# Wales Cancer Alliance Consensus Paper
# A Workforce Strategy that Delivers for Cancer
# March 2023

## The Wales Cancer Alliance

Around 20,000 people are diagnosed with cancer in Wales every year.[1] While survival has improved and just over half of people survive their cancer for 10 years or more,[2] Wales lags behind other comparable countries for breast, colorectal, lung and ovarian cancers,[3] and every year around 9000 people die from cancer.[4]

The Wales Cancer Alliance consists of 27 third sector organisations working across different tumour sites, and specialities, and representing the entire cancer pathway. We promote the best cancer prevention, treatment, research and care for people in Wales. Every year we raise funds and invest in Wales, contributing to the development of national strategies and policies that make a difference to people affected by cancer.

We believe that people affected by cancer should be at the heart of co-creating new services and cancer policy. The third sector has an important role to play in developing, reshaping, and delivering improvements in cancer care. We work in partnership and collaborate with the Welsh Government, the NHS, local government, and other stakeholders.

## Delivering for cancer patients

The workforce are critical to tackling the significant cancer challenges faced across Wales - they deliver treatment and care for hundreds of thousands of Welsh patients each year. Yet our clinicians and non-medical workforce are exhausted, with many reassessing their career decisions or leaving altogether. Succession planning is not robustly meeting the subsequent shortfall, nor addressing the clinical experience gap needed to deliver the increasingly nuanced care that is required with increasingly frail patients - many of whom present with several comorbidities.

Progress has been made in some areas over recent years. The Alliance welcomed the establishment of Health Education and Improvement Wales (HEIW) in 2018, and the organisation's strategy - produced in partnership with Social Care Wales - is clear in its ambition for a health and care workforce that is skilled, motivated, and supported by improved recruitment and retention.

These are welcome first steps, but much more needs to be done if we are going to build on these foundations to deliver the radical change needed to transform our NHS. The Alliance has agreed on the following key recommendations for the cancer workforce going forwards:

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[1] Based on WCISU registry cancer incidence data (2022)
https://phw.nhs.wales/services-and-teams/welsh-cancer-intelligence-and-surveillance-unit-wcisu/cancer-incidence-in-wales-2002-2019/
[2] Overview of cancer in Wales, Cancer Research UK (2018)
https://www.cancerresearchuk.org/sites/default/files/wales_profile_2018_english_v3.pdf
[3] Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data
[4] Based on WCISU registry cancer mortality data (2022)
https://phw.nhs.wales/services-and-teams/welsh-cancer-intelligence-and-surveillance-unit-wcisu/cancer-mortality-in-wales-2002-2021/

**Recommendation 1:** HEIW should develop a dedicated cancer workforce plan, covering the entirety of the cancer pathway and providing detailed measures on how our workforce can be supported to deliver for people living with cancer in Wales.

**Recommendation 2:** The Welsh Government should publish a regular audit of the cancer workforce in Wales and supporting future cancer workforce planning through the identification of gaps and better informed forecasting models for the next 5/10/15 years.

**Recommendation 3**: Public Health Wales must ensure that there is a robust, funded health promotion workforce plan, integrated across Health Boards and other services. Delivering effective interventions such as smoking cessation, the National Exercise Referral Scheme and alcohol and addiction recovery services.

**Recommendation 4**: HEIW must ensure that Make Every Contact Count training is incorporated across all workforce training plans to ensure that all relevant colleagues are supported to be able to provide challenging interventions when opportunities for behaviour change conversations arise.

**Recommendation 5:** NHS cancer and the cancer research leadership need to work with health board R&D Directors, cancer leads and research clinicians to understand the barriers and incentives to becoming a cancer research specialist beyond Cardiff and Swansea, galvanising and spreading the benefits of cancer research across Wales.

**Recommendation 6:** HEIW, the WCRC and Wales Cancer Network to consider the training and support needs of healthcare professionals in non-research roles, for instance CNS' to be aware of research opportunities for their patients, such as clinical trials.

**Recommendation 7:** That HEIW prioritise the diagnostic workforce. Only by diagnosing more people in the early stages can we make the biggest impact on cancer mortality. It is vital that HEIW support the implementation of the recommendations made by the Health Committee Inquiry into Endoscopy Services in Wales.

**Recommendation 8:** That HEIW supports succession planning for Cancer Nurse Specialists as they are pivotal in supporting patients through the cancer pathway.

**Recommendation 9:** That HEIW tackle succession planning and review the Cancer CNS career path to ensure that it is made more attractive as an incentive for new nurses looking to join the workforce, and that opportunities for career progression and entry into specialisms are promoted to current nurses, with time made available to enable them to have the relevant training.

**Recommendation 10**: Job planning for skill mix should be optimised as a matter of best practice. For example, by introducing band four support workers into the workforce, senior nursing colleagues will be freed up to better support people with increasing complex health issues, delivering a higher standard of care and ultimately better outcomes for people affected by cancer. Other skill mix opportunities will be also available to assist with other workforce challenges.

**Recommendation 11**: Due to the specialist nature and the psychosocial impact of cancer on children and young people, it is essential that they receive age-appropriate specialist support. It is vital that HEIW support the development of an effective paediatric and young adult cancer

workforce and ensure that specialist toolkits to support earlier diagnosis are used as a training resource for healthcare professionals.

