Written evidence submitted by the Royal College of Radiologists (CSR0007)

Executive summary

- The English Cancer Strategy 2015-2020 should be fully funded and implemented without any further delay and equivalent strategies should rapidly be developed and delivered in the three devolved nations so that patients’ experience in the standards of cancer diagnosis and treatment across the whole of the UK is consistent.

- Substantial increases in human and financial resources are required just to provide a satisfactory standard of acute i.e. emergency radiology service, seven days a week.

- Closing the diagnostic imaging capacity gap requires a co-ordinated approach to the radiologist workforce shortage including overseas recruitment accompanied by appropriate support for International Medical Graduates moving to the UK.

- The East Midlands Radiology Consortium (EMRAD) Vanguard Pilot should be rapidly evaluated and the successful aspects utilised in networked solutions for radiology service delivery across the UK. To that end, EMRAD should be supported with the requisite funding, human resource, financial, IT, legal, governance and operational support resources to test the model effectively.

- There should be an independent, public review of the future and funding of health and social care services in the UK.

Introduction and background

1. The Royal College of Radiologists (RCR) has almost 10,000 Fellows and members worldwide in the specialties of clinical oncology and clinical radiology.

2. The role of the College is to set and maintain the standards for entry to and practice in these specialties, in addition to leading and supporting practitioners throughout their careers. The College is a registered charity, charity registration no 211540.

3. This evidence takes as background the overall impact of the Comprehensive Spending Review (CSR) on health and social care and explores the particular impact on -
   (a) the care of acutely ill patients 24/7; and
   (b) cancer services

   which rely in a very major way on the services delivered by clinical radiologists and clinical oncologists. Clinical radiologists provide a medical opinion on the diagnosis and treatment of many other diseases besides cancer and of injury and are therefore crucial to the timely decisions taken with patients about their care or in re-assuring their consultant or GP that no treatment is needed.

4. The 2015 CSR has been subject to very wide scrutiny not least in its impact on health and social care. It has attracted responses from leading commentators, with two such being the Health Foundation and the King’s Fund which are notable in the bleak picture they paint:

   Extract from the Health Foundation response to the CSR:
"The share of UK GDP devoted to publicly funded health will fall from 7.3% in 2015/16 (low compared to other European countries) to just 6.7% in 2020/21."

“Given the scale of the financial crisis already hitting the NHS, there must now be real doubt over whether the quality and range of our health services can be maintained for the rest of this decade. Let alone any extras such as seven-day services and the aspirations of the Five Year Forward View.”

“The NHS may see its way through next year but beyond that the outlook is bleak.”

Extract from the King’s Fund response to the CSR:
“Looking ahead, the NHS and social care are now set for a decade-long funding squeeze which will see the largest sustained falls in spending as a share of GDP on both services in modern times. ... there is no hiding how difficult the next few years will be for health and social care services.”

5. The RCR also notes with concern the December 2015 National Audit Office report “Sustainability and financial performance of acute hospital trusts” which concluded - "It is not yet clear that the Department, NHS England, Monitor and the NHS TDA have the coherent plan that is needed to get trusts’ finances back on track and to close their estimated £22 billion gap between resources and patients’ needs by 2020-21." 

Cancer services
6. The RCR has a central interest in and makes a major contribution to the delivery of cancer services with a particular focus on diagnosis which relies heavily on radiology services and in treatment which involves services delivered through clinical oncologists whose practice covers both radiotherapy and systemic therapy (chemotherapy). The RCR’s Fellows and members are therefore pivotal to the delivery, quality and future development of cancer diagnosis and treatment in this country.

