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Workforce Scoping and Mapping Report

North East London Cancer Alliance

August 2025

COMMERCIAL IN CONFIDENCE

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North East London Cancer Alliance - Foreword

North East London faces some of the most complex and urgent challenges in cancer care - driven by a diverse population, persistent health inequalities, and rising demand across the system. At the heart of meeting these challenges is our cancer workforce: the dedicated professionals who deliver care, support patients and families, and innovate to improve outcomes.

To better understand the current state of our cancer workforce and plan effectively for the future, we commissioned Health Dynamics to provide an impartial, independent view of workforce capacity, distribution, and needs across North East London. Their work has been informed by extensive engagement with stakeholders from across all disciplines—clinicians, nurses, allied health professionals, support staff, educators, commissioners, and voluntary sector partners. This collaborative approach ensures that the report reflects the lived experience, expertise, and priorities of those working within cancer services every day.

This Cancer Workforce Scoping and Mapping Report offers a comprehensive and evidence-based picture of our workforce today. It highlights strengths, identifies gaps, and uncovers opportunities for transformation. Crucially, it will serve as the foundation for a North East London Cancer Workforce Strategy—one that is inclusive, forward-looking, and responsive to the needs of our communities.

We invite all partners through this MS Forms link to engage with the findings, contribute to the strategy, and work together to shape a workforce that is skilled, sustainable, and ready to meet the challenges ahead.

Sarita Yaganti
Programme Lead - Personalised Cancer Care
North East London Cancer Alliance

I'm pleased to share the outputs of the first phase in developing a cancer workforce strategy for North East London, presented in this scoping and mapping report.

Over the past five months, Health Dynamics have undertaken intensive engagement, analysis, and research to produce a comprehensive overview of our cancer workforce. This report follows the journey of our workforce as they support people through one of life's most challenging experiences—from screening and diagnosis, through treatment and survivorship, to palliative and end-of-life care.

The report identifies key risks, opportunities, and impacts that shape how our workforce supports our cancer patients. A clear understanding of our current workforce, along with the challenges and opportunities they face, is essential to plan effectively for future needs in North East London.

In the next phase, we'll work closely with specific workforce groups experiencing particular challenges. Together, we'll co-design workforce plans to mitigate risks and build on emerging opportunities. In addition, we'll identify areas where we can have an immediate impact. This will culminate in the development of a full cancer workforce strategy - one that meets both current and future needs.

We recognise that this report captures a snapshot in time. The landscape is continually evolving, influenced by local, regional, and national initiatives - some of which are reflected in the report. We also anticipate further guidance from the NHS 10-Year Plan, and following Cancer Plan and Workforce Plan.

We invite you to continue engaging with us to help shape this strategy - starting with your input via this survey.

Yvonne Beadle
Programme Manager – Workforce
North East London Cancer Alliance

Executive Summary

North-East London Cancer Alliance to is intending to produce a Cancer Workforce Strategy by April 2026. This report brings to a close the first phase of this work - a comprehensive workforce scoping and mapping, identifying key challenges and workforce risks. The report identifies current workforce capacities, any known immediate future staffing changes, and establishes foundational benchmarks where available for the cancer workforce strategy. All major workforce risks articulated by key stakeholders are summarised. Current workforce projects will be included as mitigations against those risks, to enable the Alliance to understand the impact of current funding. A gap analysis against the remaining risks should enable NELCA to articulate its future workforce priorities.

It is anticipated that there will be two kinds of future workforce planning support required. Using the received Health Education England STAR framework, deep dives are needed in the areas where both service model and workforce model are challenged. Such deep dives should feed into a specific, strategic look at each main professional group, ensuring that future (5 Year) workforce planning is as sustainable as is possible within the current funding and labour market constraints. Deep dives take time, and the second level of workforce support will be less demanding in terms of stakeholder involvement – using other interventions such as hackathons and rapid pathway or service redesign to find solutions.

Between the different methodologies (outlined in more detail under NELCA Vision and Strategy Development) the intention is to identify 'the art of the possible' in workforce terms. The detailed timeframe for this subsequent phase is currently under discussion and will be agreed with the steering group by the close of this first phase. Wider stakeholder engagement to implement this second phase which will begin in May 2025. The intention is to make sufficient progress on resolving issues before creating an emerging longer-term workforce strategy which will inform the 2026-27 planning round. Please see Appendix 1 for more details of the overall strategic workforce programme's timelines.

Executive Summary (continued)

The report travels the journey to providing a comprehensive and systemic approach to workforce and therefore wider service delivery risks. After considering NELCA's Vision and Mission it considers the national policy frameworks, then moves to build up a picture of NELCAs challenges:

- Population Health
- Performance
- Analysis of the available workforce data and accompanying narrative from employing organisations
- National benchmarking of workforce groups against head of population
- Wider challenges faced by each professional group
- Specialty-specific service and workforce challenges
- Impact of current workforce projects

Risks have first been captured within specialties and professional groups, and then brought together thematically across workforce and service models. Key workforce shortages have been identified in Nursing, Oncology, Histopathology, Endoscopy, Radiology and Radiotherapy. Population Health challenges, performance challenges and recruitment and retention challenges have also all been logged.

The overall recommendations of this report are based on the level of risks articulated by key stakeholders plus the information gathered about performance and population health. The second phase of NELCA's workforce strategy programme is focussed on planning those system-level workforce planning or transformation interventions which will best reduce the overall workforce risks. Some initial conversations have been held to help initiate Phase 2 which are aimed both at identifying any recent progress on workforce plans, and on gaining more specific information to aid with prioritising Phase 2 workforce planning support.

Executive Summary (continued)

During the 2025-26 financial year, the focus will be on key improvement priorities. To prioritise areas for workforce interventions, the following criteria have been used:

- **Urgency: How urgent is the problem**?
  Is it impacting on current performance? Is it impacting on patient safety and care? Is there a work-around / mitigation in place? What is the risk if we do nothing?
- **Feasibility: Is it within our influence or outside our control? Can we make a difference?**
  Does it require a change somewhere else that we do not have the ability or capacity to impact or influence?
- **Alignment to population health:**
  Are the challenges specifically related to the demographics of our North East London population? Would we widen health inequalities, or not close the gap, if we do nothing?
- **Potential impact:**
  Is the return in terms of patient quality and system performance improvement commensurate with the scale of change, work and commitment required to achieve it?
- **Known supply issues:**
  Where there is already known issues in certain areas of the workforce, and potential solutions available, but the challenge is in local implementation.

Executive Summary (continued)

The most critical workforce risk is a national shortage of a specific skill or professional group. This means that even if funding is available, it is unlikely that NELCA employers can fill all their current vacancies, stretching those who hold substantive posts to the limit of their ability to deliver. All the recommendations of this report have been framed around these shortages. Longer-term workforce plans to address these shortages will be developed in Phase 2 – particularly in Nursing, Allied Health Professions and in those diagnostic professions which are experiencing national shortages and which do not currently have a plan. Each of these areas will require a deep dive or hackathon approach to involve stakeholders in identifying the 'art of the possible'. It is recommended that the Nursing and AHP deep dives take place before other deep dives, in the hope that these two deep dives may help resolve some of the issues relating to shortages of clinical and medical oncologists.

