Minutes of the Cross Party Group on Cancer Meeting 9 December 2021
What: Cross Party Group on Cancer: *A Workforce Fit for the Future*
When: 09 December 14:00pm – 15:30pm Where: Microsoft Teams

Time	**Item**
14:00	Welcome, David Rees MS (Chair)
14:10	Speaker presentation: Professor Push Mangat (Medical Director of Health Education Improvement Wales)
14:25	Speaker presentation: Dr Toby Wells (Chair of the Standing Welsh Committee, Royal College of Radiologists)
14:35	Speaker presentation: Karen Howarth (Senior Nurse Manager, Hywel Dda UHB)
14:45	Speaker presentation: Dr Martin Rolles (Consultant Oncologist, Swansea Bay University Health Board)
14:55	Panel Discussion and Q&A, facilitated by David Rees MS (Chair)
15:30	Close, David Rees MS (Chair)

Speakers
Professor Push Mangat
Dr Toby Wells
Karen Howarth
Dr Marin Rolles

Secretariat
Alaw Davies, CRUK

Topic
The aim of the session will be to highlight the work of the cancer workforce particularly during the last eighteen months, and to identify where the gaps and pressures in the workforce are greatest.

The ongoing impact of COVID-19 on cancer services can be keenly felt, as the system tries to tackle the backlog of people who weren't seen in screening or diagnostics or had treatment postponed over the last eighteen months. This means that there may be an increase in demand for cancer services at a time of stretched capacity across the NHS.

Long-standing workforce shortages also mean that NHS staff are exhausted from responding to the pandemic, as well as trying to maintain cancer services. Even before the pandemic, Wales was experiencing significant gaps in the diagnostic and cancer workforce, such as in imaging, endoscopy, pathology, and non-surgical oncology. These gaps have severely affected its ability to diagnose cancers early, provide the most effective cancer treatment, and improve cancer survival.

1. Welcome

David Rees MS (Chair) opened the meeting and welcomed members.
The Chair briefly described the meeting agenda and etiquette.
The Chair introduced the panellists.

2. Presentation by Professor Push Mangat, Health Education Improvement Wales (HEIW)

The Chair welcomed Professor Push Mangat (PM). PM touched on the strategic aims at HEIW which included; 1. a sustainable workforce 2. excellent education and training 3. supporting quality and safety 4. capacity and capability to lead 5. to be an excellent employer and a great organisation to work in 6. To be a trusted partner and system leader.

PM outlined HEIW's annual plan, including the IMTP strategic objective to modernise workforce models to deliver service transformation arising from the NHS Wales Collaborative and national strategic programmes for:

- Imaging
- Pathology
- Endoscopy
- Major trauma
- Unscheduled care
- Critical care

PM stated that the case for change is well established, and in 2019 Cancer Research UK published a position paper for Wales. This outlined the priority of developing a diagnostic workforce, improve workforce intelligence, plan and commission additional multiprofessional education and training, regularly review the impact of new technologies and embed a prudent approach to multi professional team development. PM stated that the Richards report was also published not so long ago, which wasn't necessarily about cancer itself but was about planned care generally. The report talked about workforce capacity, integration of networks skill mic and hybrid teams, which are similar themes to my previous discussion.

PM outlined the work of HEIW in this space, which includes educational modules across all professional areas for both detection and care of cancer as well as early

detection, particularly in primary care. There's also some work going on, in familial breast cancer in mouth, cancer, skin, cancer.

PM touched on the role of pharmacy and the importance to recognize that pharmacies changing and all pharmacists by 2026 are going to come out with independent prescribing ability. Independent prescribing means that they have to be able to listen to a patient, assess a patient, take a history and get some sort of idea of what's wrong with them before prescribing a drug. They might be doing his diagnosing a set of symptoms in community pharmacy or in primary care that could lead to a diagnosis of cancer, which is an important additional workforce and source of referral. And in addition, there's specific teaching programs on identifying bowel and skin cancer, which has been done the latter in in in conjunction with public health Wales.