**Recommendation 12**: To ensure that the existing workforce is trained to deliver complex palliative care interventions and to review whether there is capacity in existing roles to be able to deliver the level of care that is required.

**Recommendation 13:** NHS Wales to identify and champion innovative best practice and technologies to save clinician time and improve efficiency, including proven AI technology.

**Recommendation 14:** The Welsh Government and UK Government to prioritise the wellbeing of the health and social care workforce and work together to identify sustainable, funded solutions to the current challenges.

## The NHS workforce challenge

The COVID-19 pandemic has placed the NHS in Wales under unprecedented pressure. Waiting lists across all specialities have grown dramatically, ambulance waits are at unprecedented levels, and large sections of the health and care workforce are facing exhaustion.

Although during the early part of the pandemic, many people put off contacting their GP with potential cancer symptoms, since March 2021 the number of people being referred each month with a suspicion of cancer has returned to pre-pandemic levels or higher. This is resulting in significant pressure on cancer services, particularly in diagnostics where we are seeing the longest waits. January 2022 saw record-low performance of just 53% of patients starting treatment within 62 days of cancer first being suspected. While we recognise the huge impact and disruption that coronavirus has caused, cancer services were already under significant pressure. The Welsh Government target that 75% of people should start their treatment within 62 days has not been met in the three years since the introduction of the Suspected Cancer Pathway.

Our workforce are key to overcoming the challenges faced by cancer services across the Welsh NHS - they are the backbone to delivering treatment and care for hundreds of thousands of Welsh patients each year.

Progress has been made in some areas over recent years. We welcomed the establishment of Health Education and Improvement Wales (HEIW) in 2018, and the organisation's strategy - produced in partnership with Social Care Wales - is clear in its ambition for a health and care workforce that is skilled, motivated, and supported by improved recruitment and retention. Their recent "Strategic Mental Health Workforce Plan for Health and Social Care"[5] sets a welcome precedent for adopting a more strategic and condition specific approach to addressing workforce planning, addressing immediate challenges but with an eye on planning the workforce Wales needs in the future.

These are welcome steps, but much more needs to be done if we are going to build on these foundations to deliver the radical change needed to transform our NHS. While the soon to be published National Workforce Implementation Plan for NHS Wales responds to national workforce challenges and pressures, more needs to be done to focus upon and meet the pressing needs of the cancer workforce. This would be a piece of work the third sector collectively engages with and supports.

We have agreed on the following key recommendations for the cancer workforce going forwards:

> **Recommendation 1:** HEIW should develop a dedicated cancer workforce plan, covering the entirety of the cancer pathway and providing detailed measures on how our workforce can be supported to deliver for people living with cancer in Wales.
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> **Recommendation 2:** The Welsh Government should publish a regular audit of the cancer workforce in Wales and supporting future cancer workforce planning through the identification of gaps and better informed forecasting models for the next 5/10/15 years.

[5] HEIW and Social Care Wales (2022) "Strategic Mental Health Workforce Plan for Health and Social Care" https://heiw.nhs.wales/about-us/key-documents/strategic-mental-health-workforce-plan/

## Our Cancer Workforce Across the Cancer Pathway

## Our health promotion workforce

Staff working in health services and other partner organisations must be able to provide swift interventions to address some of the cancer behavioural risk factors.

The Public Health Wales Strategic Plan for 2022-25[6] focuses on 'promoting healthy behaviours' within its strategic aim one and contains actions to reduce smoking prevalence, increase physical activity, promote healthy weight, and prevent harm from substance use. These activities will help prevent some cancers as well as other conditions such as heart disease, stroke, respiratory disease, and dementia. As an Alliance, we welcome and support this focus.

The Making Every Contact Count (MECC) programme aims to empower staff working in health services, and other partner organisations, to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of cancer and other chronic diseases. We welcome the intention to recommence the programme during 2022.

Messaging and interventions around prevention and health promotion, no matter how challenging, can and should be delivered by a wide range of stakeholders. Allied workforces, such as pharmacists, dentists, social workers, health visitors, and those who sit in other sectors such as social care and housing, should be equipped through MECC to deliver frontline messages highlighting risk factors for cancer and encouraging healthier choices.

> **Recommendation 3**: Public Health Wales must ensure that there is a robust, funded health promotion workforce plan, integrated across Health Boards and other services. Delivering effective interventions such as smoking cessation, the National Exercise Referral Scheme and alcohol and addiction recovery services.
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> **Recommendation 4**: HEIW must ensure that Make Every Contact Count training is incorporated across all workforce training plans to ensure that all relevant colleagues are supported to be able to provide challenging interventions when opportunities for behaviour change conversations arise.

## Our cancer research workforce

Many studies demonstrate that research intensive healthcare settings, with research established as a core component of their service delivery, demonstrate better patient outcomes - even for patients not taking part in clinical trials. The Quality Statement for Cancer indirectly reflects this through two of its quality attributes:

- That a quality cancer service is one in which all eligible patients are offered access to research trials and excellent supporting infrastructure for cancer research (quality attribute 11), and.
- That clinicians are enabled to take part in research activity (quality attribute 15)[7].