It is also recommended that this scoping and mapping document becomes a 'living document' capturing for the NELCA team any useful workforce or service information gathered that does not naturally fit into the outputs of deep dives or professional group workforce planning. This would entail a recommendation for updating the report each quarter during 2025-26, and setting up a shared website as a document and data repository. To this effect, we welcome and encourage readers to provide comment and feedback on the report, and ask that you provide this via this online form:

https://forms.healthdynamics.co.uk/Q3Wgyp

And finally, we're very cognisant of the changing NHS landscape and anticipating the release of the 10 year plan, the cancer plan and associated workforce plans. These will be considered as the programme progresses and implications included within the final development of a workforce strategy.

Setting the Scene

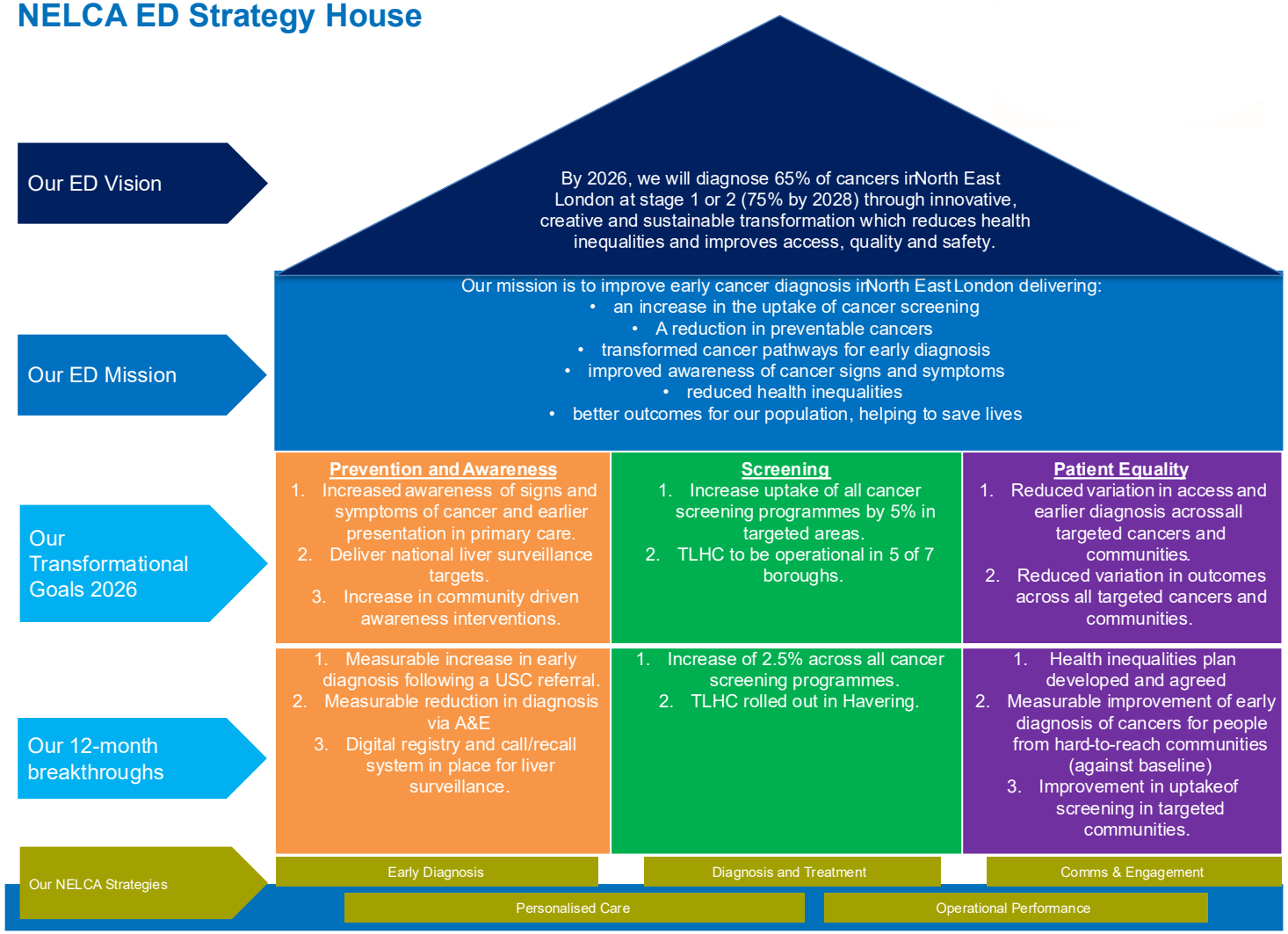
NELCA Vision and Mission

- North-East London Cancer Alliance (NELCA) articulates its vision in its most recent delivery plan[1]:
- **Vision: '***We are committed to improving cancer outcomes and reducing inequalities for local people. Our aim is that everyone has equal access to better cancer services so that we can help to:*
  - *Prevent cancer*
  - *Spot cancer sooner*
  - *Provide the right treatment at the right time*
  - *Support people and families affected by cancer'*
- **Mission:** *'We improve the outcomes and quality of life of people in north east London who are affected by cancer and diagnose patients sooner. Working as an effective team, we engage closely with our local communities and key stakeholders to transform cancer pathways and remove inequalities in access and outcomes for all residents of north east London'.*
- The delivery plan for 2024-25 is split into three main programmes of work – Prevention and Early Diagnosis, Diagnosis and Treatment, and Personalised Cancer Care. An overview of each is provided below.