7. The English Cancer Strategy (Achieving world-class cancer outcomes: a strategy for England 2015–2020) sets out a major opportunity to improve cancer services through better and earlier diagnosis, high quality, modern treatment, putting data sources on a sustainable footing and rebuilding and sustaining research into cancer. The RCR played a significant role in shaping the Strategy and issued a call for action to ensure the Strategy is implemented in full - https://www.rcr.ac.uk/posts/english-cancer-strategy-2015-20-action-needed-now

8. From the RCR’s document, it will be seen that there are five priority areas requiring the investment that the CSR neither overtly provides commitment to nor gives confidence will happen. At the time of compiling this evidence, there is no commitment to implementing the Cancer Strategy which involves the allocation of resources the Strategy so clearly recommends over the five year period. The RCR is of the view that the Strategy’s ambitions are set appropriately high but to have any prospect of achieving them requires almost immediate action. That several months have now elapsed since the Strategy was published reduces the prospect of those ambitions being realised.

9. The Strategy recognises the step change that is required in diagnostic capacity if the ambitions that it sets out are to be achieved.
10. The Strategy also focuses on radiotherapy services: in the RCR’s view if anything it understates what is required to deliver high quality radiotherapy treatment equitably throughout the country. Not only is the clinical oncology workforce currently insufficient to achieve that, but investment is needed in training and retraining the workforce to deliver emerging radiotherapy treatments such as proton beam therapy, in the radiotherapy equipment required and in the redesign of treatment pathways to provide the optimum treatment options that will be needed to respond to patients presenting earlier as a result of earlier diagnosis. The RCR set out how this needs to be addressed in the numbers of clinical oncology training places in its submission to HEE for 2015-16: 

**Acutely ill patients 24/7 and the radiology workforce crisis**

11. The RCR made a detailed submission to Health Education England (HEE) for 2015-16 which sets out the dire position of radiology services in England. 

12. Section 1.1.1 of the RCR’s submission states the problem:

“The UK currently has 4.7 trained radiologists per 100,000 population, a figure which has remained more or less static over the past 5 years. Figures for comparable European nations include Germany 8.1, France 9.3, Sweden 10.3, Denmark 12.1 and Italy 16.0.”

“The population of England is expected to rise to around 57.4 million by 2022. If the target of eight WTE [radiology] consultants per 100,000 is to be met, a headcount of 4,864 consultants will be required. The 2014 headcount was 2,663.”

13. This situation has been discussed at the highest level by the RCR with HEE who were sympathetic and acknowledged that the RCR’s case was well made and a real need had been demonstrated. However, HEE is constrained by its expenditure limits and with cuts threatened by the CSR. The mandate to HEE that half of all training places should be allocated to general practice is a further severe and artificial constraint. Recent experience suggests that such an ambition as regards GP training is unlikely to be achieved and valuable training places which could be allocated to begin to alleviate the dire situation in clinical radiology remain unfilled and unused.

14. The substantial increase in human and financial resources is required just to provide a satisfactory standard of acute i.e. emergency radiology service 24/7 seven days a week. Radiologists play an essential role in the diagnosis and treatment of acutely ill patients e.g. with stroke, those who are breathless, or may need emergency abdominal surgery, or after major trauma.

15. Elective radiology services seven days a week are not achievable in the foreseeable future in the NHS.

16. The impact on patients is already being felt in dangerous delays in reporting of x-rays and scans causing anxiety, as well as inefficiencies for referring clinicians. The RCR has demonstrated this in its surveys on radiology reporting:
https://www.rcr.ac.uk/posts/patients-still-waiting-far-too-long-results-scans-0

https://www.rcr.ac.uk/posts/rcr-and-bsir-respond-shortfall-interventional-radiology-provision
17. As well as making the case for a major increase in radiology training numbers, the RCR has been advocating the use of small sums of public money to provide some interim relief - although not the solution:

- NHS England should organise and fund international recruitment initiatives. The RCR has already taken the initiative by running a session Working in the UK at the major European Congress of Radiology in 2015 at the expense of its Fellows and members and is offering two such sessions at the March 2016 Congress: https://www.rcr.ac.uk/clinical-radiology/being-consultant/working-uk/working-uk-sessions-ecr-2016

- NHS England should organise and fund induction programmes for International Medical Graduates;

- Pilot level funding by NHS England of human resource, financial, IT, legal, governance, and operational support is required to deliver networked NHS radiology services across the country. The RCR first proposed a network model in September 2014: https://www.rcr.ac.uk/clinical-radiology/service-delivery/sustainable-future-diagnostic-radiology/network-solutions which is now part of the RCR suite of advice and guidance of sustainable solutions for radiology services. These measures are considered essential to support radiologists as they struggle to keep services going in the face of the severe underfunding.