For medical training, HEIW have increased medical and clinical oncology training, urology training, gastroenterology respiratory and for a couple of years now they've been maximizing the output from the Imaging Academy. Prior to that, HEIW were training 13 trainees a year. It's now up to 20, so they are in a position to start addressing some of the imaging shortfalls that are in radiology.

In terms of imaging and radiography HIEW have been increasing healthcare scientists year on year to come to undertake additional roles which will assist them in both the diagnosis and the performance of radiological procedures and if necessary, the reporting of them. So, there's a fair amount of work going on in these areas, and PM states that it's important that that we develop this alongside the Imaging Academy which has the ability to train other professionals apart from radiologists.

PM listed his key messages:

- Our future plans have to integrate digital and technological advances
- Retention needs as much of a focus as recruitment and educations
- Multi professional team-based models are key to the solution in common with many other clinical services
- Multi professional working requires strong clinical and executive leadership to address the barriers
- Planning to embed workforce and service pathway models simultaneously
- Palliative care progress framework and successions planning/ ongoing development and resource availability
- Need to maximise the benefit of rolling out good practice and eliminating variations in terms of workforce opportunities
- Need to ensure culture and behaviour doesn't affect opportunity to evolve

- 3-year funding from SCP to HEIW to support agreed Cancer site pathway

3. Presentation by Dr Toby Wells, Royal College of Radiologists

The Chair introduced Dr Toby Wells (TW).

TW shared a graph showing the backlogs post COVID, measured by times to scan not report. The graph shows the prior to COVID, waiting times were under control and not many people were waiting more than eight weeks for anything. However, when the pandemic started, waiting times increased and are gradually getting back t pre-COVID levels, but are nowhere near baseline yet. This is the same for MRI and CT. Ultrasound position is worse. TW states that interestingly it varies quite a lot with different health boards. Some health boards have caught up and sound better than others. One positive of COVID is that we have got better at sharing or figures and producing.

TW stated that part of the problem is the radiology workforce and the Royal College of Radiologists (RCR) attains census information every year. This census showed the impact of the pandemic and that 48% of radiologists across the UK are now planning on cutting their hours and working less.

The RCR census in Wales showed that more clinical radiology consultants are working less than full time which is compounding the challenges faced. Many vacancies remain unfilled, and in North and West Wales four-in-five vacancies have ben unfilled for over a year. Across Wales, the number of interventional radiologists has declined over the past five years. Expenditure on insourcing, outsourcing and ad hoc locums has tripled in the last five years to £8 million in 2020 as demand for reporting continues to increase at a pace that outstrips workforce growth.

TW listed some solutions to the challenges facing the workforce including admin support / software to arrange scans and distribute reports, machines to perform the scans, radiographers to operate the machines and radiologists to interpret the scans.

TW outlined his key messages:

- Covid catch up has highlighted the importance of radiology. Changes to pathways (eg straight to scan) during COVID have improved efficiency and eased pressures on other departments but increased pressure on radiology. Delays to surgery often mean patients have to be rescanned pre op.
- Resulted in welcome investment in replacements scanners and radiology trainee numbers

- Need to recurrent investment to expand radiographers and radiologists' numbers, expand equipment, and in informatics systems to maximise efficiency.
- Workforce generally positive but tired (and less willing to do extra work even for extra pay and asking to drop work).

3. Presentation by Karen Howarth, Hywel Dda University Health Board.

The Chair welcomed Karen Howarth (KH).

KH outlined the role of a cancer Clinical Nurse Specialist, which includes supporting patients through the diagnostic pathway, explaining their diagnosis and treatment plans, and sign posting them to services. Once cancer CNS's have assessed their psychological, social and spiritual needs, they prepare patients for life after treatment, whether it is curative or palliative. Cancer CNS's also prevent admissions to hospital and extra GP calls appointments by providing expert advice and support. They are their advocate they see patients at their most vulnerable and walk them through their journey and hopefully make it a good experience.