[1] Our vision for the future: Delivery Plan for 2024-2025, NELCA, 2024

NELCA Prevention and Early Diagnosis Programme 24-25

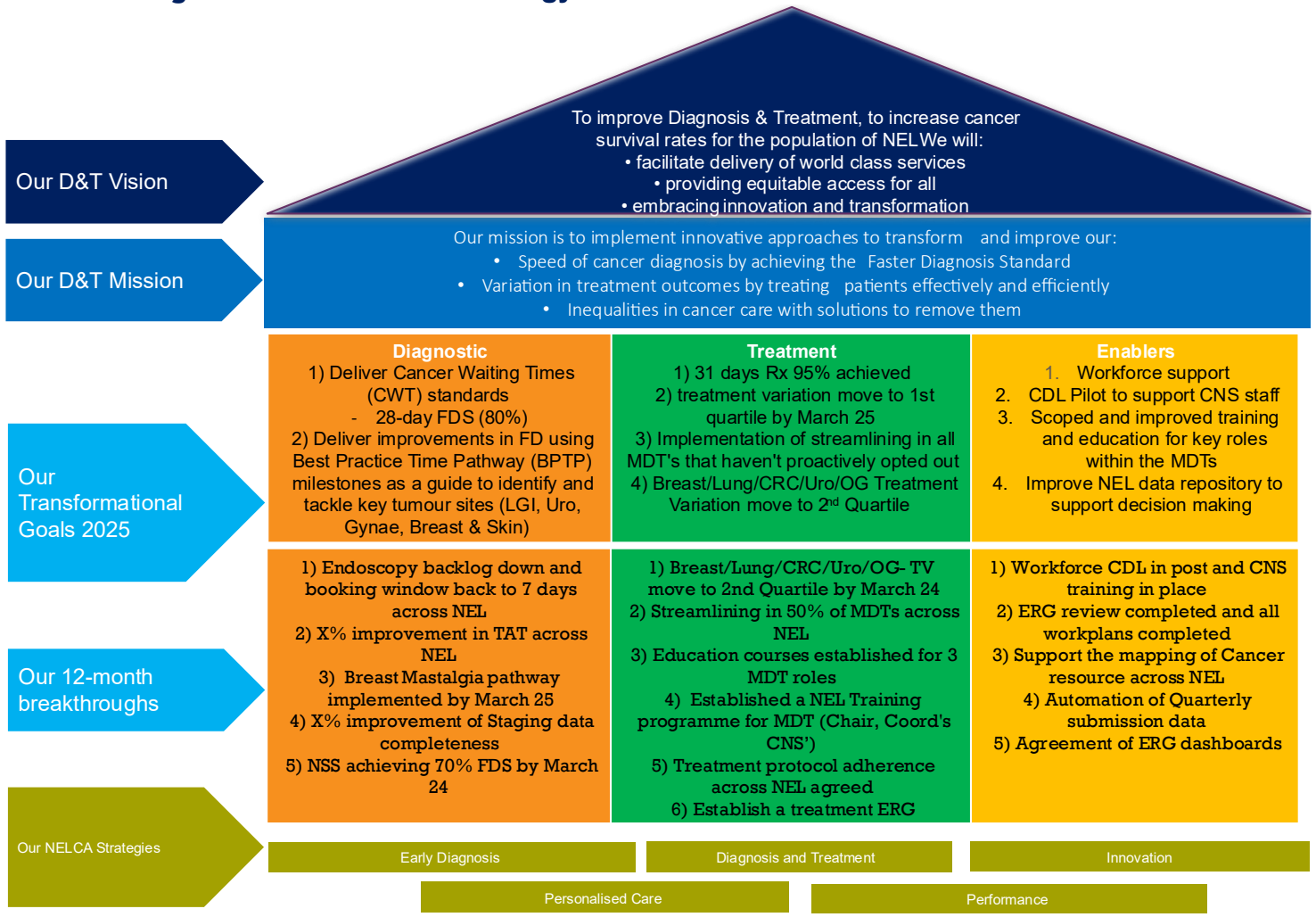
NELCA ED Strategy House



- The pictorial gives a clear summary of the Prevention and Early Diagnosis programme. Both tumour sites and specific populations/groups of people with protected characteristics have been targeted to address health inequalities and improve prevention.
- A detailed programme of work includes substantial community outreach, targeted health-checks and innovation. The aim is to both prevent and improve timely presentation for cancer.

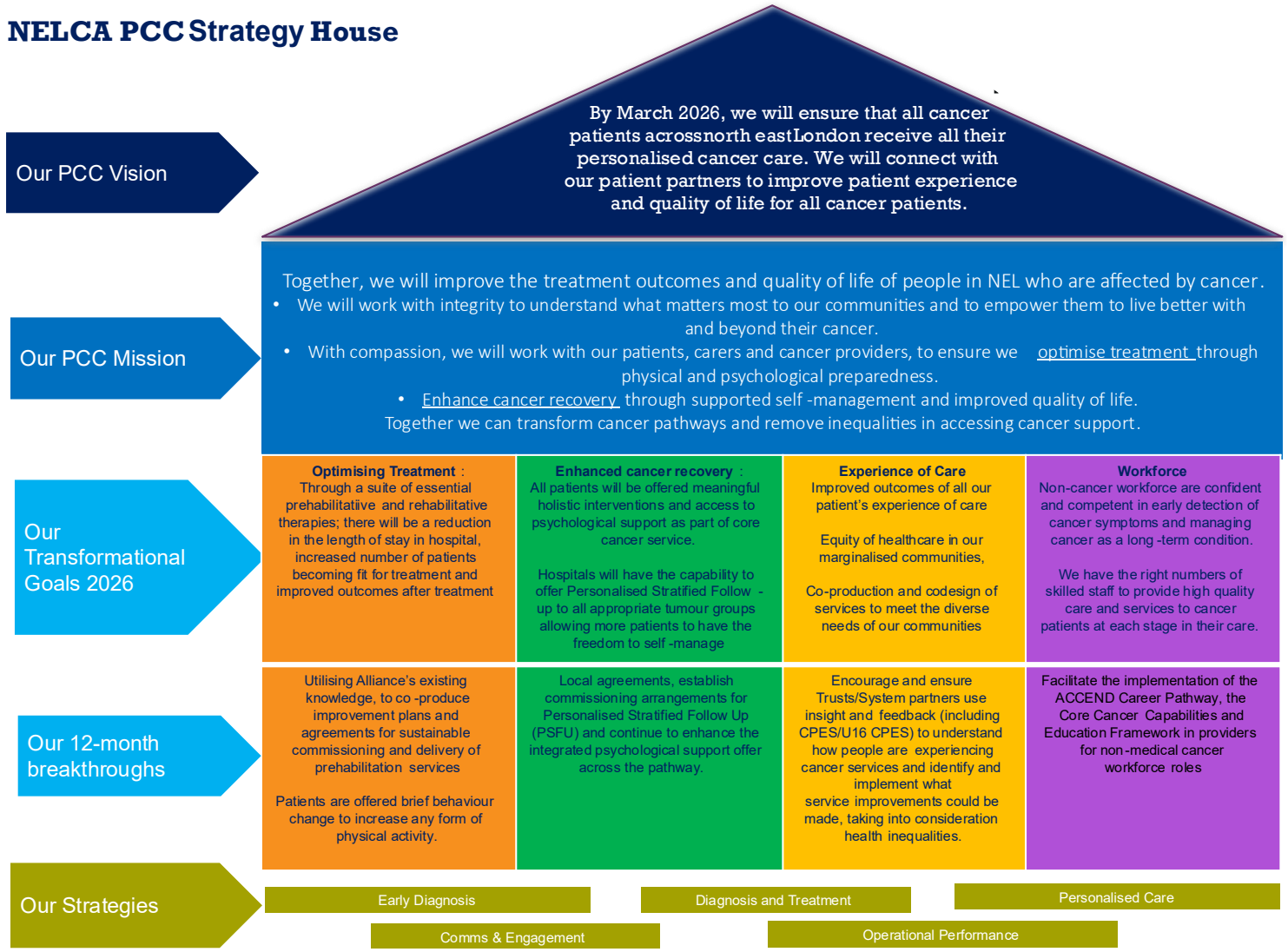
NELCA Diagnosis & Treatment Programme 24-25

NELCA Diagnosis & Treatment Strategy House



- The NELCA Diagnosis and Treatment Programme focusses on performance, with a series of interventions and projects aimed at rapid improvement of both quality and waiting times.
- The Faster Diagnosis Standard and Best Practice Time Pathways provide the framework for much of the work in Diagnostics. Much of the focus in Treatment is on removing unwarranted variation, and on improving the functioning of the many Multi-Disciplinary Teams.

