# APPENDIX 2


Radiotherapy Consultation
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Our Ref: HASC/PT
Your Ref: 07338

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Dear NHS England

MODERNISING RADIOTHERAPY SERVICES IN ENGLAND – DEVELOPING PROPOSALS FOR FUTURE SERVICE MODELS

I refer to the Publications Gateway Reference: 07338 and the consultations on a new model for radiotherapy services in England. The consultation is seeking feedback on a new specification for adult radiotherapy services.

The issue of patients having to travel across the Solent to receive treatment at mainland facilities is not new. It is accepted that for more specialised services these have to be delivered by hospitals on the mainland. These are normally seen as being either at Southampton or Portsmouth. This requires a patient, often accompanied by a family member, friend or carer to travel with them to provide support and where necessary assist with the transport arrangements.

The Council's Policy and Scrutiny Committee on Adult Social Care and Health has noted that for our sub region there is a suggestion of creating a network at Oxford for radiotherapy patients in Hampshire, Isle of Wight and Dorset.

The travel arrangements for a journey from the island to Oxford have great implications for patients not only in terms of distance and time but also costs.

In reviewing the documentation that has been published as part of the consultation process a number of questions have been identified. I set out below the relevant *extracts from these documents, in italics,* along with **questions in bold capitals** and identified as **Q**.

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***Modernising Radiotherapy Services in England – developing proposals for future service models document - extracts***

*6. We want to ensure sustainable, high-quality, safe and efficient services. We also want to improve access for patients, enabling them to receive care as close to their homes as possible, where clinically appropriate.*

***1.1 Responses received***

*13 NHS England received responses through a number of different routes: (i) direct correspondence; (ii) a webinar (iii) 4 regional public engagement events; and (iv) the engagement portal, the latter two generating the largest volume of responses.*

**Q1 - WHERE WERE THE REGIONAL PUBLIC ENGAGEMENT EVENTS HELD?**
**Q2 - WHEN WERE THESE HELD?**
**Q3- HOW MANY ATTENDED EACH EVENT AND WHAT INTERESTS WERE REPRESENTED?**

*14. Over 250 individuals attended the regional events and a total of 271 engagement responses were received through the portal, all of which were anonymous.*

*15 .In addition, a number of detailed responses were also received from a variety of stakeholders, specifically:*

- *3 NHS organisations*
- *Clinicians.*
- *Medical and Professional associations including; The Radiotherapy Board (comprising Society and College of Radiographers, Institute of Physics and Engineering Medicine and the Clinical Oncology arm of the Royal College of Radiologists, Cancer Research UK and the Royal College of Radiologists.*
- *One Private Healthcare provider*

**Q4 - DID ANY LOCAL STAKEHOLDER GROUPS RESPOND?**

*16. All of these detailed responses, though not received through the consultation portal, have been taken into account in the production of the engagement report and the key themes raised by these responders are included within section 2.1.*

***2. Engagement feedback***

*17. The responses received by NHS England from the public engagement exercise can be broadly grouped into five categories:*

*i. Provider Board structure, management, governance and accountability;*
*ii. Workforce Impact;*
*iii. Suggested geographies;*
*iv. Improvement measurement (pre and post minimum numbers); and*
*v. Impact on patients.*

***Measuring improvement and the impact on patients***

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*22. The last two areas of feedback essentially explore both sides of the same issue, i.e., the scale of disruption to clinical services and patients must be proportionate to the level of benefit for patients. This means that it is important to be able to make the case for change and evidence the impact of the change once made.*

**Q5 - IS THERE ANY CLINICAL RESEARCH INTO THE IMPACT OF TRAVEL TIMES ON PATIENT OUTCOMES?**

*23. The CRG has advised that the improvements that are hoped to be achieved include:*

- ***Improved clinical outcomes for cancer patients.*** *This would be a contribution to overall system measures, such as 1, 5 and 10 year survival.*
- ***Increasing access to innovative treatments.*** *This can be quantified and measured.*
- ***Increasing the proportion of treatments delivered by experts in the subspecialty area.*** *This could be measured, subject to an appropriate metric definition and inclusion within the Radiotherapy Quality Dashboard.*
- ***Minimising adverse events and adverse side effects.*** *This could be measured through the Quality Surveillance Team.*
- ***Increasing access to, and participation in, clinical trials to*** *aid improvements in treatment technique, protocol and survival.*