As a small nation with its own devolved health system, Wales offers a unique opportunity for cancer research and clinical trials as an attractive location for research activities. A comparatively small,

[6] Public Health Wales (2022) Our Strategic Plan 2022 - 2025 https://phw.nhs.wales/about-us/our-priorities/long-term-strategy-documents/public-health-wales-strategic-plan-2022-25/

[7] Welsh Government (2021)The Quality Statement for Cancer https://gov.wales/quality-statement-cancer-html

geographically concentrated cohort of cancer research clinicians and nurses strive to operate within the constraints of limited resources, staff shortages and targets, amongst many other operational pressures. For instance, the COVID-19 pandemic led to clinical trials being paused or stopped due to the redeployment of staff and resources to respond to the pandemic. Recovery of cancer clinical trial activity to pre-pandemic levels has only occurred within Cardiff and Vale UHB - elsewhere it is struggling.

However, the pandemic did galvanise researchers not only across the UK but the world to innovate and develop even faster. People across the world have also witnessed first-hand the power of research in managing COVID-19 and the impact this has had in saving lives.

We live in an innovating age: multiple opportunities exist for world-class Welsh cancer research to improve patient waiting times, develop and trial new treatments, optimise the delivery of healthcare, and streamline operations. This activity depends upon a skilled, motivated workforce capable of managing and administering the complexities of cancer research embedded within the NHS. Unfortunately, funding for NHS Wales research and development has not increased since 2009, complicating efforts to increase access and improve the infrastructure of cancer clinical trials.

Additional funding aside, we believe urgent action must take place to recover clinical trials activity across Wales to pre-pandemic levels, ensuring that cancer research nurses are deployed back into their original roles and making clinical trials more viable.

We also believe that to achieve the relevant quality attributes within the cancer quality statement, HEIW, the Wales Cancer Research Centre (the WCRC) and the Wales Cancer Network need to work with health board R&D directors, cancer leads and research clinicians to understand the barriers and incentives to becoming a cancer research specialist beyond Cardiff and Swansea. The findings of this work would contribute to and inform further activity including the implementation of the Wales Cancer Research Strategy (CReSt).

Provision also needs to be made to understand and address the needs of our genetic workforce, given its growing inter-relationship with the cancer pathway. As our understanding of genetics increases, it is possible to identify more people with a higher genetic risk of developing certain types of cancer (including bowel, breast and ovarian). Once identified, it is vital that people are put onto robust surveillance programmes or are offered preventative treatment or surgery. By ensuring we are delivering the best possible genetic screening for high-risk patients we place an additional burden on our overstretched services.

> **Recommendation 5:** NHS cancer and the cancer research leadership need to work with health board R&D Directors, cancer leads and research clinicians to understand the barriers and incentives to becoming a cancer research specialist beyond Cardiff and Swansea, galvanising and spreading the benefits of cancer research across Wales.
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> **Recommendation 6:** HEIW, the WCRC and Wales Cancer Network to consider the training and support needs of healthcare professionals in non-research roles, for instance CNS' to be aware of research opportunities for their patients, such as clinical trials.

## Our cancer screening workforce

The role of the adult cancer screening programmes is to detect breast, bowel, and cervical cancer early, all face workforce challenges.

In breast screening, 23% of the breast clinical radiology workforce in Wales is forecast to retire within 5 years (according to the latest Royal College of Radiologists census). There's also a lack of recent data on mammographers in Wales. While gaps in data are not unique to Wales, it's also the case in England, it needs addressing and scrutinising.

In cervical screening, the colposcopy workforce is ageing with vacancies in many health boards. Ensuring the colposcopy service is staffed and trained is essential for this preventative measure, especially ensuring those living in remote areas can access such services. Numbers attending colposcopy are also anticipated to rise because of HPV primary screening and this must be accounted for.

In bowel cancer screening, the introduction of the easier-to-use faecal immunochemical testing (FIT) in 2019 has improved uptake - this is welcome news. Since 2021, the starting age for bowel cancer screening has lowered to 58 as

The Senedd's Health Committee held an inquiry in 2019 into Endoscopy Services in Wales and the impact on introducing the new Faecal Immunochemical Test (FIT) into the screening programme. FIT represents an opportunity to diagnose more bowel cancers at an earlier stage and even prevent bowel cancer through the removal of precancerous polyps. This can be done through the ability to set a sensitivity threshold, above which patients are referred for a colonoscopy.

However, as FIT is being introduced in Wales, with full roll out expected by the end of the summer 2019, this threshold is being set at 150ug of haemoglobin per gram of faeces. This decision was taken to manage demand on endoscopy services rather than on clinical benefit. Furthermore, Wales has the highest threshold (i.e., the least sensitive) of the UK nations to introduce FIT. While there is a target to optimise bowel screening by reducing the sensitivity threshold to 80ug, as well as reduce the starting age for participation from 60 to 50 as per UK National Screening Committee recommendations by April 2023, this is reliant on increasing endoscopy capacity.