NELCA Personalised Cancer Care Programme 24-25



- The purpose of the Personalised Cancer Care Programme is to improve the outcomes and quality of life of people in North East London who are affected by cancer.
- CNS and AHP teams deliver the bulk of personalised care interventions; all three Trusts also have additional dedicated support staff who are crucial to the efficient, effective, and safe delivery of co-ordinated and personalised care. The programme focuses on optimising treatment, enhancing recovery, ensuring quality of care and workforce.

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NELCA Workforce Vision and Strategy Development

- Workforce development is seen as a vital cross-cutting initiative to all three programmes. The development of a NELCA Workforce Strategy is a priority for the next 12 months and will support decision making in future strategic workforce priorities and activities for the Alliance. NELCA's ambition is to develop a workforce strategy that identifies, prioritizes and addresses our immediate and future cancer workforce needs, whilst attracting, training and retaining a diverse, skilled and innovative NEL cancer workforce. This Scoping and Mapping report concludes the first phase of the workforce strategy development and provides a baseline and decision tool for identifying the next steps and areas of focus for the second phase of the work.

National Guidance and Workforce Delivery

- The National Workforce Plan commits the NHS total workforce to grow by around 2.6–2.9% a year, with an expansion of the NHS permanent workforce from 1.4 million in 2021/22 to 2.2–2.3 million in 2036/37, including an extra 60,000–74,000 doctors, 170,000–190,000 nurses, 71,000–76,000 allied health professionals (AHPs), and 210,000–240,000 support workers alongside the expansion of new roles such as physician associates and nursing associates, and greater use of apprenticeships.

Train: Grow the workforce

- There will be a major increase in training across professions, with more than 500,000 healthcare professionals being trained over the next five years. Our long-term assessment is that domestic education and training needs to expand by around 50% to 65% over the next 15 years to give us at least
  - 60,000 more doctors
  - 170,000 more nurses
  - And 71,000 more allied health professionals (AHPs)

Retain: Embed the right culture and improve retention

- By better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS will ensure up to 130,000 fewer staff leave the NHS over the next 15 years.
- Building on the People Plan, alongside delivery of the EDI improvement plan, will give staff the support they need to thrive, helping to make the NHS People Promise a reality for all.

Reform: Working and training differently

- We will build teams with broad and flexible skills, and deliver more services in the community, supported by new roles and the right technology.
- Education and training will be reformed to support education expansion and so that students have a more positive experience of learning, and are prepared for work in a modern NHS.

NELCA Workforce Vision and Strategy Development

- In 2017, Health Education England produced a Cancer Workforce Plan, which outlined the depth of the skills challenge in times of unprecedented advances in the NHS' ability to prevent, diagnose and treat cancer[2].
- Cancer Alliances were established across the country bringing together clinical leaders and teams to further the Cancer transformation agenda. In relation to the cancer workforce, £130m was invested in technology and equipment to ensure all patients have access to the latest radiotherapy and £200m to accelerate the rapid diagnosis and assessment of patients and to enhance their quality of life. The plan recognised the critical importance of the many professional groups on the cancer pathway - histopathologists, endoscopists, radiologists, oncologists, surgeons, pharmacists, allied health professionals, other health scientists and nurses were all considered in some detail. The focus of this plan was on the mechanisms needed to develop both capability and capacity – progress was tracked against numeric targets for gastroenterology, radiology, oncology, and diagnostic and therapeutic radiography with an interim report provided in 2019[3]. Nursing workforce growth was addressed separately as part of a national 50K nursing initiative.
- The interim report acknowledged that the scope and pace of cancer workforce transformation should be further and faster. It proposed a series of actions to increase the pace of transformation:
  - Increasing capacity through international recruitment
  - Upskilling to increase workforce capacity to support earlier diagnosis of cancer
  - Creating new routes into the cancer workforce – these included a Level 4 apprenticeship in breast imaging, Level 6 in sonography and both diagnostic and therapeutic radiology, and a Level 7 in Advanced Clinical Practice
  - Genomics workforce scoping and assessment, and a genomics education programme
  - Sharing of best practice in workforce innovation across the Cancer Alliances – some elements of this were included in the report.

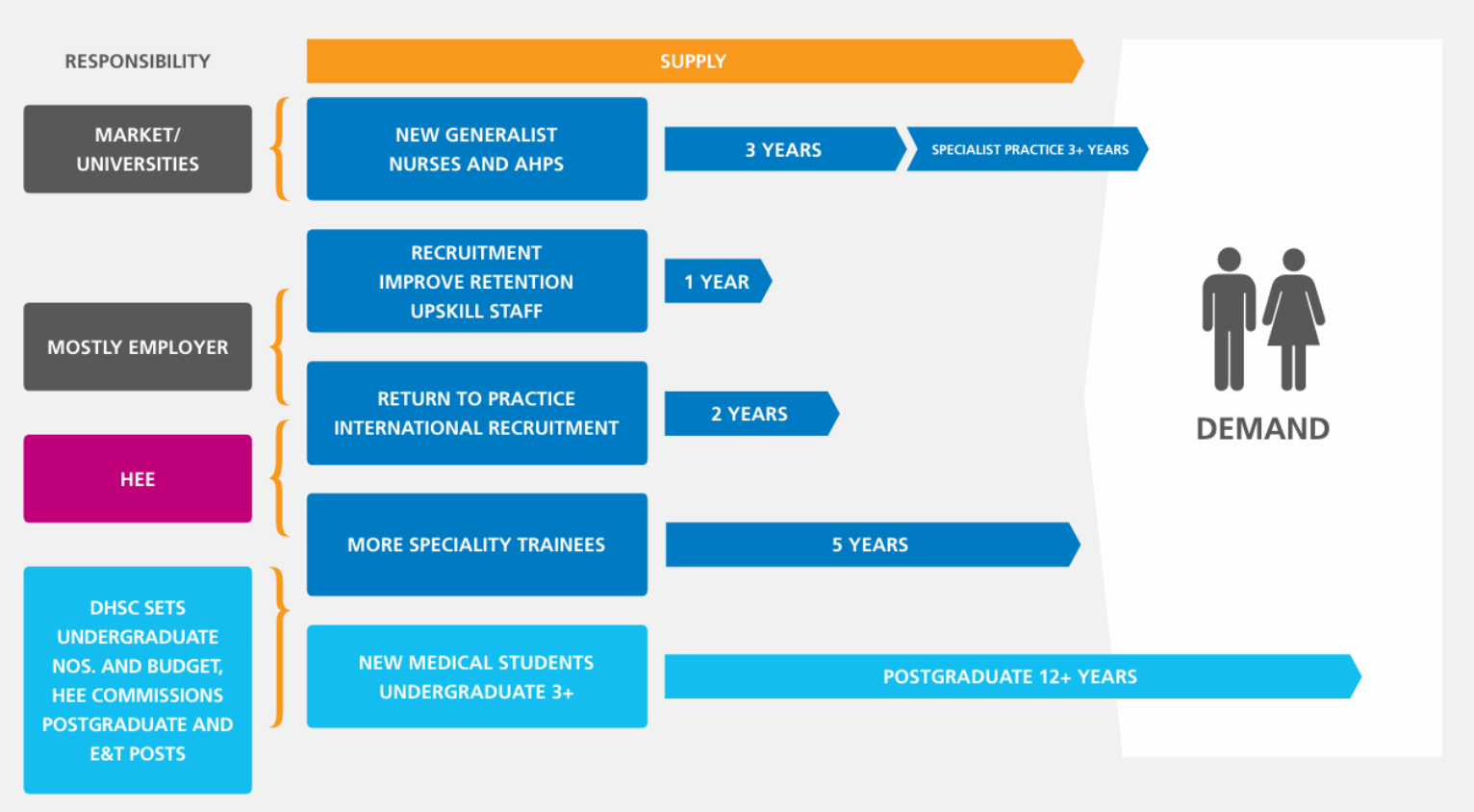
[2] Cancer Workforce Plan Phase 1: Delivering the cancer strategy to 2021, Health Education England, 2017
[3] Progress update Update on Phase 1 of the Cancer Workforce Plan, Health Education England, August 2019