*This could be measured, subject to an appropriate metric definition and inclusion within the Radiotherapy Quality Dashboard.*

*However, further work is required to be undertaken to develop metrics and agree reporting arrangements.*

**Q6 - IS THERE AN APPROPRIATE METRIC DEFINTION TO MEASURE THE RECOVERY PERIOD FOR PATIENTS TRAVELLING LONGER DISTANCES FOR TREATMENT?**

*The CRG has advised that the improvements that are hoped to be achieved include:*

- ***Improved clinical outcomes for cancer patients.*** *This would be a contribution to overall system measures, such as 1, 5 and 10 year survival.*
- ***Increasing access to innovative treatments.*** *This can be quantified and measured.*

***3.1 Summary of responses received through the engagement portal***

***3.1.5 Question 3b: Can you think of anything else that should be considered that may impact on the case numbers proposed?***

*30 Responses received via the engagement portal suggested that the following areas could have an impact of the proposed case numbers:*

- *How the boundaries of networks were defined (including any cross-border working between England and Wales or England and Scotland), could impact on the case numbers.*
- *The importance of following established referral pathways and the potential impact of changing these established arrangements*
- *Patients receiving palliative treatment for rare/ less common cancers should be treated locally.*

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### *3.1.6 Question 4a: What equality and/or health inequality issues may arise as a result of the proposals, as they currently stand?*

*31. 240 responses to question 4a and 4b were provided via the engagement portal and identified the following issues:*

- *The potential impact on the distance that patients receiving complex treatment or treatment for less common cancers was identified by 214 (89%) of the respondents*.

**Q7 - THIS IS A HIGH RESPONSE AND INDICATES A KEY ISSUE THAT HAS TO BE ADDRESSED. WHAT ACTIONS ARE BEING TAKEN ON THIS MATTER?**

- *The potential impact on patients' access to services and patient choice was highlighted by 145 (61%) responses identified.*

**Q8 - A HIGH RESPONSE AND A KEY ISSUE THAT HAS TO BE ADDRESSED. WHAT ACTIONS ARE BEING TAKEN ON THIS MATTER?**

- *Possible impact of staff (53; 22% of responses) including: staff travel time; staff recruitment and retention; and opportunities for staff training and development*

### *3.1.7 Question 4b: What steps could be taken to avoid any equality and/or health inequality issues?*

*32.* ***A range of steps that could potentially help to avoid any equality and health inequality issues were identified including:***

- *Ensuring that the availability of public transport and patient transport is considered and taken into account by the networks (18: 8%)*

**Q9 - HOW WILL THIS BE TAKEN INTO ACCOUNT AND WILL THIS INCLUDE ALL ASPECTS OF PUBLIC TRANSPORT INCLUDING FERRY TRAVEL FROM THE ISLE OF WIGHT?**

- *Accommodation for patients and carers should be made available where it is needed (31; 13%)*

**Q10 - WHO DECIDES IF ACCOMMODATION IS NEEDED AND HOW WILL IT OPERATE TO ENSURE CONSISTANCY ACROSS ENGLAND?**

## *4. NHS England response to the feedback*

### *4.1 How the feedback has been considered*

*• NHS England has established a Project Steering Group and a Radiotherapy Expert Advisory Group to lead the next stage of the process.*

*• The Expert Advisory Group is comprised of a small number of dedicated clinicians including representatives from the Radiotherapy CRG. The first task of the group has been to reassess the assumptions on which the preferred option was based.*

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• *The work of the Expert Advisory Group and NHS England has led to a number of specific actions having been taken to engage further to explore some of the concerns expressed during the public engagement*.