In April 2019, the Health Committee reported on the challenges in the current NHS Wales endoscopy workforce and called for swift action to put in place plans to increase endoscopy capacity by October 2019[8]. Activity in this area is due to be reviewed by the Health Committee during its short follow-up inquiry in late 2022[9]. Until we address this challenge, we will continue to deliver a suboptimal bowel screening programme.

## Our primary care workforce

Shortages in primary care have been widely documented. This includes closures of practices as well shortages of GPs and practice nurses. There are around 18 million primary care contacts in Wales each year. In 2008, the number of GP practitioners in Wales (excluding retainers and registrars) was 1,940. By June 2022, this number increased slightly to 1,982 servicing an ageing population with increasing medical and care needs.[10]

Both GPs, practice nurses and other community-based colleagues are ideally placed to deliver a wide range of cancer prevention interventions as well as ensuring adherence to latest NICE guidance in relation to referral. Primary care is the main route to diagnosis and once diagnosed, it is the primary care workforce that are increasingly supporting patients in the community as they live with cancer as a chronic condition or are left with the consequences of treatment.

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[8]Senedd Cymru, Health and Social Care Committee (2019) Endoscopy Services in Wales, April 2019
[9] Senedd Cymru, Health and Social care Committee (2022) Endoscopy services: follow up inquiry https://business.senedd.wales/mgIssueHistoryHome.aspx?IId=40224
[10] Welsh Government (2022) General practice workforce: as at 30 June 2022 https://gov.wales/general-practice-workforce-30-june-2022

Early anonymous survey work by the Cancer Research Wales funded Wales Interventions and Cancer Knowledge about Early Diagnosis (WICKED) uncovered concerns regarding the uneven application across Wales of NICE Early Diagnosis of Cancer Guidance 12 (NG12). It is likely that, as with all guidance, awareness and implementation by individual clinicians will be variable.

The consistent application of NG12 by GPs would result in patients across Wales receiving evidence-based investigations and referrals for suspected cancer, resulting in earlier diagnosis of cancer, and improving outcomes. The need to increase awareness and understanding of NG12 has contributed to the development of the *ThinkCancer!* primary care workforce intervention[11]. Currently at the trial stage, *ThinkCancer! has* been well received by participants and adapted its delivery model to be delivered online to primary care practices.

Alongside investing in sufficient numbers of GPs and practice nurses, it is also vital we ensure GPs have the training and support needed to refer patients on when they present with symptoms that could indicate a cancer diagnosis. The 2016 Wales Cancer Patient Experience Survey found that more than one in six (17%) of those patients who visit their GP prior to diagnosis, visit three times or more before being referred for diagnostic tests.[12] It is vital we continue to invest in continuous professional development training in cancer and decision support tools to ensure all GPs have the tools they need to identify possible cancer symptoms.

Training and support around non-specific symptoms, that could indicate a cancer diagnosis is also important since non-specific symptoms often occur with metastatic cancers such as secondary breast cancer.

Other changes can also be made to support the primary care workforce to refer patients with any type of suspected cancer, for instance, ensuring patient referral pathways can accommodate a range of symptoms i.e., nonspecific symptoms; investing in IT software that can alert GPs to potential symptoms when there is a history of cancer, and the adding the symptoms of secondary cancers to treatment summaries of previous cancers that are shared with GPs.

## Our cancer diagnostic workforce

It is well recognised that diagnosing cancers at an earlier stage, when they are more treatable, improves survival. For the 8 most common cancer types combined, survival is more than 3 times higher for those diagnosed at an early stage compared to a late stage.[13] In Wales, early diagnosis is a mixed picture. Around 85% of breast cancers are diagnosed at Stage 1 or 2, while this drops to 42% for bowel cancer, and just 28% for lung cancer.[14]

Wales lags many other countries in terms of cancer outcomes. Diagnosing more cancers earlier will require more and varied cancer tests. However, demand on diagnostic services is already set to increase as cancer incidence rises, due in part to an ageing population. It is essential that there is sufficient capacity in Welsh diagnostic services, and workforce is a key component of this.

It is important to positively recognise that throughout the pandemic, into this recovery “phase”[15] the Welsh Government and NHS Wales prioritised the earlier diagnosis of cancer. Recent years have seen the introduction and standardisation of the Suspected Cancer Pathway and the development and roll-out of a vague cancer symptom pathway that utilises rapid diagnostic clinics across Wales.

[11] https://www.medrxiv.org/content/10.1101/2020.11.20.20235614v1.full.pdf
[12] Wales Cancer Patient Experience Survey 2016.
[13]Based on data calculated in England. Public Health England demonstrated that, for the 8 most common cancers combined, when diagnosed at an early stage (I and II) survival was 81%, falling to 26% when diagnosed at later stages (III and IV)
[14] Wales Cancer Intelligence and Surveillance Unit (2015), Cancer Incidence by Stage at Diagnosis in Wales 2015.
[15] Welsh Government (2022) Our programme for transforming and modernising planned care and reducing waiting lists in Wales

However, such measures - and the initiatives that are desperately needed to reduce historically poor cancer waiting times are at risk of not being able to achieve their potential if gaps in the workforce restrict overall diagnostic capacity.