NELCA Workforce Vision and Strategy Development

- Health Education England also produced a Strategic Framework for Cancer in July 2018, which was published as an interim working paper, rather than an official report[4]. It took a 'Health Economics' view, focussing in on both supply and demand and looking at the levers for improving the workforce. The interim working paper was used to inform the first NHS Long-term Workforce Plan, published in August 2019.
- The picture painted by this working paper was of growth in both demand and complexity - the incidence of cancer increasing by 2% p.a. amongst a growing, ageing population with more co-morbidities, increased mortality and potential re-occurrence. Early diagnosis and better outcomes meant activity was being 'redistributed' across the patient pathway rather than completely removed – a gain for the patient, but a change requiring re-planning of workforce resources. It was anticipated that developments in IT, digital and AI would increase productivity, but that genomics, plus increased expectations, would require more personalised medicine. The paper describes eloquently the need for a dynamic and agile approach to future workforce development.
- When considering supply, the paper asked key questions:
    1. The size of the pie: How many health care professionals will be needed? What scale of growth will be required to meet the forecast increase demand?
    2. What new skills and new roles will be needed in different parts of the pathway?
    3. What skills/tasks could be delegated or supported by AI and other innovations?
    4. Where should staff/resource be distributed across the four parts of the pathway?
    5. Tactical but mission critical: how do we source supply?
- It concluded that: '*The combined impact of 1-4 has led to 'boom and bust' in the workforce, increasing the risk of a gap between real demand (need rather than affordability) and supply (qualified staff). Investment in the workforce has not been aligned with service ambitions and planning. Agreeing a multi-year investment plan for all professions would be a more sustainable and flexible way of ensuring supply meets demand, although in the longer-term, planning should be viewed through the lens of patient needs*'

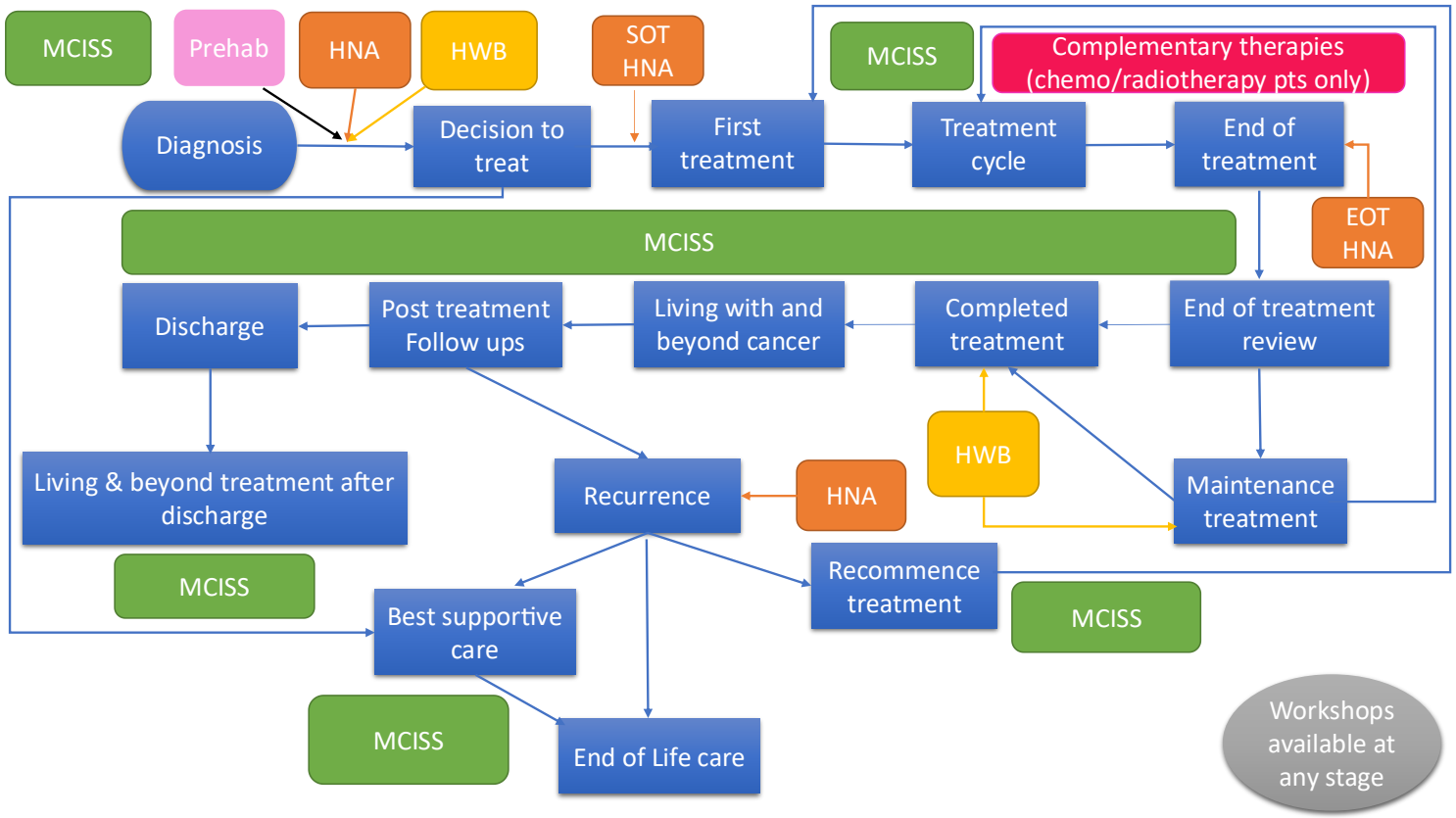
[4] Strategic Framework for Cancer Workforce Interim working paper July 2018, not official or final HEE position, Health Education England, July 2018

