staff sharing expertise and learning from each other and others seeing the impact as having a negative effect reducing opportunities for staff development.
- The potential for the proposal to impact on staff recruitment and retention (18: 8%). A number of responses viewed the lead provider organisations as offering more complex treatments and smaller providers having their services reduced resulting in staff choosing to work in lead provider trusts and smaller providers struggling to retain and recruit staff.
- Issues around the availability and sustainability of funding to support the proposals (43: 18%)

28. Responses also identified that:

- The lead provider organisation could provide guidance/ mentorship to the smaller providers in the network (9: 4%)
- Technical support to enable effective staff communication by video and teleconferencing (11: 5%)
- The need for strong leadership within networks at clinical, managerial and board levels (7: 3%)

3.1.4 Question 3a: Do the case numbers presented within the clinical and service model reflect clinical best practice?

Question 3a

No, 21

Yes, 21

Yes, with caveats, 50

No, lack of evidence base , 35

- Yes
- Yes, with caveats
- No, lack of evidence base
- No

29. 231 responses were received via the on-line portal, 127 of which answered the question either responding yes; yes but expressing some caveats, responding no due to disputing the evidence base for case numbers, or responding no. The majority (71; 56% of the 127 responses that answered the question) agreed that the case numbers presented did reflect clinical best practice principle, some expressing caveats, the remainder disagreed by responding that the numbers were not evidence based (35: 28%) or simply disagreed (21: 16%). Caveats included comments that the numbers presented may be too high for some tumour sites e.g. anal cancers.

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

30. Responses received via the engagement portal suggested that the following areas could have an impact of the proposed case numbers:
- How the boundaries of networks were defined (including any cross-border working between England and Wales or England and Scotland), could impact on the case numbers.
- The importance of following established referral pathways and the potential impact of changing these established arrangements
- Patients receiving palliative treatment for rare/ less common cancers should be treated locally.

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

31. 240 responses to question 4a and 4b were provided via the engagement portal and identified the following issues:

- The potential impact on the distance that patients receiving complex treatment or treatment for less common cancers was identified by 214 (89%) of the respondents.
- The potential impact on patients' access to services and patient choice was highlighted by 145 (61%) responses identified.
- Possible impact of staff (53; 22% of responses) including: staff travel time; staff recruitment and retention; and opportunities for staff training and development

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

32. **A range of steps that could potentially help to avoid any equality and health inequality issues were identified including:**
- Ensuring that the availability of public transport and patient transport is considered and taken into account by the networks (18: 8%)
- Accommodation for patients and carers should be made available where it is needed (31; 13%)

- Opportunities for patients and services to participate in clinical trials should be maintained and encouraged to support innovation and patient access to new treatments (15; 6%)

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

33. The majority of responses to this question covered points that had already been raised earlier in the responses to questions 1-4. However some responses highlighted additional factors that could be considered in developing the service specification.

- An improved case for change providing clear evidence for benefits to patients and staff and outlining measures of improvement including access to radiotherapy services.
- There should be a transparent process for appointing lead providers.
- Networks should aim to ensure engagement from all staff groups and allow senior team members in all specialities to attend essential network meetings. There should be equal representation on the board from small, medium and large cancer centres and this should include patient representation.
- The service specification should not be overly prescriptive in defining how network partners achieve good technical inter-connectivity. Network wide clinical audit and collection /reporting of electronic outcomes data may require additional data analysts and time.
- The proposal could take into consideration which centres have space to house new equipment and /or expand their services.
- The service specification should try to take into consideration the changes in radiotherapy that will arise over the next ten years, such as on-line/ reactive adaptive therapy.

34. Many of these views were also expressed by the Professional Organisations that submitted detailed responses. In addition, responses highlighted the importance of a robust co-ordinated approach to radiotherapy service planning and the practicalities of changing from a 5 day model to a 7 day model, in terms of workforce arrangements, recruitment, machine servicing and managing breakdowns.

35. NHS England received a detailed response from Cancer Research UK but it is also possible that some patient groups submitted anonymous responses through the on-line survey.

3.2 Summary of responses received from the engagement events

35. The proposal is to create networked clinical oncology services in England sufficiently sized to align with existing cancer pathways, full range of specialist cancer surgery services and the associated specialist MDT arrangements. It is proposed that a networked service should cover a population of 3-6 million and be aligned with the Cancer Alliance and would be led by a specialist regional provider of radiotherapy. This would mean that some cancer treatments would

be concentrated into a fewer number of centres to ensure availability and maintenance of clinical expertise.