While data on the diagnostic workforce is patchy, we are aware of significant gaps across Wales, including:

- Wales has one of the worst shortages of radiologists in the UK, with the situation being described as “alarming” and 30% of consultants expected to retire by 2021.[16]
- In addition, England is expanding to around 40 lung health check programmes, which will absorb a significant amount of this workforce and leave less to deal with other work.
- Radiography – there is an overall vacancy rate of 9%, rising to 36% for band 4 radiographers.[17]
- Endoscopy – approximately 1 in 10 nurse endoscopy posts are vacant.[18]
- Cellular pathology – just under 30% of consultant histopathologist posts are vacant, while 36% of the consultant workforce are expected to retire in the next 5 years.

These gaps are already having a significant impact on diagnostic capacity and on people affected by cancer. One such example is the introduction of the new faecal immunochemical test (FIT) in the bowel screening programme. (See screening section above)

As well as establishing the National Endoscopy Programme, the Welsh Government launched the Imaging Academy in February 2019, with £3.4m investment. Such an innovative training approach could see 20 radiologists trained each year although only 13 places have been filled for this year. It is important that the Academy operates at full capacity and involves other imaging specialists to have the greatest effect on reducing workforce gaps in the medium to long-term.

In addition, safe and effective high-quality pathology services are dependent on having the right number of staff to deliver services. Demand for pathology services has grown significantly in recent years and if we are able to deliver prompt diagnosis and insight into tumour pathology to help inform treatment decisions.

Histopathology shortages across the UK have been widely identified and, as outlined above some Health Boards face significant challenges in recruiting an ageing workforce. The Royal College of Pathology Wales Regional Council Workforce Report for Histopathology highlights the fact that 26% of consultant posts are vacant. There is a need for ongoing redesign of the service with more funded training.

Such gaps in the diagnostic workforce are not unique to Wales and similar challenges are faced by other UK nations. Hence, while increasing training places is important, new ways of working need to be introduced to increase diagnostic capacity. Adopting a national approach to skills mix means using existing staff more effectively. For example, non-medical endoscopists can perform some tests to free up consultant time.

Finally, while cancer places a large demand on diagnostic services, addressing workforce gaps will have benefits far beyond cancer, given the number of health conditions that require diagnostic

[16] Unless otherwise stated, data for clinical radiology taken from the latest RCR Clinical Radiology Workforce Census (2019) https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-report-2018.pdf

[17] Unless otherwise stated, data for clinical radiology taken from the latest RCR Clinical Radiology Workforce Census (2019) https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-report-2018.pdf

[18] Bowel Cancer UK (2018), written evidence to the Health, Social Care and Sport Committee Inquiry into Endoscopy Services http://www.senedd.assembly.wales/documents/s81222/Paper%201%20-%20Bowel%20Cancer%20UK.pdf

testing. It is critical that the diagnostic workforce is considered a priority for the forthcoming workforce strategy, led by HEIW and Social Care Wales.

> **Recommendation 7:** That HEIW prioritise the diagnostic workforce. Only by diagnosing more people in the early stages can we make the biggest impact on cancer mortality. It is vital that HEIW support the implementation of the recommendations made by the Health Committee Inquiry into Endoscopy Services in Wales.

## Our cancer treatment workforce

Once a patient receives a cancer diagnosis, they will begin a treatment plan that could involve any combination of surgery; chemotherapy; radiotherapy; immunotherapy; and other ongoing treatments. While a round of active treatment would in the past typically end following surgery, radiotherapy, or chemotherapy delivery, it can now extend until disease progression, placing additional pressures on both the immediate and wider cancer workforce. For example, there is both the administration of maintenance and immunotherapy treatments and regular checks for adverse events and disease progression. To deliver this requires a complex and well-defined workforce that works together to ensure that patients have timely access to the best available treatments, regardless of whether their care aims are curative or palliative.

Similarly, to the diagnostic workforce, the data on the treatment workforce is limited. Often, local health boards plan workforce needs based on available resource rather than on clinical and patient need. As such, vacancy rates do not always give the full picture of gaps in the treatment workforce across Wales.

Most recently, the Royal College of Radiologists warned that workforce shortages in clinical oncology risk patient experience and care. Only 3 new consultant posts joined NHS Wales between 2013 and 2018, representing the smallest increase across the UK, while 12% of posts in Wales are vacant.[19] This is against the backdrop of increasing cancer incidence.

Across the UK, 73% of respondents to a Cancer Research UK survey of the cancer treatments workforce identified staff shortages as a barrier to providing efficient cancer treatments and excellent patient experience.[20] This results in:

- Insufficient capacity to undertake clinical research
- Deteriorating patient experience
- Missed opportunities for service improvement
- Less frequent sharing of best practice with other cancer treatment providers
- Lack of capacity to build long-term plans
- Inefficient use of the workforce's skills and experience
- Decreased staff wellbeing and morale, and increased working hours

Furthermore, changes to the way we treat cancer in the future will require more staff to deliver world-class care. Some examples of such changes include:

1. Changes in treatments: the growth of hypofractionation, IMRT, SABR and proton beam therapy will affect the resources required to treat patients using radiotherapy.