NELCA Workforce Vision and Strategy Development



- The thought provoked by a multi-year investment plan is that information on careers in cancer should be made available to 13–18-year-olds, including work placement opportunities, careers talks etc. A helpful diagram brought together workforce development drivers and timeframes.
- Case studies of nursing, therapeutic radiographers and oncologists were included to show the importance of understanding the contribution of each part of the workforce to overall patient care. This report will mirror that approach, analysing population health and demand, then current workforce supply and future risks within each professional group before looking at specialty specific issues.

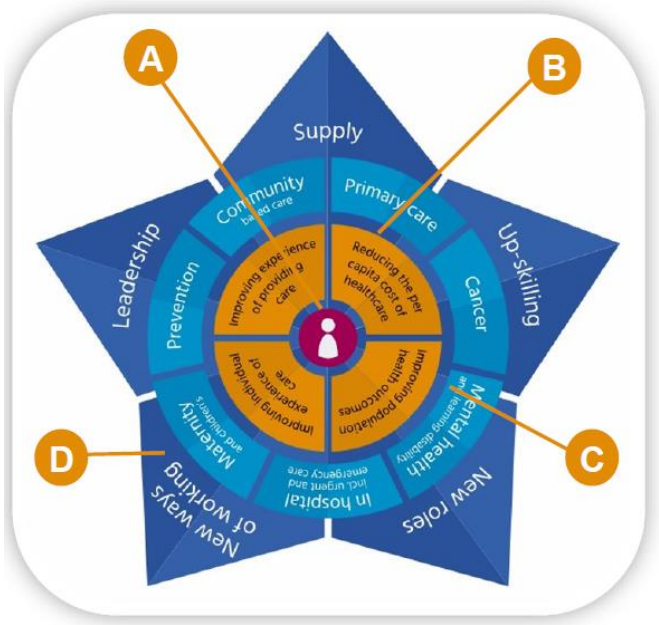
Scope



- The scope of the NELCA workforce mapping exercise is the whole cancer pathway. This includes the workforce involved in delivery of all three NELCA clinically related programmes – Prevention and Early Diagnosis, Diagnosis and Treatment, and Personalised Cancer Care, see diagram below. Assessments have been made of the workforce involved in both primary and secondary care, using nationally available ESR and primary care data. This has been sense-checked with each major delivery partner to ensure that the data does not either under- or over-represent their current cancer workforce. The voluntary and community workforce will be referenced, but the complexity of collection of this data means that only a narrative will be provided where relevant.

Methodology

- In a methodology which echoes Health Education England's national cancer workforce strategy, a strategic workforce planning approach has been taken to ensure that both demand for services and then the resultant pressures on supply of the workforce are fully understood. This will enable stakeholders across North East London Cancer Alliance to reach a common understanding of the workforce risks within their Integrated Care System. This economic understanding of the workforce risks is derived from analysing in more detail the nature of the current service model.



A At the centre is the overarching goal to deliver **patient-centred care**, i.e. care that is tailored to the needs, circumstances and preferences of the individual receiving care.

B The orange segments symbolise the **quadruple aim of the NHS Five Year Forward View**. Every entry included in the tool contributes towards meeting one of four aims:

- Improving the individual experience of care
- Improving the health of populations
- Reducing the per capita cost of healthcare
- Improving the experience of providing care.

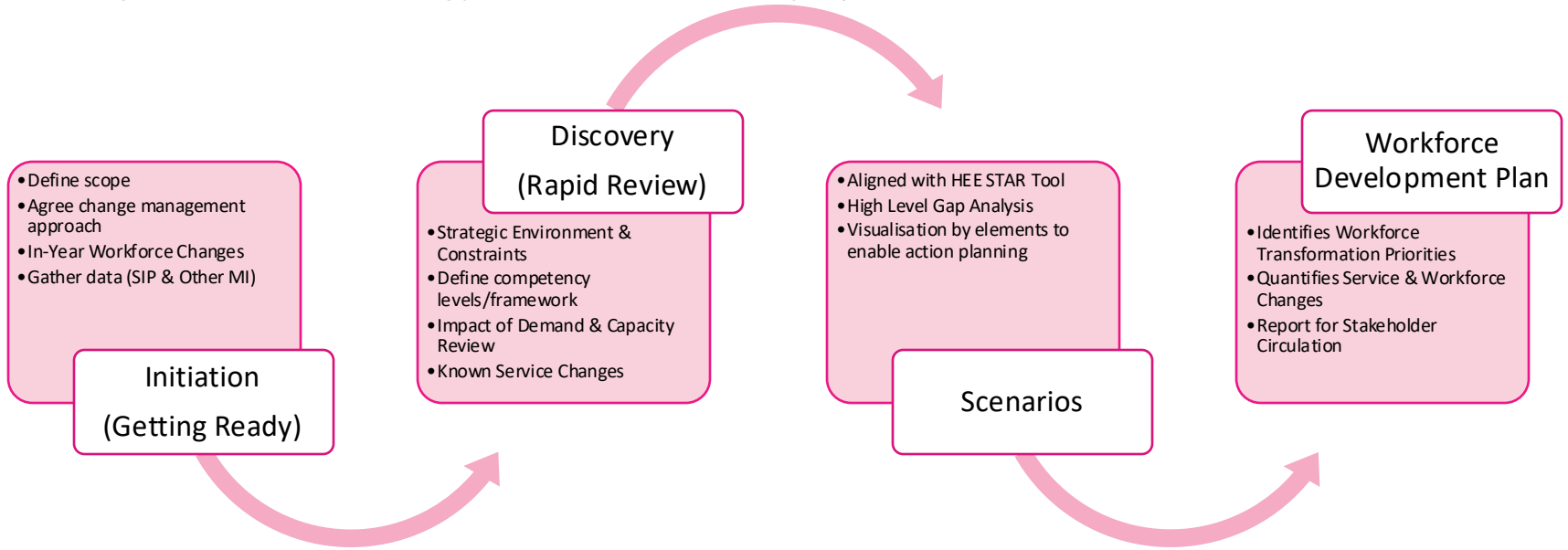
C Content can be viewed by **clinical area**: Primary care, Cancer, Mental health and learning disability, In hospital (including urgent and emergency care), Maternity and children's, Prevention, and Community based care.

