RCR response to National Cancer Plan consultation

In what capacity are you responding to this survey?

On behalf of an organisation

What is the name of your organisation?

The Royal College of Radiologists

Where does your organisation operate or provide services?

UK-wide

What type of organisation are you responding on behalf of?

Professional membership organisation

Are you happy to share your email address with the Department of Health and Social Care?

Yes – policy@rcr.ac.uk

Prevention and awareness

Which cancer risk factors should the government and the NHS focus on to improve prevention? (optional – choose no more than three)

- Alcohol
- Tobacco
- Obesity
- Physical inactivity
- UV radiation
- Air pollution
- I don't know
- Other

Please explain your answer (optional – max. 500 words)

Demographic change: health policymakers need to be aware that the UK is an ageing society. We know that diseases like cancer are more common in older people; 90% of cancer cases are in people aged over 50. One third of new cancer cases in the UK each year are in people aged 75+, and the highest cancer rates are in the 85-89 age bracket. Moreover, age correlates with comorbidity, with older patients more likely to have multiple major conditions; this can make effective treatment more complicated, costly and time intensive. Ageing cannot be prevented, clearly. However, as these trends accelerate, further investment in research and treatment capacity will be needed. The impact of an ageing society on cancer care can be planned for and managed. The NHS needs to plan for a significant rise in incidence of major illnesses as the UK ages. This will include a shift in cancer research priorities, patient treatment pathways, and the provision of tailored services such as supportive oncology. We expand on these elements throughout our response. The RCR is well placed to advise, assist and deliver on these shifts.

Lifestyle and environmental factors: The incidence of major illnesses is also rising in part due to lifestyle changes, including dietary changes, consumption of alcohol and

tobacco, and a lack of physical activity. Pollution and other environmental factors are also linked to rising incidence of cancer, respiratory illness, and other major conditions. These are all potentially preventable causes of cancer and other major conditions; there is, therefore, significant potential for positive impact, if these drivers are effectively tackled.

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Early diagnosis

What actions should the government and the NHS take to help diagnose cancer at an earlier stage? (optional – select up to three)

- Improve symptom awareness, address barriers to seeking help and encourage a timely response to symptoms
- Support timely and effective referrals from primary care
- Make improvements to existing cancer screening programmes, including increasing uptake
- Increase diagnostic test access and capacity
- Develop and expand interventions targeted at people most at risk of developing certain cancers
- Increase support for research and innovation
- I don't know
- Other - increase the radiology workforce

Please explain your answer (optional – max. 500 words)

Radiology workforce growth: clinical radiologists are essential to making diagnoses from medical images. However, there is currently a 30% shortfall of consultant radiologists in the UK; this is expected to hit 40% by 2028 should nothing be done. Growing this crucial workforce is an essential enabler of early diagnosis and thus effective patient care. More specialty training posts and support for NHS trusts to take up these posts is required. Also, future workforce planning must consider how to improve recruitment and retention to remote and rural cancer centres, where workforce shortages are disproportionately the greatest across the country. This would help reduce inequality of access to expert care.

Optimising imaging activity: demand for diagnostic imaging is rising significantly; the number of CT and MRI scans performed grew by 11% in 2023. But much of this activity may be perceived as being lower value, insofar as it consists of repeat imaging or inappropriate scans for a given patient's case. There is a need to optimise the imaging the NHS conducts, to enable faster diagnoses and to focus diagnostic resources on those patients who are most likely to benefit. iRefer is clinical decision support software that recommends to referring clinicians the correct imaging investigation for a given case; already in use across many GP surgeries and NHS trusts, it is proven to reduce the incidence of repeat or low value investigations and thereby deliver cost savings. iRefer should be rolled out to all primary and secondary care settings to further accrue these benefits.