36. Four engagement events were held between October and December 2016, one in each of the four NHS England regions: Midlands and East, North, South and London. Each event followed a similar format starting with a presentation from the Chair of the Radiotherapy CRG, Professor Nick Slevin with contributions from members of the Radiotherapy Expert Advisory Group, followed by the opportunity for participants to ask questions of clarification before breaking into groups to discuss the questions linked to the proposal. Groups of 6-10 individuals were asked to provide verbal and written feedback on the questions. A total of 28 groups provided written feedback and it should be noted that not all groups answered all of the questions.

37. The majority of participants at the engagement events, (13 of the 15 tables that directly addressed this question) supported the general proposal to create networked services for radiotherapy, whilst raising some caveats or concerns in relation to how the proposal would be implemented. One group reported that its members were unable to decide whether they supported the proposal and one group stated that it disagreed with the proposal.

38. The main questions and issues emerging from the engagement events have been covered in section 2 of this document and related to:
   - *Provider Boards, Governance and Accountability;*
   - *Workforce Impact;*
   - *Suggested Geographies;*
   - *Improvement Measurement*
   - *Impact on Patients*

39. Additionally participants at the four engagement events highlighted:

   - **The importance of robust and reliable IT systems**
   Reliable IT infrastructures and systems were seen as essential support data sharing, treatment planning and facilitate remote working between teams

   - **Impact on patients access to services**
   Participants from all four events identified the potential impact on patients' ability to access treatment for less common cancers/ cancers requiring radical treatment as a concern, highlighting the potential for the distance travelled to increase for some (but not all) patients and that provision of patient transport and hotel services for patients and carers may need to increase. Participants noted that certain populations such as the elderly, the frail, those from lower socioeconomic groups, might be disproportionately affected.

   - **Communication about the proposed changes to services**
   Participants identified the need for good communication between staff and patients to inform patients of the benefits that the proposed changes could bring and highlighted the importance of involving expert patients in designing how the changes are communicated.

- **Other issues and concerns raised included**
- A need to understand how the independent care and treatment sector fits with the proposed network structure
- Networks should recognise the role that participating in clinical trials can play in driving innovation and improving the quality and standards of care.
- The potential role that professional bodies can play in supporting the implementation of the proposals.

3.3 Summary of issues raised from the webinar

40. A webinar was held on 13 December 2016 and had 43 participants. The webinar began with a presentation and was followed by a question and answer session between the participants and members of the Radiotherapy EAG.

41. Questions, comments, issues and concerns raised in the webinar covered similar topics as previously described/ outlined in section 2 of this report and included:

- **Composition of the Provider Board**
Further clarity was needed about Board composition and the feasibility of the timescales (2 -3 years) acknowledging that step changes over a period of time would be required and this could take over 2 years.

- **Use of similar equipment across a networked service**
A question was raised about the NHS budget to fund the replacement of equipment and whether this would ensure that all trusts in a networked service used similar equipment and was a cost- effective approach.
The document does suggest that there may be benefits in all centres within the geography harmonising the equipment base. Additionally peer review and clinical trials offer opportunities to compare outcomes and quality of delivery.

- **The role of IT**
It was noted that IT has a crucial role to play in enabling the proposed network model and maximising its potential and that connectivity would allow affective planning centrally and local delivery. An example of progress in achieving IT integration comes from the North East.

- **Workforce**
Important to address the workforce issues – the point around training places was emphasised in terms of a lack of commitment by centres to train more Physicists, but to use this as an opportunity and press for more funding for training

- **Rollout of innovation**
It was noted that any service can develop innovative solutions but it is in the rollout where real benefits could be achieved. It was suggested that the roll out of innovative solutions across the network could be achieved through a single team of individuals from all centres working together. In addition it provides opportunities for do once and share / role development.

- **Evidence and data**

Supporting evidence lacking for the numbers – does centralisation give better care? Data is essential going forward to be able to assess whether there has been a reduction in variation and improvement in outcomes.

- **Brachytherapy services**

A specific issue was raised about brachytherapy and whether this should be concentrated to fewer centres and the potential impact this could have on patients – again reiterated that concentration of expertise is not just to the large centres but a balance has to be struck between travel and access.

4. NHS England response to the feedback

4.1 How the feedback has been considered

- NHS England has established a Project Steering Group and a Radiotherapy Expert Advisory Group to lead the next stage of the process.
- The Expert Advisory Group is comprised of a small number of dedicated clinicians including representatives from the Radiotherapy CRG. The first task of the group has been to reassess the assumptions on which the preferred option was based.
- The work of the Expert Advisory Group and NHS England has led to a number of specific actions having been taken to engage further to explore some of the concerns expressed during the public engagement.