D Content is framed around the **five key enablers** of workforce transformation, or the **domains**: Supply, Up-skilling, New roles, New ways of working, and Leadership.

- A second set of risks come from the structure of specific workforces (professional groups or roles). Age (both of retirement, and the age profile of the current workforce) can create specific risks which will need to be addressed to ensure a sustainable future workforce. Once all risks (both economic and structural) are understood, the report will move to making recommendations based on potential workforce interventions. These will be based on the recognised national workforce transformation framework – Health Education England's STAR framework.

Workforce Planning and Transformational Interventions

- The more complex workforce transformation interventions require quite substantial time-commitments from stakeholders. They are therefore only justified when the return in terms of patient quality and system performance improvement is commensurate with that commitment. One to one interviews with Expert Reference Group (ERG) Chairs and Clinical Leads have collected improvement requirements as systemically as possible; these have then been analysed to establish what level of intervention might be most appropriate.
- Deep dives are recommended where the issues impacting on service and workforce models are not fully understood; they use a received methodology to enable a Multi-Disciplinary Team to undertake a rapid journey through pathway and workforce redesign. The methodology is outlined in the graphic below.



- The time commitment is quite substantial – requiring several workshop meetings with all disciplines present, and if necessary, follow up meetings with individuals to resolve specific key lines of enquiry.

Workforce Planning and Transformational Interventions

- Hackathons are a more successful intervention where the issues are already known but consensus needs to be brokered or there is a need to move theory on to practice. Please see the explainers below.

Deep Dive	**Rapid transformation of service and workforce models**
	Where the issues are not fully understood.
	Designed to provide rapid transformation of both service and workforce models using the best advice of a multi-disciplinary group who work in that area. It goes through the relevant service and workforce interventions which can be taken - from demand management to creating new roles….it works where both service and workforce model may need changing.
Time commitment - stakeholders	At least four multi-disciplinary meetings, 3 x 90 minutes 1 x 60 minutes
Time commitment - consultant	Series of workshops and activities to help unpick the issue and then develop a solution c. 8 days given that 'discovery' has been undertaken
Hackathon	**Where the issues are broadly known and the solution needs developing**
	For example, development of a workforce plan for a particular workforce group, or activity redistribution, or skill mix development/deployment
	Some of the areas where risks have been identified, there is only a need to look at how we resolve workforce shortages in the longer term, or to look at how we re-distribute current activity along the pathway.
	Something like dermatology feels like activity redistribution, rather than requiring a full deep dive. Nursing requires longer term solutions to long-term shortages. Also, AHPs.
Time commitment - stakeholders	2 x half days or one full day workshop
Time commitment -consultant	To support 2 x half days or one full day workshop, preparation and follow up - c. 3 days
Other activities / support	**Quick wins/support that can be, or is already being, provided that will quickly help to resolve the issue**
	Issue and solution is already known
	For example, producing succession plan for highly specialist nurses in gynae
Time commitment - stakeholders	Specific meetings - likely 2 per issue to be resolved (so minimum 2 hours)
Time commitment -consultant	Variable depending on solution - minimum would be a day.

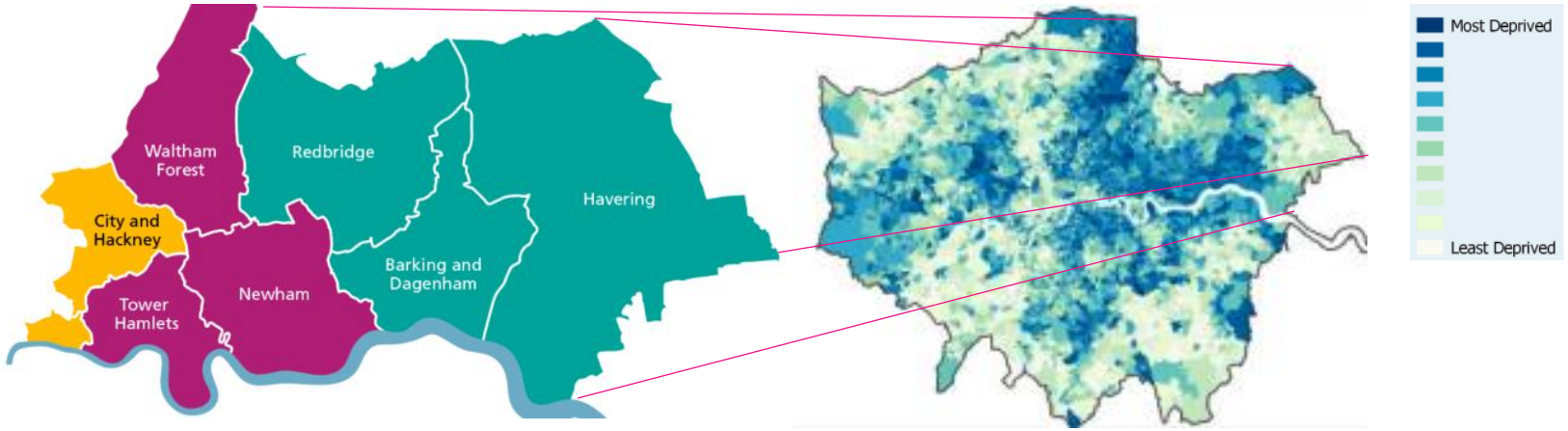
Workforce Planning and Transformational Interventions

- The key outputs from Phase 2 of the workforce strategy development programme (May – September 2025) is to achieve the 'art of the possible' in terms of workforce improvement interventions. For the professional groups which have the most serious shortages, this second phase will develop plans to mitigate the identified immediate workforce risks. Phase 3 of the workforce strategy programme will then use this increased understanding to pull together a longer-term workforce strategy (September to December 2025) for input into the next operational planning round. Success will be measured through NELCAs strategic programmes and will be judged partly by quality or performance improvement in the areas addressed. Phase 2 will provide concrete outputs from deep dives or hackathons in terms of workforce plans for specific, challenged, professional groups. Phase 3 will then focus on the system-wide actions required to ensure that these workforce plans are implemented, capturing the changes needed in recruitment, retention, education and development, new roles and new ways of working and workforce structure or skills mix.

Population Health & Inequalities

Population Health Demand - Deprivation

- Understanding and analysing local population demographics helps to understand a population's wider determinants of health and inequalities in health outcomes. This is important when considering and planning services and related workforce needs. For example, greater levels of deprivation are linked with poorer health outcomes (later stage cancer diagnosis, increased co-morbidity, increased mental health needs). Any increase in population health demand will impact both the size and skills of the workforce required.