**Q11 - WHAT ARE THE SPECIFIC ACTIONS BEING TAKEN TO DEAL WITH THE CONCERNS EXPRESSED?**

*42.The table below summarises the feedback received by question and the action that has been recommended.*

*We asked*
*3a. Do the case numbers presented within the clinical and service model reflect clinical best practice*

*You said*
*Patients travelling long distances*

*We hope that this service will address variations in access and mean more patients have high quality treatment. It is clear from the proposals that a small proportion of patients – with rare disease or requiring highly specialised radiotherapy – will potentially need to travel further than their local centre to receive the best treatment. Cancer Research UK is supportive of this in principle as we believe that this will mean these patients get a higher quality treatment in a centre that has the expertise and experience to provide it*

**Q12 - WHAT ARE THE FIGURES WHICH SUGGEST THAT A SMALL PROPORTION WILL NEED TO TRAVEL FURTHER?**
**Q13 - WHILST ACCEPTING THAT CANCER RESEARCH UK IS SUPPORTIVE OF THE PRINCIPLE DID IT COMMENT ON TRAVEL DISTANCES AND COSTS?**

*We did*
*It is noted that during the engagement events the PPE representatives communicated the preference to travel to centres of excellence for treatment of the less common conditions. This will be further tested through consultation*
**Q14 - WHAT FORM WILL THIS CONSULTATION TAKE?**

*The service model has been clarified within the service specification to describe a model that operationally could ensure that patients are treated locally where possible - this could link to the integrated operational models between neighbouring trusts at a local level*

*We asked*
*4a. What equality and/or health inequality issues may arise as a result of the proposals, as they currently stand*

*You said*
*Patients may not wish to stay away from their families for the duration of their treatment*
**Q15 - REQUIRES ACCOMMODATION FOR PATIENT AND FAMILY MEMBER/FRIEND/CARER TO ASSIST IN RECOVERY. WILL THIS BE LOOKED AT?**

*Patients may choose not to have radiotherapy*
**Q16 – HAS THE IMPACT ON LOCAL HOSPITALS BEEN CONSIDERED IF PATIENTS DETERIORATE BECAUSE OF NOT BE ABLE OR WILLING TO TRAVEL TO RECEIVE TREATMENT?**

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*Affordability for low income families which will be tested through consultation*
**Q17 - WHAT FORMAT WILL THIS CONSULTATION TAKE?**

*We did*
*Points noted and as above links to the level of integration between neighbouring trusts to create a single team with the appropriate multi-professional team available at the treating centre to provide the holistic care required by these less common cancer. This has been further clarified in the service specification*
**Q18 - DOES NOT DEAL WITH THE ISSUES HIGHLIGHTED IN THE "YOU SAID" SECTION SO CLARIFIACTION REQUIRED AS TO ACTIONS BEING TAKEN.**

*We asked*
*4b. What steps could be taken to avoid any equality and/or health inequality issues?*

*You said*
*It is important that an improvement in outcomes is able to be demonstrated following these changes*
*Patient transport and accommodation should be available*
*Good information for patients required to explain why they should travel to another centre*

*We did*
*The service specification includes these recommendations and will be further tested through consultation*

**Q19 - WHAT IS ACTUALLY CONTAINED IN THE SERVICE SPECIFICATION ABOUT PATIENT TRANSPORT AND ACCOMMODATION?**

**Q20 - HOW WILL THESE BE TESTED THROUGH CONSULTATION AND WHO WILL THIS INVOLVE?**

*Service specification*

**2.11 Patient access to radiotherapy**

*The Board must have arrangements in place to ensure that patients are able to access the Services, in accordance with wider arrangements set out within the NHS Constitution and NHS England policies, such as those relating to hospital transport and travel costs, as follows:*

*http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Travelcosts.aspx*

*In determining the configuration of the Service, the Board must consider access arrangements across the Network. The Clinical Model sets out that this is particularly important in relation to the provision of radiotherapy for people with rare and less common cancers (Scenarios C and D) where the provision of care is likely to remain concentrated into a few centres within the Network. The Board must consider the availability of patient accommodation when determining the Network locations for the provision of care for people with rarer and less common cancers. It is recognised that patient accommodation is not within the scope of NHS services. However, it is the case that many providers already have arrangements in place with the charitable sector for the provision of patient accommodation.*

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*The Specification seeks to encourage the further development of such arrangements and their application to radiotherapy services.*

**Q21 - IS THERE A FRAMEWORK FOR THE ISSUES THAT MUST BE CONSIDERED WHEN LOOKING AT ACCESS ARRANGEMENTS?**

**Q22 - WILL THIS LOOK SPECIFICALLY AT AREAS WHERE TRANSPORT IS LIKEY TO BE MORE OF AN ISSUE SUCH AS FROM THE ISLE OF WIGHT?**