KH explained that when COVID hit, as staff they started streamlining the pathway when other services stopped. Some patients ended up having their diagnosis over the telephone to prevent them coming back into hospital. Follow up cancer clinics stopped until they could re commence them safely so they started using anything they could to keep in touch with patients. This involved using personal mobile phones to WhatsApp, using FaceTime just to reassure them that that they were there and that they weren't forgotten. CNS's had to stop touching patients and holding their hand or giving them a hug when they're upset, which is the antithesis of what they do. When patients were having life changing surgery and were not allowed to have any visitors, CNS's became their lifeline. Some of KH's colleagues were re-deployed to other ward areas, leaving the CNS teams really short.

KH outlined that CNS's are exhausted, tired, burnt out, stressed, daunted and anxious about the future and what is to come. They are seeing bigger cancers coming through, and the volume is increasing, and patients haven't been able to access, or have been too scared to seek medical attention. KH thinks a lot of CNS's feel a bit devalued as well, because colleagues were redeployed to other areas and it just reaffirmed that's the CNS role is not understood or valued by some people. A lot of KH's colleagues are due to retire next year and are not planning to return as they previously would have because of what's happened with COVID.

KH stated that for the future, there is a need to invest in the CNS workforce and this applies across the NHS workforce too. The population is growing and aging and we

one in two people develop cancer in their lifetime. However, the number of CNS investment is not increasing. A lot of CNS's are set to retire in the next three years, which will leave a huge deficit in the workforce. And if we do not invest in succession plan now, it will have a big impact on their work. There is a need for a structured career path for cancer nurses. Historically, CNS posts were taken up by staff nurses who had been in the speciality for a long time, or ward sisters and staff nurses who wanted escape from ward areas.

Cancer nursing has changed dramatically. Therapies have progressed and patient needs have evolved, and we need to fully understand these principles so that cancer nursing can excel.

KH feels that clinical supervision should be available to all cancer workforce and promoted as an essential component, not just something that you take up when you can no longer cope. It will hopefully build resilience into the workforce as well. CNS's only last up to about 10 years in the role. And if we give them the tools, hopefully we can increase that and making more substantive sustainable workforce.

4. Presentation by Dr Martin Rolles, South Wales West Cancer Centre, Chair of WCN Clinical Reference Group

The Chair introduced Dr Martin Rolles (MR).

MR explained that when we talk about the cancer workforce, we just think about that cancer pathway, or rather the cancer ecosystem. So, it's not just consultants in cancer centres. This is a quite complex pathway that patients follow, and the cancer workforce are the professionals of all specialties who work at any part of this complex and sometimes fragile pathway. This includes public health, GPS, nursing staff and the allied health professionals that work in primary care. The same applies to secondary care, and as TW said, diagnostics is critical. The point is that if one part of this doesn't work, so if we're fragile in one part of the workforce, the rest of it does not work efficiently. So, it's all very well investing in hospitals, but if we haven't got diagnostics or we haven't got good primary care, or if public health isn't working then the rest of it loses value and it's wasted money on wasted resource and worse patient outcomes.

MR stated that this pathway, or this ecosystem, has been profoundly disrupted in lots of obvious and more subtle ways, and it's going to take years to work our way out of it. The point here is that cancer is just shrugs - it doesn't care. So, cancer in Wales just carries on regardless. So, whilst we become much less efficient in some ways, and while we're suffering in terms of staffing and the way hospitals work, the cancer keeps going. This means harms are building up in the community and a lot of what

we've been trying to do over the last two years is to minimize the problems, but this is very difficult.

