

Supplementary written evidence submitted by #CatchUpWithCancer campaign (CSV0055)

Rt Hon Jeremy Hunt MP
Chair, Health and Social Care Select Committee

2 November 2021

RE: Requested radiotherapy information following 26 October evidence session.

Dear Jeremy,

As requested, I am writing to provide you with further details about the chronic and severe problems in the radiotherapy sector, that I believe are highly relevant to both the current covid-induced cancer backlog and to the longer term, post-pandemic cancer landscape and improved cancer survival.

I have been working with the APPG for Radiotherapy since 2018 and our submission to the Select Committee details the work to date, including an MP-led Inquiry into Radiotherapy and a 6-point Covid recovery plan. Despite extensive documentation of the problems and solutions, nobody is currently empowered to respond.

High Level Issues

Before going into detail, there are a number of high-level points to consider:

1. Radiotherapy is a vital tool in our arsenal of cancer treatments. It is one of the three main pillars of cancer treatment alongside surgery and systemic treatment (chemotherapy/immunotherapy etc.). 1 in 4 of us will need radiotherapy at some point in our lives as it is required in 50% of cancer patients and 4 out of 10 cancer cures. The UK needs a world class radiotherapy service if we are to deliver world class cancer care.
2. Radiotherapy is incredibly cost effective. Typically, the cost of a radiotherapy cure is between £4-£7k, a mere fraction of the costs of surgery and chemotherapy. Some immunotherapy treatments cost £100K a patient. Radiotherapy machines are expensive (approx. £2M each), but treat thousands of patients, last ten years and so cost in the region of £400 a patient.
3. Radiotherapy is remarkably Covid-resilient. It does not affect the immune system as does chemotherapy and does not have the infection risk and ITU demands associated with surgery. And in many cases, it can be a substitute for surgery (lung, prostate and bladder cancer etc.).
4. Radiotherapy techniques are advancing at a considerable rate with digital and technology developments resulting in a transformation in treatment. With more advanced machines, using advanced imaging and IT connectivity, we can treat even more patients even more quickly.
5. Radiotherapy technology is rapidly advancing but UK patients continue to miss out. Radiotherapy has a great future and is now being additionally used to increase survival with immunotherapy and new high dose "Flash" radiotherapy, is being heralded as a revolution in

enhancing the effects of radiotherapy. The future holds much promise, with new particle therapy being developed and with the UK high energy physics community researching lasers to generate high energy ion therapy.

Given the above, I hope you will agree that radiotherapy should be given great priority in policy terms. However, my main point to you and your fellow committee members is that this is far from the case. The sector has suffered years of underinvestment by successive Governments and there is a persistent institutionalised failure both to understand radiotherapy and to harness its potential. Radiotherapy needs central planning and investment in people, equipment, and IT, with systems to invest in rapidly improving technology. This has not happened, and with the current bureaucracy and perverse tariff systems has led to underperformance and inefficiencies. Sadly, the radiotherapy service is now on its knees in many parts of the UK.

We think that the above points mean that radiotherapy should be featuring in cancer-related policy discussions from the Prime Minister down. But our experience is that it is rarely considered and that those advocating for it have to fight to get heard.

The lack of understanding goes right to the top of the policy world. On a number of occasions even very senior Ministers confuse 'radiology' with 'radiotherapy'. Whilst we can all trip over a word and occasionally misspeak, I fear that this shows a very real lack of understanding that permeates through large parts of the health policy-making world. This has tragic and wasteful consequences.

In the UK we spend of the order of 5% of the cancer budget on radiotherapy, whereas other advanced economies spend up to 10% or more. With a relatively modest investment of £850 million over 3 years, radiotherapy can secure a dramatic and guaranteed improvement in cancer survival.

The current problems in Radiotherapy

The main problems in radiotherapy are:

1. Out of date equipment: Half of Trusts are having to use machines past their 10-year suggested life which has consequential reliability issues and inability to deliver modern precis radiotherapy. There is an urgent need for new machines. Additionally, technology is moving on fast and older machines do not have the ability to treat patients as effectively and quickly as new ones. There is not even a rolling program of machine replacement, let alone a program to expand the machine portfolio. When challenged, the Government cite the £130M additional funding for radiotherapy replacement machines from 2016 which was spent by 2019. To keep re-announcing this £130M funding in 2021 or including it as a main pillar of the long-term plan simply reinforces the perception that the Government do not understand the situation.
2. There is a lack of access. CRUK figures show that 27% of UK cancer patients are given radiotherapy. This compares disastrously with the recommended international guidance which sets out that 53-60% of cancer patients should be given radiotherapy. This lack of access is reinforced by the fact that 3.5m people in England do not have a radiotherapy centre within the recommended 45-minute travel time of their home. For example, 24% of curable lung cancer patients are not receiving any treatment when they would have benefitted from/be cured by radiotherapy (PHE audit 2019).

3. Responsibility for radiotherapy is split across a number of bodies (NHSE, HEE, NHS Providers, NHS supplies, NHS digital , NHS X etc). Perhaps most tellingly, responsibility for the areas that affect radiotherapy is also split at ministerial level.
4. Lack of IT: It is now possible to use off the shelf, relatively inexpensive, connectivity software that enables clinicians to treat patients even if the clinician is at another centre or working from a laptop or some such. This functionality would almost immediately help increase throughput of patients as it acts as a 'workforce multiplier'. However, except in a few cases we are not making use of this capability.
5. Bureaucracy is holding back the system leading to underperformance, inefficiencies and waste. There are perverse tariffs that mean even in centres that have more modern machines that can treat patients more quickly in fewer sessions, staff are not allowed to do so. Instead, they have to treat less effectively over more sessions as the tariff generates income to the Trust based on the number of visits. There is still, despite persistent representations from ourselves and others, rationing of access to advanced precision radiotherapy. This has led to one private provider reporting a 500% increase in precision radiotherapy and a 3x increase in self-payers. Such need to pay was reported by the patient representative at the beginning of the committee session. This rationing is reducing patient survival and creating even more inequalities. It is not an exaggeration to say that radiotherapy in the UK is at crisis point.