**Q23 - WHAT FACTORS WILL BE TAKEN INTO ACCOUNT WHEN LOOKING AT THE AVAILABILITY OF PATIENT ACCOMMODATION AND WILL THIS INCLUDE ONE OF COSTS?**

*Integrated Impact Assessment Report for Service Specification*
*B3.7 Are there changes in the support services that need to be in place?*
***No***
*Please specify:*
*Arrangements for transport and hotel / hostel accommodation may need be reviewed, subject to applicable national and local policy. It will be important for each Network to understand the arrangements across the Network and for each Provider within the Network to ensure that consistent arrangements are put in place that reflect patient needs appropriately.*
**Q24 - ARRANGEMENTS FOR TRANSPORT AND HOTEL/HOSTEL ACCOMMODATION MUST BE REVIEWED SO THAT THERE IS A CLEAR UNDERSTANDING OF THE IMPLICATIONS FOR ALL PATIENTS HAVING TO USE THE FACILITY WITHIN A NETWORK AND THERE MUST BE CLEAR EVIDENCE THAT THE SOCIAL/CLINICAL IMPLICATIONS HAVE BEEN FULLY ASSESSED AND RISKS MITIGATED**

Whilst the Committee accepts that patient safety and good clinical outcomes may result from having a facility at Oxford it has strong reservations about the impact on any island resident having to travel to this location. Not only will there be financial costs involved to a patient together with the time required for travel, especially if using public transport, but this could impact upon the clinical outcome from any treatment. The travel requirements may result in a patient requiring such treatment to decline this on the basis of costs, difficulties with transport, and the trauma generated through the not insignificant experience peculiar in travelling from an Island.

An best case (assuming connections are smooth and no delays or problems encountered) example of what this may entail for a patient having to travel from the Island to Oxford compared with a patient from Southampton for an appointment at 10.00am in a winter month is as follows :-

- Travel from home to Cowes.

- Use of Somerton Park and ride – bus leaves 06.51. Parking is free but the return ticket on the bus is £3.50 (per person).

- 07.15 RedJet service from Cowes. The journey time for the vessel is approximately 25 minutes but account must also be taken that there would be a need to be at the terminal at least 10 minutes in advance to purchase a ticket and board. A return ticket for this would

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cost £22.60. Sometimes, on occasion, there are more passengers than capacity, so it is not always possible to catch the crossing you intend to.

- There is a popular free bus service, operating most of the day, but not all of the day, from, the RedJet terminal at Southampton connecting to the train station. This can be very packed, especially at peak times, when space is crammed and sometimes can be oversubscribed, and may require the patient to stand for the 10 minute bus or wait for the next bus (30 minutes or an hour, depending on boat schedules). The alternative would be a taxi at a cost of approximately £5.

- The train journey element would be similar to that for a patient from Southampton. This would be on a Cross Country service at 08.15 which requires no changes but can often be very busy and unless a seat is reserved in advance can mean standing (also assuming the electronic system for seat reservations is working on the train). The approximate travelling time for the train journey is 1 hour 25 minutes. A return ticket would cost £42.50.

- There would be a need to have a taxi from the train station to the hospital.

- The return journey is a reverse of the above.

- If the appointment was at a later time, further complication could ensue, as the ferry crossing is not a 24hr service, so, if connections are missed the patient and their companions would be forced to find accommodation for the night.

The Island patient has therefore incurred a cost of £26.10, not including the cost of petrol/ parking/ taxi/ bus fare getting to Cowes, above that for a Southampton patient who can have a lift from a friend to the train station, and that assumes that there are no complications or delays in their multi-leg journey or hospital appointment. The typical journey from the Island requires six changes in the form of transport, double or more than a Mainland patient from, say, Southampton, in just getting from home to the hospital, that is twelve changes in transport for the round trip, a gruelling task for even a fit and healthy person.

This cost has then to be replicated for each attendance. Often patients appreciate and need the support of a family member or friend when travelling to receive such treatment, so the financial impact is doubled, more if their companion has to take time off from work as well.

I look forward to your response to the questions and issues raised.

At present, given the information supplied, the Committee believes that the proposal to use Oxford in this role would have a detrimental impact upon Island patients due to the financial and practical implications of the travel arrangements involved. There needs to be clear clinical evidence that the travel requirements placed upon island patients do not impact in any way on the treatment that is to be delivered.

Yours faithfully

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