Artificial intelligence to support early diagnoses: AI tools are poised to revolutionise the efficiency of radiology practice and of other diagnostic specialties by assisting clinicians to identify disease at an early stage. AI can support radiologists to make rapid and accurate diagnoses; the RCR estimates that nearly 7 in 10 UK radiology departments are using AI tools. As the demand for diagnostics and cancer care rises with incidence, AI will help us to change how we work and support us in providing all patients with the care they need. The RCR is a leader in this space; we have produced clinical guidelines for radiologists to identify, assess, deploy and use AI tools; we are providing educational resources and courses for radiologists looking to expand their skills and knowledge; and we are identifying the barriers and enablers for AI deployment in NHS diagnostic services.

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Treatment

What actions should the government and the NHS take to improve access to cancer services and the quality of cancer treatment that patients receive? (optional – select up to three)

- Increase treatment capacity (including workforce)
- Review and update treatment and management guidelines to improve pathways (processes of care) and efficiency
- Improve the flow and use of data to identify and address inconsistencies in care
- Improve treatment spaces and wards, including facilities available to carers
- Improve communication with patients, ensuring they have all the information they need
- Increase the availability of physical and mental health interventions before and during cancer treatment
- Increase the use of genomic (genetic) testing and other ways of supporting personalised treatment
- I don't know
- Other

Please explain your answer (optional – max. 500 words)

Oncology workforce growth: Clinical oncologists (CO) are the only workforce who can provide all non-surgical cancer treatments. Investing in CO will enable better access to all those treatments, including those currently in the research and development phase, which would help to reduce inequalities in access and outcomes. COs' unique, holistic perspective means that we are good at pragmatic service design and research. If the CO workforce is expanded, and if COs are thereby given more time in their job plans to identify and implement change, it will have huge benefits to patients. Examples of where COs, via the RCR, can add value include leading MDT reform, skill mix, and treatment innovation.

Time to treatment: Delays in starting treatment affect cure rates. We need to be ambitious about treatment times, such that patients receive radiotherapy or SACT within days or a few weeks, rather than many weeks or months, of a diagnosis. Indeed, we should be tailoring optimal treatment times by cancer type. To enable this and to allow for fluctuations in demand, we need to plan services at less-than-100% capacity. Centralised targets are less important to patients' care than is collecting and using rich

data and metrics on which clinicians can base and improve service provision, which we are not currently leveraging to maximum potential.

AI in treatment: the RCR sees immense value in the use of AI tools to support auto-contouring, boosting clinicians' productivity and reducing delays for patients. AI-powered auto-contouring software (AIAC) can help oncologists speed up and boost the accuracy of radiotherapy treatment planning, getting patients to treatment faster. As AIAC evolves it will enable oncologists to define cancers more accurately so treatment can be more effective, improving cure rates and reducing side effects. To ensure best practice is shared, avoid unnecessary duplication of effort, and reduce inappropriate variation, national guidance is required for the selection, deployment, assessment and use of AIAC tools. The RCR is well placed to advise and support the rollout of AIAC – with strong links with leading clinical oncologists who have pioneered the deployment of AI tools, and decades of experience in audit, clinical guidance and developing educational resources.

Personalised medicine and genomics: in cancer care this will become increasingly common in future. Analysis of large real-world datasets and new technologies like circulating DNA measurement all have the potential to help reduce therapeutic waste and therefore significantly improve system capacity. For instance, ~90% of patients get no benefit from adjuvant drug treatments; we need ways to identify the 10% that do so we can avoid unnecessary treatment for others. Likewise for palliative SACT, we need better predictive tests to identify those most likely to benefit from a treatment and those for whom the treatment will not work. We should also prioritise identifying treatments that work best in older or frail patients or those with comorbidities who are often excluded from clinical trials.