Current status on the front line

A survey of front-line radiotherapy staff in October 2021, 18 months into the pandemic showed that:

- a. the service in many areas is 'on its knees'.
- b. a staggering 79% of staff who responded said they, or someone they knew, were thinking of leaving the profession.
- c. in some areas, waiting lists had increased to over 8 weeks (when a 4-week wait has been shown to reduce survival by as much as 10%).
- d. 80% said that with current resources they were unable to get capacity up to even 100%, never mind the 110% the Government say is needed if the backlog is to clear in the next decade!
- e. 90% had no confidence in the senior NHS or government in recognizing the problem or doing anything about it by providing the investment needed.
- f. staff were exhausted from the herculean efforts they had to make to respond to Covid over the last 18 months. Many reported that they felt demoralized and expressed incredulity at the current messaging being that 'all is OK'.

The solutions

You will be aware that during the oral evidence session I set out my view that to tackle both the cancer backlog and to build a post-pandemic world leading cancer service the country needs a radical new cancer plan with specific and focused Ministerial direction. I stand by that view. Data

and implementation science based on value-based care is leading to radical thinking around the world in how cancer services can be planned to improve outcomes for patients. In MedTech services like radiotherapy there are specific innovations for real world continual improvements in care, and in the introduction and assessment of incremental improvements in technology. The UK should be leading in these areas, and not ignoring them.

Specifically, to allow the radiotherapy sector to play its full role we need:

1. A Minister in charge of, and accountable for, the transformation of radiotherapy.
2. Investment to replace out of date equipment, provide dedicated imaging equipment for radiotherapy departments and deliver a new central rolling program of machine replacements (like Scotland has) and software upgrades. This investment will need to be of the order of £200-300M over three years to catch up, plus around £85M a year ongoing.
3. An expansion of capacity and access. The Government is spending around £10 billion in regional diagnostic hubs. This is to be welcomed and will improve diagnosis. But we are missing the opportunity to place radiotherapy machines in those hubs. Such a move would transform access, speed and quality of care, and improve survival. This could be achieved for the relatively modest cost of £250M.
4. An investment in the 'off the shelf' IT technology readily available to speed up and manage workflow, remote working and quality assurance, and peer review. This is likely to be the fastest way to mitigate workforce issues and ensure expertise can be shared remotely. This will allow standardisation and implementation of world class anywhere and everywhere in the UK. This can be achieved with off the shelf technology for £200M
5. Investment in workforce to allow more patients to be treated. It is only by treating patients that we can improve survival. The professional bodies have provided figures and around £200M is needed.
6. The removal of the bureaucracy and perverse tariffs in purchasing and putting improving patients' care at the centre of decision making.
7. Stop rationing advanced precision radiotherapy. There is often little difference in real cost and clinicians should be allowed to make individual treatment decisions in the patient's best interest.

This needs central planning and support for individual Trusts to undertake the radical changes that are needed; Trusts' elective backlog targets will consume their current capacity. A radiotherapy industry taskforce has been meeting weekly during the pandemic to provide practical technical help to radiotherapy centres and derive short and long term solutions. Designated radiotherapy specialist providers stand ready with plans to assist the NHS in making this specialist investment. These experts have up till now been marginalized and largely ignored by NHSE to date. They should be engaged and deployed.

Conclusions

Catching up with the cancer backlog, realizing the ambitions of the long-term plan and improving survival to being one of the best in the world, rather than one of the worst, does not need some magical new cancer treatment and is not really complicated. We just need to stop being in denial about the scale of the problem and do things faster, differently and better.

We need the will to do this with the vision, leadership, authority and bureaucracy-busting to not just improve diagnosis but match this with increasing and better treatment capacity. We need to treat

cancer patients far quicker than we are doing now and remove the dreadful inequality of access to quality care, which has been developing over years and been exacerbated with Covid. Radiotherapy should be seen as a silver bullet in this crisis. Solving the radiotherapy problem will make a massive difference in catching up with cancer and improving overall cancer survival. Not solving the radiotherapy problem will be the continual drag on our cancer survival figures and continue to make the situation worse with every day.

After years of systematic neglect, perverse restrictions and woeful lack of investment, radiotherapy is on its knees in some parts of the UK. Staff need the tools to do their job and not their hands tied behind their backs. Nobody has been held accountable for this and there is currently no plan to address this. Yet with a relatively small investment, the radiotherapy service can be transformed with a dramatic impact on reducing the backlog and improving survival in the long-term.

This is a damning indictment of the current status of cancer care in the UK. Cancer care in the UK will collapse if radiotherapy collapses. Yet, with modern technology, radiotherapy is as close to a 'silver bullet' to tackle the Covid induced cancer backlog as we can get. It is also one of the main tools that can enable us to achieve the ambitions of the long-term plan.

A radical new national plan is needed in both organization and workforce, and technology investment. A failure to tackle these issues will undoubtedly mean that we will continue to lose cancer patients that should not be lost. I hope you will agree such an outcome is unthinkable. Action is urgently needed.

Many thanks for considering these issues. Please do not hesitate to contact me if you require further information.



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