[19] https://www.bbc.co.uk/news/uk-wales-47584063

[20] Cancer Research UK (2017), Full Team Ahead: Understanding the UK non-surgical cancer treatments workforce, https://www.cancerresearchuk.org/sites/default/files/full_team_ahead-full_report.pdf

2. Development of new technologies: new software will help automate some work. However, some new technology makes the treatment techniques more complex and time-consuming to plan.
3. Changes to treatment delivery: some treatments will be delivered through networks. This will affect where staff is needed and how they will be working within Wales.
4. Changes in the duration of treatment: treatment that might previously have been concluded within six to twelve months can now last for years.

In line with diagnostics services, taking a skills-mix approach to the treatment workforce can alleviate some of this pressure. Training advanced clinical practitioners and non-medical professionals to assist with tasks such as treatment reviews and planning would add capacity. However, it is important to note that consultants would require time to train such professionals, in addition to their existing workload. This focus on the need to provide adequate time for training supervision needs to be built into all aspects of workforce planning in the future.

## Our specialist nursing workforce

We know from previous iterations of the Wales Cancer Patient Experience Survey that having access to a Key Worker and a Clinical Nurse Specialist (CNS), is associated with better patient experience across the entire care pathway. In Wales, everyone with a cancer diagnosis should have a named Key Worker and the opportunity to have a supported conversation about meeting their needs.

The 2021 WCPES found that 89% of patients reported having access to a CNS, leaving one in ten patients without support. It also found further areas for improvement, with just 42% of patients offered the opportunity to discuss their needs as part of development of a care plan and only 68 % of patients reporting it as easy to contact their CNS.[21]

The 2016-2020 Cancer Delivery Plan for Wales recognised the difference that “key workers” can make to a patient’s care and that key workers are normally cancer clinical nurse specialists. The plan committed to ensuring that patients consistently have access to a key worker as a key element of recovery. The findings of the WCPES show the difference in access to a CNS makes, and the further work needed to ensure all patients can access a CNS together with the importance of ensuring CNSs are adequately resourced to provide the wrap-around care valued by patients.

Macmillan Cancer Support commissioned censuses of the cancer specialist nursing workforce in 2014 and 2017. Between 2014 and 2017, they found that the workforce increased from 184 to 250 WTE specialist cancer nurse roles - although these numbers are not directly comparable it suggests a positive trend. The proportion of these nurses over the age of 50 (and closer to retirement) also fell over this period from 53% to 42%. However, there were several areas where the proportion of nurses over the age of 50 was worryingly high - for instance 74% of breast and 50% of gynaecology specialist cancer nurses.

Research carried out by Macmillan in 2021 found around one in five (21%) of those diagnosed with cancer in Wales in the past five years reported lacking specialist cancer nursing support during their diagnosis or treatment. Around one in ten (11%) reported experiencing a potentially serious medical impact because of a lack of nursing support, such as ending up in A&E or being unclear about issues or side effects from medication. Macmillan estimates that an additional 166 specialist cancer nurses - an increase of 80% - will be needed by 2030 to deliver adequate care and support for the anticipated 230,000 people living with cancer by this time.

[21] Wales Cancer Patient Experience Survey 2016.

A matter of concern is the unequal access to CNSs across different cancer types, contributing to inequalities, poor cancer patient outcomes and poor experience. Insight gained by Breast Cancer Now demonstrates that secondary breast cancer patients are less likely to have access to a CNS, compared to an individual with primary breast cancer – despite secondary breast cancer patients being on lifelong treatment and often have extraordinarily complex emotional and supportive care needs.

A significant part of CNSs' time is taken up by administrative work. Band 4 navigator or support roles should be created to support CNSs in triaging and administrative responsibilities. This would include simple questions and requests, freeing up CNS time for the more complex work they have the specialist skills to deliver. This would ensure that limited resources are spent in the most impactful way possible.

> **Recommendation 8:** That HEIW supports succession planning for Cancer Nurse Specialists as they are pivotal in supporting patients through the cancer pathway.
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> **Recommendation 9:** That HEIW tackle succession planning and review the Cancer CNS career path to ensure that it is made more attractive as an incentive for new nurses looking to join the workforce, and that opportunities for career progression and entry into specialisms are promoted to current nurses, with time made available to enable them to have the relevant training.
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> **Recommendation 10**: Job planning for skill mix should be optimised as a matter of best practice. For example, by introducing band four support workers into the workforce, senior nursing colleagues will be freed up to better support people with increasing complex health issues, delivering a higher standard of care and ultimately better outcomes for people affected by cancer. Other skill mix opportunities will be also available to assist with other workforce challenges.

## Our paediatric and young adult cancer workforce

Around 235 0 to 24 year-olds are diagnosed with cancer in Wales each year, with many more on active treatment at any one time. Although survival rates are relatively high, around 80%, cancer remains the single largest cause of death from disease for this age group.

Because children and young people's cancer is rare, cancer treatment for this age group is specialised. Cancer services for children and young people focus expertise in age appropriate, specialist treatment centres across the UK and are supported by other services that are delivered closer to families' homes (shared care centres for children – 0 to15yrs and designated centres for teenagers and young adults (TYA) – 16yrs and over).

There is a network of specialist hospitals known as Principal Treatment Centres (PTC), for diagnosing and treating children's and TYA cancers across the UK.