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Living with and beyond cancer

What can the government and the NHS do to improve the support that people diagnosed with cancer, treated for cancer, and living with and beyond cancer receive? (optional – select up to three)

- Provide more comprehensive, integrated and personalised support after an individual receives a cancer diagnosis and (if applicable) after treatment
- Improve the emotional, mental health and practical support for patients, as well as their partners, family members, children and carers
- Offer targeted support for specific groups, such as ethnic minority cancer patients, children and bereaved relatives
- Increase the number and availability of cancer co-ordinators, clinical nurse specialists and other staff who support patients
- Increase the support hospice services and charities who provide care and support for patients
- Improve access to high-quality, supportive palliative and end-of-life care for patients with incurable cancer
- I don't know

- Other

Please explain your answer (optional – max. 500 words)

Supportive Oncology and Enhanced Supportive Care: these are terms for is the prevention and management of the adverse effects of cancer and cancer treatment. They involve multidisciplinary expertise from oncologists, nurses, physiotherapists, dieticians, psychologists and more. It is about not only curing disease, but also helping patients manage their symptoms and psychological effects and continue to live their lives to the full. Currently, supportive oncology is under-utilised and there is a lack of ownership of the coordination of care. It should be integrated into cancer departments as a priority to improve patient experience and alleviate pressure. Dedicated funding and workforce development are required. A clear tariff for these services would also help with commissioning and the provision of services (since currently there is no tariff, and providers struggle to recoup funds). It should be embedded in NHS standards and guidance. Doing so would reduce emergency admissions, reduce the length of inpatient stays, help us to address the late effects of cancer treatment, and enhance patient quality of life.

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Research and innovation

How can the government and the NHS maximise the impact of data, research and innovation regarding cancer and cancer services? (optional – select up to three)

- Improve the data available to conduct research
- Improve patient access to clinical trials
- Increase research into early diagnosis
- Increase research into innovative treatments
- Increase research on rare and less common cancers
- Speed up the adoption of innovative diagnostics and treatments into the NHS
- I don't know
- Other

Please explain your answer (optional – max. 500 words)

Clinical trials: there is huge potential for the NHS, as one organisation, to design and run multicentre clinical trials that answer clinically relevant, pragmatic questions and then enable research findings to be implemented quickly. This is the best way to ensure that the evidence to justify novel therapies is obtained, that new techniques are implemented safely across the whole NHS, and that UK patients gain access to novel treatments at the earliest opportunity We must create systems whereby clinical research delivers for patients, not just for industry. Nationally-funded clinical trials can address research questions that the pharmaceutical and medical technology industries are less likely to fund, such as the identification of patient groups who should *not* be treated with a given medication (since not all treatments benefit every patient) or designing optimal treatments for elderly or more frail patients.

Non-clinical AI tools: the most value from AI will come from tools that augment or automate administrative processes and free up clinicians' time to spend caring for patients. For example, ambient voice technology could help produce patient notes and clinic letters in real time as the oncologist speaks directly to the patient. AI tools could automate and flexibly update clinic templates, MDT meetings and staff rotas to increase productivity and quality. There needs to be greater collaboration between the NHS, clinicians and industry, such that industry develops the AI tools clinicians really need (rather than those that are easiest to develop). The RCR is well placed to facilitate and deepen these links.

Data collection and implementation: Good quality data is essential for continuous quality improvement, audit and research. National data collections, such as the Radiotherapy Dataset and the NATCAN audits, should be maintained and expanded. Moreover, as per the Sudlow Review, linking existing datasets would unlock a huge wealth of data for research and ultimately better patient care. Similarly, there would be huge value in a national approach to collecting patient outcomes data, including Patient Reported Outcome Measures, to enable us to focus on what matters most to patients. Investing in the quality improvement aspect of data collection would pay huge dividends in terms of effective use of data; clinicians need sufficient time for QI. There must be a focus on using this data to implement change. Every cancer centre should have a QI programme to use data to improve care quality; the RCR is contributing to this via our data leads network. Finally, these large, linked datasets are the basis for the development and testing of AI algorithms; this would help ensure the algorithms functioned effectively and safely. Fully exploiting the potential of the data the NHS already has or could collect would be transformative.

Reimbursement: Block contract reimbursement hinders innovation. A new tariff system which rewards evidence-based innovation is required, with robust costing of activity recognising both fixed and variable costs. This must avoid perverse incentives (e.g. increasing the use of prolonged radiotherapy fractionation courses through per-fraction tariffs).