The recognition as a Vanguard of the East Midlands Radiology Consortium (EMRAD) was very welcome: https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/acute-care-collaboration/  

**Data and IT**

18. The CSR allocation to IT in healthcare is substantially less than many, including the RCR, had expected. £200m a year split between 500 NHS organisations in England is inadequate to transform NHS IT to -

- underpin key sources of data such as the Radiotherapy Dataset, the Diagnostic Imaging Dataset and the Systemic Anti-Cancer Therapy Dataset and put them on a sustainably funded footing;

- eliminate costly repeat imaging where access to images and imaging reports is not universal and easily achievable. Not only does this import greater cost to the NHS, it can increase patient anxiety, delay diagnosis and delay treatment potentially leading to worse outcomes;

- link together separate sources of data so that services can be planned with confidence and to ensure the best deployment of scarce resources;

- deliver innovative networked radiology services efficiently;

- ensure adequate and more detailed coding accurately to reflect costs and remunerate providers appropriately.

**A way forward?**

19. A key role of the RCR is in making the case to ensure that clinical radiology and clinical oncology services are delivered and developed in the best interests of patients. The current position is unsafe and compares adversely with other countries of similar GDP per capita.

20. There is no indication that it will improve as a result of decisions made in the CSR or in the lack of any other concrete commitments by the Government. It seems likely that the reverse will happen and there will be further deterioration in the quality and availability of services. The RCR therefore has a duty to add its voice to those of many others on
behalf of patients whose expectations are far from being met in regard to timely diagnosis and as regards the timely treatment of cancer and acutely ill patients.

21. The picture painted by many commentators particularly at the time of publication of the CSR was of an NHS surviving on a hand-to-mouth basis with all the disadvantages of short term planning and in-year “fixes” becoming apparent in the immediate impact on patients. The failure to plan for the longer-term and take an holistic view is also all-too obvious.

22. The future demands on healthcare services in the UK are well-known; some of the key issues are:

- an ageing population: people living longer with multiple morbidities
- an increase in population overall
- cancer becoming a long term disease requiring very different treatment regimens and service delivery
- the expectations of improved diagnosis and treatment of cancer raised through the Cancer Strategy
- the need to provide integrated services as between primary care, secondary care and social care with NHS bed blocking being a symptom of the lack of integration
- widespread concern over NHS, social care and public health funding
- deteriorating NHS performance (e.g. emergency care trolley waits, diagnostics reporting delays, delays in cancer treatment, access for general practice appointments)
- impact of devolution of health and social care services to the English regions.

23. Against the background of these multiple factors, the RCR sees the need for a frank public conversation about and a review of the future and funding of health and social care services in the UK. There are plentiful studies and options to draw on and so this need not and should not be a long, drawn-out process. If that were the case then it would allow the Government and those who plan and deliver health and social care services to remain unresponsive to the dire need for positive action for even longer and allow services to fall apart.

24. In the meantime with such a comprehensive and well thought through plan for cancer services having been produced so recently there is no excuse for not committing to implement the Cancer Strategy in full. The executive summary to the Strategy makes clear that investment now will result in a significant positive resource impact:

“The National Audit Office has estimated cancer services cost the NHS approximately £6.7bn per annum in 2012/13. The Five Year Forward View projections indicate that this will grow by about 9% a year, implying a total of £13bn by 2020/21. The recommendations set out in this report will cost an estimated £400m per annum, of which approximately £300m per annum may already be included within the FYFV baseline projections. However, in the medium term, implementation of these recommendations should contribute substantially in excess of £400m per annum to the projected £22bn funding gap.”