Children will typically receive their cancer treatment at a PTC. In some cases, children may also receive some treatment at a local hospital. This is known as 'shared care'. TYA have more choice about where they receive treatment. They may receive treatment in a PTC, however if appropriate they may choose a hospital closer to home.

In Wales, we do not have designated TYA hospitals. The PTC for TYA patients in Mid and South Wales is in Cardiff & Vale UHB but does not sit in the Noah's Ark Children's Hospital for Wales

(Teenage Cancer Trust Unit). The PTC for TYA for North Wales is in Clatterbridge (not the children's hospital). The TYA Cancer standards in Wales state that teenagers under 18 should be treated in TYA PTC with proximity to the Children's Hospital for Wales, but those aged 18 or over get the choice

Children and TYA cancer services are operationally segregated, whilst allowing transition through both. This is illustrated and reinforced by the fact that childhood cancer services are WHSCC commissioned, while TYA cancer services are not. Consequently, the only TYA specialist staff outside of the PTC are completely 3rd sector funded.

The psychosocial impact of cancer on children and young people with cancer can be significant and to help with managing this it is crucial that they receive age-appropriate specialist support. With a need to support the unique needs of young cancer patients, there must be an effective paediatric and young adult cancer workforce.

A wide range of professionals will be involved in the diagnosis, treatment, and care of young cancer patients and their families – GPs are a key part of young cancer patients' experiences, and charities such as The Joshua Tree provides post treatment support for the child and wider family around coping with the future and other holistic needs.

Early cancer diagnosis is critical to ensure treatment starts as soon as possible and to give a child or young person the best chance from the start. Children and TYA are overrepresented in those cancer patients who are diagnosed through emergency admission. We know that children make up the highest proportion of cancer patients that are diagnosed through emergency admissions (though not what impact that has) and that many young people and parents have a poor experience of diagnosis. Young Lives Vs Cancer's *Best Chance from the Start* (UK wide) research report on experiences of diagnosis (2016)[22] found that:

- Over half of young people and almost half of parents visited their GP at least three times before their cancer diagnosis. Nearly half of young people felt their GP did not take their concerns seriously and a third of parents felt their GP did not take into account their knowledge of their child. Just over a third of young people and a quarter of parents felt that their GP did not have enough time to listen to them talk about their symptoms.

- A third of parents and just over half of young people felt their diagnosis was delayed. Of those, almost half felt that this perceived delay impacted on their prognosis. They also reported losing trust in their GP.

- Almost half of GPs polled said that lack of training opportunities is a barrier to identifying childhood cancer and more than half said discussions about specific cases with experts, such as paediatric specialists, would help them to identify the need to investigate whether a child or young person had cancer

Considering this, Young Lives Vs Cancer and Teenage Cancer Trust teamed up to create an e-learning module for healthcare professionals on the signs of cancer in children and young people. This was developed in partnership with the Royal College of GPs. We would like to see more support for the NHS workforce in recognising the signs of childhood and young adult cancer and knowing when to refer a suspected cancer.

[22] Young Lives Vs Cancer (2016) Best Chance from the Start
https://www.younglivesvscancer.org.uk/wp-content/uploads/2018/08/The-Best-Chance-from-the-Start-Report.pdf

**Recommendation 11**: Due to the specialist nature and the psychosocial impact of cancer on children and young people, it is essential that they receive age-appropriate specialist support. It is vital that HEIW support the development of an effective paediatric and young adult cancer workforce and ensure that specialist toolkits to support earlier diagnosis are used as a training resource for healthcare professionals.

## Our allied health professional workforce

A broad and varied team is needed to deliver the holistic, wraparound care that someone diagnosed with cancer needs. The allied workforce, including pharmacists, dentists, social workers, dieticians, health visitors, speech and language therapists, physiotherapists, occupational therapists, and others - including the social care and housing workforce - provide vital support. However currently, there is a lack of joined-up care being provided, so that the onus is on people with cancer to seek out the support they need at a time when they will likely be feeling incredibly overwhelmed.

Many people with cancer will experience distressing and debilitating symptoms, with which allied health professionals can provide a huge deal of support. For example, people with pancreatic cancer will typically experience significant nutritional and digestive symptoms with which a dietician can provide support, for example through providing advice and information on how best to take Pancreatic Enzyme Replacement Therapy (PERT).

Current shortages have shown that people are not getting this crucial support however, with fewer than 1 in 10 pancreatic cancer patients being referred to a dietician. We need to ensure that patients have the specialist support they need readily available to them, throughout their patient journey. If a person living with cancer has issues with speech, language, or problems swallowing because of their cancer or treatment, speech and language therapists can provide invaluable support.