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Inequalities

In which of these areas could the government have the most impact in reducing inequalities in incidence (cases of cancer diagnosed in a specific population) and outcomes of cancer across England? (optional – select up to three)

- Improving prevention and reducing the risk of cancer
- Raising awareness of the signs and symptoms of cancer, reducing barriers and supporting timely response to symptoms
- Reducing inequalities in cancer screening uptake
- Improving earlier diagnosis of cancers across all groups
- Improving the access to and quality of cancer treatment
- Improving and achieving a more consistent experience across cancer referral, diagnosis, treatment and beyond
- Improving the aftercare support for cancer patients

- I don't know
- Other

Please explain your answer (optional – max. 500 words)

Access to specialised treatments: specialised treatments cannot practically be given in every cancer centre. However, we can use health services research to inform a systematic approach to service design, which would mean a more equitable rollout of new treatments like SABR and molecular radiotherapy (MRT). For MRT, a systematic approach would benefit in terms of setting clear funding mechanisms/tariff rates for activity (currently this is very confused), coherent and consistent data collection, and a stable supply of radionuclides and radiopharmaceuticals (for which the UK has no domestic production facility). For example, Ga68 PET may be required for patient selection for MRT, but access is starkly inequitable and limited in most places outside of London.

Service design to tackle inequalities: The RCR strongly supports the focus on enabling local clinical teams to lead and develop the right services for their populations but devolving too much from the centre risks wasting time and money through duplication of effort. It will increase unwarranted variation and widen health inequalities as local decisions vary.

Clinical teams need practical guidance and standards to support them to improve care and reduce variation. The RCR produces guidance like these, such as our consensus guidance.

- There is a lack of nationally agreed optimal treatment pathways. National optimal pathways for radiotherapy and systemic anti-cancer therapies would reduce variation and inequities. National protocols for each treatment would also improve productivity by reducing duplication of effort.
- Additional tools to reduce duplication, such as the RCR's radiotherapy consent forms and CRUK's SACT consent forms, should be supported.
- Educational resources, particularly for new treatments and pathways, are beneficial. One example would be the SABR-RCR workshops, which have helped centres to adopt and deliver SABR to patients to excellent standards across the country.
- National procurement of hardware and consumables, including drugs, can be improved, since we are not getting value for money with current approaches. Procurement of expensive equipment, for reasons of cost savings, is best done centrally. A rolling investment model for radiotherapy linear accelerators driven from the centre would help to reduce variation and uncertainty. Likewise, national procurement of kit and consumables for specialised treatments like molecular radiotherapy would facilitate equitable rollout.
- Running national clinical trials at multiple local centres enables faster, safer, wider adoption of trial results when published.

Multidisciplinary team meetings: multidisciplinary care is rightly embedded in how cancer teams work. However, it is clear that MDT meetings in their current form are not the best way to improve best patient care. They are increasingly time-consuming and inefficient with a focus on process not patients which may make inequalities worse. MDT meetings need to re-focus on those patients where an in-depth team approach can

really improve decisions and recommendations. Guidance to reform MDT meetings has been issued but not widely adopted; the RCR is collaborating with clinicians across the sector to identify best practice, encourage reform and improve productivity.

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Priorities for the national cancer plan

What are the most important priorities that the national cancer plan should address? (optional – select up to three)

- Prevention and reducing the risk of cancer
- Raising awareness of the signs and symptoms of cancer
- Earlier diagnosis of cancer
- Improving the access to and quality of cancer treatment, including meeting the cancer waiting time standards
- Improving patient experience across cancer referral, diagnosis, treatment and beyond
- Improving the aftercare support for cancer patients
- Reducing inequalities in cancer incidence, diagnosis and treatment
- Other

Please explain your answer (optional – max. 500 words)

All of these areas are important, as evidence by our responses above. Throughout our submission we have focused our attention on those areas where the RCR can actively contribute towards improvements.

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