National Assembly for Wales
Health and Social Care Committee

Inquiry into the progress made to date on implementing the Welsh Government's Cancer Delivery Plan

Evidence from Standing Welsh Committee of the Royal College of Radiologists – CDP 33

2 April 2014

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay CF99 1NA

Dear Sir

Response of Royal College of Radiologists Standing Welsh Committee to the National Assembly for Wales' Health and Social Care Committee Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan

The Standing Welsh Committee (SWC) of the Royal College of Radiologists represents the specialties of Clinical Radiology and Clinical Oncology within Wales. The majority of Oncologists and Radiologists working in Wales are Fellows of the College. We would make specific observations as follows, based on our consultation with colleagues in Wales.

1. The Standing Welsh Committee of the Royal College of Radiologists supports the aims of the Welsh Cancer Delivery Plan (CDP.) This sensibly takes a patient and population centred approach to the different stages of the Cancer Pathway. The aspirations are appropriate.
2. The importance of public health, early diagnosis, rehabilitation and survivorship, and the role of the third sector are recognised. Whilst there are clear targets for cancer management in secondary care, this is put into overall context rather than dominating. That is likely to be helpful in encouraging the production of integrated and balanced programmes.
3. The production by individual LHBs and NHS Trusts of their own local annual CDPs and Cancer Annual Reports (CAR) is, overall, felt to have been a useful exercise. It allows for tailoring and prioritising for local needs, which will vary. Existing programmes can be included into the larger delivery plans.
4. The CDP is ambitious, which is a good thing. It is multifaceted, and addresses some very complex problems. It is unlikely that all of the targets will be met by 2016. The health of populations is slow to change. Changes to hospital infrastructure and staffing take time. Some of the challenges are organisational, and some are

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undoubtedly financial. The current financial climate will influence this, and a pragmatic and long term view is necessary.

5. Funds are mainly used effectively and probably give value for money. The current level of funding for cancer services in Wales is inadequate. There is inequity of access to appropriate treatments. Better funding may improve the efficiency of the CDP.

   There are disparities across Wales in ability to access certain treatments. A significant proportion of this is due to geographical location – for instance patients living further away from radiotherapy centres may choose to have non breast-conserving surgery, to avoid the 3 weeks radiotherapy. Whilst there is no easy solution, the perceived barriers to travel need to be broken down e.g. access to hostel accommodation, transport arrangements etc. The local MDTs need to ensure patients are fully aware of the reasons why some treatments may not be available locally.

   Non surgical oncology services need to be centralised and site specialised in order to ensure patients receive the highest quality care. This is not possible with the model of care in some DGHs with a sole oncologist treating all cancers. Health Boards need to ensure that cancer services are delivered in conjunction with the Cancer Centre, and that the guiding principles of ensuring treatment is given as close to home as possible is not done at the detriment of ensuring care is delivered by a site specialist team.

   The source of funding for "specialised cancer services" is not clear. There are different models of delivering "specialised cancer services" in Wales – with some services receiving WHSCC funding and others being funded through the LHB budget. At LHB level, the financial arrangements for provision of cancer care are opaque. It is thus impossible to know whether the amount spent for specialised cancer services per head of population is equal across Wales but we suspect not. There are disparities between Cancer Centres in terms of access to Clinical Nurse Specialists, Oncology Consultant numbers and radiographer numbers.

6. In Clinical Radiology, demand for diagnostic CT , MRI and ultrasound scanning currently outstrips capacity, as shown by longer waiting times for diagnostic tests in Wales compared with England. Access to PET scanning is commissioned at a lower level in Wales than in England.

   We have an aging population of consultant radiologists in Wales with considerable anticipated retirements in the coming years and there have been insufficient Welsh trainees coming through to replace them. Furthermore, the increasing number of cancer MDTs adds to the time pressures on radiologists, both in preparing for and attending these meetings. This makes it increasingly difficult to cope with workload. There is inequitable access to MRI scanning for suspected cord compression across

Wales; at some hospitals, there are no formal arrangements for MRI radiographers to provide out of hours emergency MRI scans. There is no capitol replacement programme in some Welsh Health Boards for diagnostic equipment which can lead to aging imaging technology.

With kind regards,

Yours faithfully

Dr Richard Clements
Chair, Standing Welsh Committee
The Royal College of Radiologists