## Our end of life care workforce

In developing a workforce strategy that is fit for purpose, it is critical that full account is taken of the projected increases in demand for end-of-life care in Wales. We know that the number of cancer diagnoses is rising, with an expected increase of 14% over the next ten years.[23]

Annual deaths are also projected to increase by 25 per cent over the next 20 years,[24] with people aged 85 and over likely to make up more than half of all deaths. Coupled with this, both adults and children are living longer with more complex needs and multi-morbidities, including cancer, requiring diverse expertise and skills from the caring workforce. To sustain current trends in preference for end of life care in the community it is estimated that community palliative care and care home capacity will need to double by 2040 to meet projected future demand.[25]

There is consensus in end of life care that the shortage of community nursing and social care support will only increase in the future and that steps must be taken to create more care capacity in the community, as well as increasing and solidifying support available for unpaid carers. This should include more clinical nurse specialists (in hospitals and communities), general district nurses, and a general increase in capacity in the social care workforce.[26]

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[23] GPone.wales.nhs.uk. (2019). GP-one | Rise in cancer numbers in Wales continues. [online] Available at: http://www.gpone.wales.nhs.uk/news/40274 [Accessed 6 Jun. 2019]

[24] Etkind, S.N., Bone, A.E., Gomes, B. et al. How many people will need palliative care in 2040? Past trends, future projections and implications for services. BMC Med 15, 102 (2017). https://doi.org/10.1186/s12916-017-0860-2

[25] Bone, Anna E. et al (2017) 'What is the impact of population ageing on the future provision of end-of-life care? Population-based projections of place of death' https://doi.org/10.1177/0269216317734435

[26] Marie Curie, Dying Well in Wales lecture series (2021) event-briefing-23-july-2021.pdf (mariecurie.org.uk)

We would also like to see an exploration of the extent to which cancer specialists need further training and support to enable them to better support complex care pathways for people with increasingly complex needs. A key element of this will be the capacity of cancer care professionals to support an individual in their Advance Care Planning.

Due to the rise in numbers of patients requiring end of life care, we would also like to see this, and other workforce strategies specifically address the question of whether current specialist palliative care capacity (both doctors and nurses) is sufficient to meet rising future needs.

> **Recommendation 12**: To ensure that the existing workforce is trained to deliver complex palliative care interventions and to review whether there is capacity in existing roles to be able to deliver the level of care that is required.

## Innovation to support the workforce

Demand for NHS services is currently high, and demand is likely to increase in the future driven, in part, by an ageing population. It is essential that we plan, develop, evaluate, and build on existing innovations and identify new ways to reduce clinician time and the need for use of specialists for some NHS work.

A recent example in Swansea Bay University Health Board demonstrated efficiencies using online group clinics, provided instead of individual face-to-face appointments. Where the same information is being given out to patients, group clinics provide the opportunity to avoid unnecessary trips to hospitals and save valuable clinician time.

Rapid diagnostic clinics; community diagnostic hubs; targeted forms of screening, such as lung health checks; surgical hubs, and artificial intelligence (AI) are all innovative ways to improve patient outcomes through improvements in technology and better management of demand, allowing clinicians to diagnose and treat cancer earlier.

There have been lots of clever advances in AI over recent years. For example, AI has reduced the misdiagnosis rate of precancerous polyps in colorectal cancer screening. Future AI could be used to find cancers on a mammogram or to review breast biopsies, identify people at higher risk of a condition from their medical notes and help staff to organise and deliver services more efficiently, perhaps by learning where and when clinics should be run and reduce overall pressure on workload.

There needs to be a forward look that identifies areas where the anticipated demand from other parts of the UK will mean that Wales is left behind.

> **Recommendation 13:** NHS Wales to identify and champion innovative best practice and technologies to save clinician time and improve efficiency, including proven AI technology.

## The wellbeing of our workforce

The pandemic and subsequent cost of living crisis has underlined the challenges facing the health and social care workforce. Having a healthy, motivated, supported and engaged workforce leads to better outcomes and experiences for service users.

The NHS Wales workforce is facing one of the most difficult times in its history, and we cannot thank them enough for all they have achieved over recent years. Local health boards across Wales

launched various wellbeing initiatives and support; this is a positive step to demonstrating the value of these key workers. Yet, staff across the system are feeling exhausted and fatigued from increasing demands on healthcare services, plus pay and conditions that are no longer rewarding.

Wales must find a way through this challenging environment; finding practical, sustainable ways of managing the workforce and future workload to tackle the NHS Wales backlog and ensure the wellbeing of the NHS workforce in the long-term.

> **Recommendation 14:** The Welsh Government and UK Government to prioritise the wellbeing of the health and social care workforce and work together to identify sustainable, funded solutions to the current challenges.

## Conclusion

In considering the development of an all-Wales workforce strategy for health, the Wales Cancer Alliance recognises the pressures under which the existing workforce is delivering. With unprecedented demand, it is not realistic, nor appropriate to keep investing more and more money to continue to deliver services as they have always been delivered. In training and employing more staff, consideration must be given to utilising existing staff more effectively.

By adopting skill mix approaches and remodelling services, the future for healthcare delivery in Wales should be viewed with cautious optimism. The NHS is a wonderful establishment, the commitment of our current workforce is not in question and as an Alliance, we view ourselves as a vital partner in championing our clinical community and supporting them to deliver the best possible care for cancer patients.

We see through the Wales Cancer Services Action Plan an opportunity to take a fresh approach to service delivery and we would expect HEIW's ambitions for a dynamic future NHS workforce to be front and centre.

For further information about the Wales Cancer Alliance or to get in touch, please visit our website: www.walescanceralliance.org

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