Ref: APPGRT, Solutions to the COVID induced cancer backlog

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Dear APPGRT

Please find my personal thoughts on the questions you have asked below. The response is my personal opinion and not necessarily that of the Trust but is informed through my professional background as a Radiotherapy Service Manager.

1) How large is the cancer backlog and what are the risks to patients?

I don't know that we will ever know the size of the backlog accurately. We can make estimates based on the drop in levels of activity from the previous years but this will not account for the patient who have died without having had access to diagnostic tools or have been diagnosed too late such that only palliative care/ end of life care has been delivered. Looking at activity levels it will be thousands of patients and we are already seeing an increase in the number of palliative patients coming in to the departments due to late diagnoses.

2) Has the current response of Government and NHS leaders to the COVID induced cancer backlog been sufficient and is the current system equipped to tackle the crisis? What is needed to change?

At the moment the pressure is loaded on to the front to the system and great investment is being made into the development and improvement of the diagnostic pathway. Radiotherapy being the end of the pathway will have to deal with the flow as it hits, at a point when the workforce is demoralised and resilience is low as a consequence of Covid and a feeling of not being valued when a derisory 1% or less pay rise is being suggested. We are already seeing staff looking for other career paths that will give them a more fulfilling career/ work life balance. What has either not been considered or has been ignored is that around half the patients who are diagnosed have to be treated in radiotherapy departments. We do not have the capacity or staffing to support a surge in activity of the size being anticipated of between 20 – 30%. This underlines the significant underinvestment in a service that pound for pound is more effective and cheaper than most chemotherapeutic regimens. I do not mean to downplay the role SACT plays in the cure of cancer but it is more expensive and is only responsible for around 10 -15% of the cures. We needed more investment in equipment, training and education and better access to innovative treatments. This however will not address the current pressing problem and is a long term solution to improving an effective cancer service within the NHS for the future. Many of these issues have already been highlighted in previous reports from the APPGRT and do not need to be repeated here.

3) • Do we have the capacity within cancer diagnostics services, cancer treatments and the cancer workforce to deal with the COVID induced cancer backlog?

There has been investment in the diagnostic services but this does not address the structural deficiencies in the staffing model we are currently working with. The lack of professional recognition, training and development opportunities and a workforce that has worked solidly through the Covid crisis. Radiotherapy is suffering from acute shortages of Radiographers, Medical Physicists and Clinical Oncologists. The training numbers for Clinical Oncologists may have been increased but it takes at least 5 years to train a clinical oncologist so the benefit will not be here when needed over the next year as we try and recover.

Therapeutic Radiographer numbers are low and there are more vacancies than students qualifying and Medical Physics have struggled especially since the Modernising Scientific Careers training was introduced which has seen the number of Radiotherapy Medical Physicists in training fall. So the short answer is we may have only just enough capacity in the diagnostic pathway but the services will be very stretched but within the Radiotherapy community I fear we do not have the capacity or resilience to manage what is coming.

4) Are current levels of funding enough to tackle the backlog?

The block contracts that everyone is currently working from do not account for the expected urge in referrals and so the work will be being delivered with less resource against each activity. There is no ability to bid for additional money as it will be a cost pressure against a fixed income. New activity is not being encouraged by Trusts as a result, so any investments for quality improvements or additional activity are not being considered.

5) What are the reforms, support and resources cancer services need to tackle the COVID induced cancer backlog.

I think it may be too late for the recovery program/ backlog as even if fully funded equipment was made available there are only so many hours in the day for each staff member to work. This crisis highlights the chronic underinvestment that has gone on for decades (I'm old enough to remember this!) within cancer services. Radiotherapy is really a Cinderella service, overworked and underappreciated. There is a communication issue around what RT can deliver and does achieve for patients. SACT has a much higher profile and therefore greater investment, partly due to big Pharma but also due to public misunderstanding of what Radiotherapy is and a general fear of 'radiation' such a bad thing, scary look at Chernobyl and the consequences on the psychology of receiving radiotherapy. I still get asked if patients are radioactive after treatment and when can they see their grandchildren safely or comments about when will the burns come. It is really saddening to work in a profession that people are scared of.

6) Are there any opportunities to tackle the cancer backlog being missed?

Although I am fearful of what is coming and how the services will cope, I also see this as an opportunity for us to address/ underscore the underlying issues in cancer services by gaining the recognition that investment in infrastructure, training, staffing and innovative treatments will benefit patients in the future. Sad to say in the RT Expert Advisory Group I participate in we have tracked the number of RT trials that are currently available and there are less than ever before and many are currently suspended due to activity being focused on Covid trials. Without Radiotherapy trials being developed and reported we cannot hope to consistently improve the quality of life and potential cures for our patients.

7) What technological or innovative solutions might be implemented long and short term to tackle the cancer crisis?

There needs to be better investment in Technology, adoption of Artificial Intelligence to support the diagnosis and treatment of cancers, better arrangements for the inclusion of patients in trials, and a greater portfolio of trials available for patients. We need better information sharing arrangements for Peer Review and a database that links side effects to the treatment received. More Patients Reported Outcome Measures that are actually used to identify good and less good practice rather than just being data collected but not used. We need a communication program to educate the public on the advantages of early diagnosis and especially information that dispels the myths that persist about radiotherapy and showing the benefit it offers, alongside being cost effective. This does not take away form continued investment in modern radiotherapy treatment equipment.

8) What do cancer services need to look like in the future to improve survival of cancer patients?

Services need investment in modern equipment and the staffing to go along with this. It will not be cheap to start with but more staff in all the staff groups need to be encouraged to join the professions. Much

more investment in the IT infrastructure is needed and arrangements for the meaningful gathering and auditing of the data we gather on and about our patients so we can effect meaningful positive change. It is very sad that was a nation we rank relatively low on the survival rates for patients diagnosed with cancer in first world countries when we have a free to access healthcare system that should provide all the care patients require.

9) What policy recommendations should the APPGs make to the Government for tackling the Covid-induced cancer crisis?

I think it is mostly too late for immediate actions to mitigate the coming crisis but is an opportunity to allow us to be better prepared for the future. I know I sound like a glass half empty person but I feel it is better to be prepared for the worse and anything positive that comes along is an absolute bonus. I can foresee that unfortunately the improvements we have made over that last decade in cancer survival will show a significant hiccup as a result of the Covid crisis and will take several years to recover from. Please speak up again about all the recommendations you have previously made to improve the status of cancer services previously.

10) • Anything else you would like to say?

I really appreciate the work and issues you are trying to highlight for our patients and I hope that my pessimism is misplaced. If I can contribute in anyway please count on my support.

Regards

Carolyn O'Donovan
Therapeutic Radiographer