42. The table below summarises the feedback received by question and the action that has been recommended.

We asked	You said	We did
1a. Do you support the proposal to create networked services	Yes - 24% Yes with amendments – 38% No – 24% Responders were concerned about the potential dominance of a lead provider, able to close services, centralise treatments and innovative approaches all to the exclusion of others. The concept of lead provider was considered by some to be hierarchical and potentially non-collaborative undermining the thrust of 'better together' This could lead to: disenfranchised smaller centres and the potential for unforeseen consequences on individual provider activity and income streams for radiotherapy.	Good support but in order to achieve collective population-based oversight of individual tumour sites across the networked service by the sub-specialist team each network will be governed through Radiotherapy Network Board, **hosted and supported by a constituent provider** and chaired by the lead Cancer Alliance (where the radiotherapy network spans more than 1 Cancer Alliance) for the network and linked to STP arrangements.

1b. How should networked services could be organised	The Radiotherapy Physics responders did not consider that the unification of RT equipment and the integrated single RT Physics workforce was appropriate citing the multi-professional nature of the service, safety and development issues was necessary across all services.	The integration of clinical teams has been clarified in the service specification and will be dependent on the level of integration required between centres to ensure clinical oncologists are not working single-handed, treating a minimum of 25-50 cases each and the teams plan and deliver the appropriate number of tumour specific radical treatments.
2. What comments and/ or ideas do you have about how the proposals could work in practice?	Population sizes that cross boundaries into Wales and Scotland must be included in the discussions regarding centre size and scope of practice – this includes issues of population size and the potential significant loss of income for a trust should some of their patients have treatment at another centre.	The population data attributed to individual radiotherapy centres has been confirmed by Public Health England. The service model is based on the population served by the local trust and aligned to the range of cancers specialist teams hosted at the trust rather than the population attributed to each radiotherapy centre via RTDS.
3a. Do the case numbers presented within the clinical and service model reflect clinical best practice	Less than half the responders answered this question. Of those that did: Yes – 17% Yes with caveats – 39% No lack of evidence – 17% No – 27% Patients travelling long distances Many responders considered 25-50 cases per clinician was "a good place to start" Views emphasised the need for true partnerships Increases the potential to access clinical trials	It is noted that during the engagement events the PPE representatives communicated the preference to travel to centres of excellence for treatment of the less common conditions. This will be further tested through consultation The service model has been clarified within the service specification to describe a model that operationally could ensure that patients are treated locally where possible - this could link to the integrated operational

	We hope that this service will address variations in access and mean more patients have high quality treatment. It is clear from the proposals that a small proportion of patients – with rare disease or requiring highly specialised radiotherapy – will potentially need to travel further than their local centre to receive the best treatment. Cancer Research UK is supportive of this in principle as we believe that this will mean these patients get a higher quality treatment in a centre that has the expertise and experience to provide it	models between neighbouring trusts at a local level
3b. Can you think of anything else that should be considered that may impact on the case numbers proposed	It was recognised by participants at the events that patient numbers is not the only consideration and there should also be a focus on driving improvement through meeting clinical standards, developing protocols (nationally where possible) and formal radiotherapy quality assurance processes regardless of centre size. Large centres do not always mean good outcomes and small centre does not always mean poor outcomes. All treatments regardless of delivery site (as well as patient numbers) must be subject to meeting standards, protocols and QA standards wherever they are delivered monitored and acted upon by the Board.	The service specification will include a range of clinical indicators and it is anticipated that over time and working with PHE that a refined dataset will be developed to assess patient outcomes. The requirement for network boards to agree and ensure that clinical protocols, audit and peer review mechanisms will be embedded in a MOU and inter-provider agreements.
4a. What equality and/or health inequality issues may arise as a result of the proposals, as they currently stand	Patients may not wish to stay away from their families for the duration of their treatment Patients may choose not to have radiotherapy Affordability for low income families which will be tested through consultation	Points noted and as above links to the level of integration between neighbouring trusts to create a single team with the appropriate multi-professional team available at the treating centre to provide the holistic care required by these less common cancer. This has been further clarified in the service specification.
4b. What steps could be taken	It is important that an improvement in outcomes is able to be demonstrated	The service specification includes these

| to avoid any equality and/or health inequality issues? | following these changes

Patient transport and accommodation should be available

Good information for patients required to explain why they should travel to another centre | recommendations and will be further tested through consultation

17 |
| 5. Is there anything else we need to take into account when developing the service specification | A need to understand how the independent care and treatment sector fits with the proposed network structure

Networks should recognise the role that participating in clinical trials can play in driving innovation and improving the quality and standards of care.

The potential role that professional bodies can play in supporting the implementation of the proposals | NHS England will be working with all its key stakeholders during implementation. |

5.0 Keep in touch

For updates on the SRS/SRT procurement exercise and any latest developments please visit the RT CRG page, sign up to be a registered stakeholder of the group or subscribe to the specialised commissioning stakeholder newsletter