MR outlined that one of the problems in terms of the cancer workforce and sustainability is the fact that the amount of work is increasing continuously and there are several reasons for this. Firstly, we've got an aging population and cancer is primarily a disease of middle and later years and as the population naturally gets older, the amount of cancer rises. We also know that Wales has proportionately more elderly people than most parts of the rest of the UK. So, we just naturally generate more cancer by virtue of the age of the population. The second point is that treatments are getting better, so we've got more cancer survivors who need who need aftercare survivorship support. The treatments are more complex, so we require more specialization that means more people to actually to see less patients because.

MR stated that you can't just purchase an expert team off the shelf, they take years to develop. We know that in the whole of the UK we are short of oncologists and the same applies to expert specialists, both in the medical and non-medical side of for cancer workforce. We need nearly 200 to fill a combination of current vacancies and projected demand. And we're not training enough new oncologist so that we don't get enough trainees graduating to consultant levels at every year to fill the vacancies. We have to think strategically in long term.

MR summarised how Wales can get a sustainable cancer workforce by:

- Realism and pragmatism
    - Expert HR cannot simply be purchased
- Take a strategic approach
    - Decades, ongoing
    - Development of teams, not just individuals
    - The Non-Surgical Oncology Workforce Project
- Invest in training in Wales
    - Hard to recruit from outside
    - Most Welsh trainees stay in Wales
- Skill-mix
    - Traditional job boundaries may be unnecessary and limiting
    - Physician Associates
- IT
- Data

6. Panellist Discussion

The group discussed the importance of specialist nurses and allied health professionals and how they are absolutely critical to the patient experience. It was highlighted that there has been a danger in the past of looking to those specialties to undertake non-medical roles rather than true patients support. The group discussed the need for a comprehensive workforce plan for cancer in a format that is transparent that we can inform that we can challenge. The group discussed more creative approaches to work patterns, and whether health boards are accommodating more flexibility. The group discussed the decisions being made now to ensure the workforce is ready for innovations that come in the future.

Close

The Chair thanked all speakers and participants for their contribution.

Meeting closed 15:30

Attendees

1. Alaw Davies (CRUK)
2. Pushpinder Mangat (HEIW)
3. Tracey Burke
4. Sarah Clark
5. David Rees MS
6. Karen Howarth (Hywel Dda UHB)
7. Katie Till (CRUK)
8. Dawn Casey (CTM UHB – Patient Care and Safety)
9. Toby Wells (Swansea Bay UHB)
10. Kate Roberts
11. Benji Williams (CTM UHB)
12. Martin Rolles (Swansea Bay UHB)
13. Thomas Davies (Macmillan)
14. Mike Hedges MS
15. Andy Glyde (CRUK)
16. Greg Pycroft (Cancer Research Wakes)
17. Joe Kirwin
18. Georgina Smerald
19. Madeline Phillips
20. Ryland Doyle (Staff Cymorth yr Aelod | Member Support Staff)
21. Sara Bale
22. Joanne Ferris
23. Lisa Williams (Cardiff and Vale UHB)
24. Louise Carrington (NHS Wales Health Collaborative)

25. Lizzie Ellis
26. Lee Gonzalez (Staff Cymorth yr Aelod | Member Support Staff)
27. Bethan Hawkes (NHS Wales Health Collaborative)
28. Mandy Edwards (Aneurin Bevan UHB)
29. Jayne Caparros (Swansea Bay UHB)
30. Brain Forbes
31. Anthony Davies (HSS -DPH – Population Healthcare)
32. Hannah Edwards-Jones (NHS Wales Health Collaborative)
33. Peter Henley (Cancer Research Wales)
34. Joseph Woolcott
35. Sikha de Souza (Public Health Wales)
36. Tom Crosby
37. Sian Lewis (CTM UHB)
38. Jacqueline Pottle (BCUHB)
39. Lowri Griffiths
40. Chris Rowland
41. Kate Baker (Interim Macmillan Head of Therapies)
42. Annette Beasley (Cardiff and Vale UHB)