Indices of multiple deprivation

- An analysis of the indices of multiple deprivation (IMD) across the London boroughs of London City, Hackney, Waltham Forest, Tower Hamlets, Newham, Redbridge, Barking & Dagenham, and Havering reveals notable disparities, particularly in areas with higher levels of deprivation. The map above shows that the concentration of the blue coloured areas (most deprived end of the scale) is more in North East London than any other part of Greater London.

Population Health Demand - Deprivation

Boroughs with Higher Levels of Deprivation:

1. **Newham:** In 2021, Newham had the highest proportion of households experiencing deprivation in at least one dimension among all local authorities in England and Wales, with 60.7% of households affected. This marked a decrease from 75% in 2011. Neighbourhoods such as Plashet West (71.9%) and Little Ilford West (71.3%) were among the most deprived areas in England and Wales. High deprivation levels often correlate with limited access to healthcare services and poorer health outcomes.
2. **Barking & Dagenham:** As of 2019, Barking & Dagenham had the highest IMD score in London and ranked 21st in England and Wales. Neighbourhoods in Gascoigne, Heath, Thames, and Village wards were among the 10% most deprived nationally. Elevated deprivation levels are associated with increased health challenges and reduced access to quality healthcare.
3. **Tower Hamlets:** In 2021, 53.6% of households in Tower Hamlets were deprived in at least one dimension, down from 67.3% in 2011. Areas like Shadwell North (68.2%) and Poplar Central (66.5%) were notably affected. High deprivation levels can lead to adverse health outcomes and limited healthcare access.

Boroughs with Moderate Levels of Deprivation:

1. **Redbridge:** In 2021, 53.7% of households in Redbridge were deprived in at least one dimension, a decrease from 61.2% in 2011. Neighbourhoods such as Ilford North West (68.3%) and Loxford Park (66.5%) were among the most affected. Approximately 5.2% of residents reported bad or very bad health, highlighting the need for improved healthcare access.
2. **Havering:** In 2021, 52.7% of households in Havering experienced deprivation in at least one dimension, down from 60.3% in 2011. Areas like Harold Hill East (68.3%) and Harold Hill West (61.8%) were particularly affected. Moderate deprivation levels suggest a need for targeted healthcare interventions.

Population Health Demand – Deprivation and Income

Boroughs with Lower Levels of Deprivation:

1. **Hackney and Waltham Forest:** Both areas have pockets of deprivation that require attention. Addressing these disparities involves enhancing healthcare services, improving education and employment opportunities and ensuring equitable access to resources.

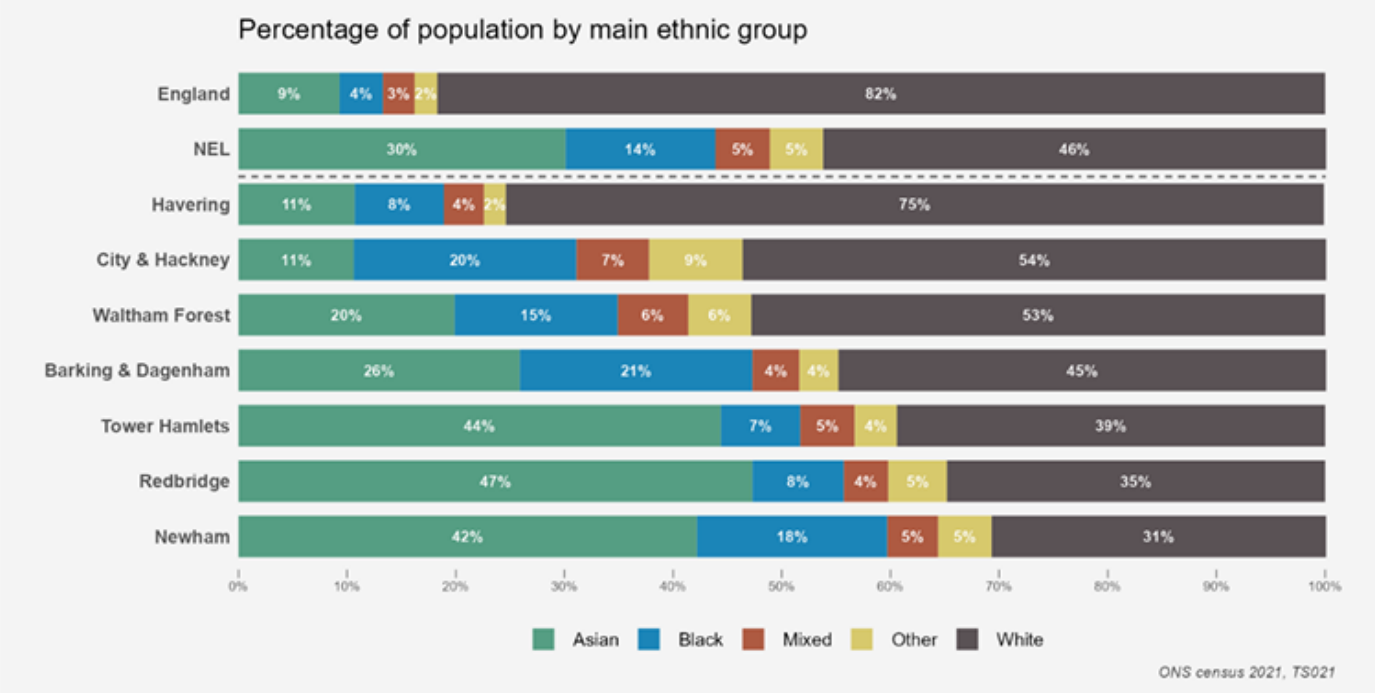
Impact of Income on Health and Healthcare Access:

- Income significantly influences health outcomes and access to healthcare services. Lower-income populations often face barriers such as limited access to nutritious food, inadequate housing, and reduced healthcare accessibility, leading to higher rates of chronic diseases and poorer overall health. For instance, areas with high deprivation, such as Barking & Dagenham (29.3%) and Newham (28.8%), have some of the highest rates of obesity among 10 to 11-year-olds in the UK.

Population Health Demand - Ethnicity

Ethnicity

- NEL is one of the most diverse areas within the country. The diagram below illustrates demographic breakdown of the main groups of ethnicity, by place[6].



[6]Annual Health Inequalities Information for NHS North East London Data Summary, NHS North East London ICB - July 2024

Population Health Demand - Prevalence

- By 2030, the number of people living with cancer and beyond in North East London is expected to rise from 43,204 (2017) to 65,900, a rise of nearly 53%[7].

Cancer site prevalence has been based on the first cancer diagnosis received in the 23 years to December 2017:

- Breast and Prostate cancer are the most common cancer diagnosis amongst the prevalent population. Both have high incidence and relatively high survival rates.
  - 1.4% of the female population in London has a diagnosis of breast cancer (60,375 women)
  - 0.9% of the male population of London has a diagnosis of prostate cancer (41,478 males)
  - 0.3% of the male population and 0.2% of the female population has a diagnosis of colorectal cancer (22,168 people in total)

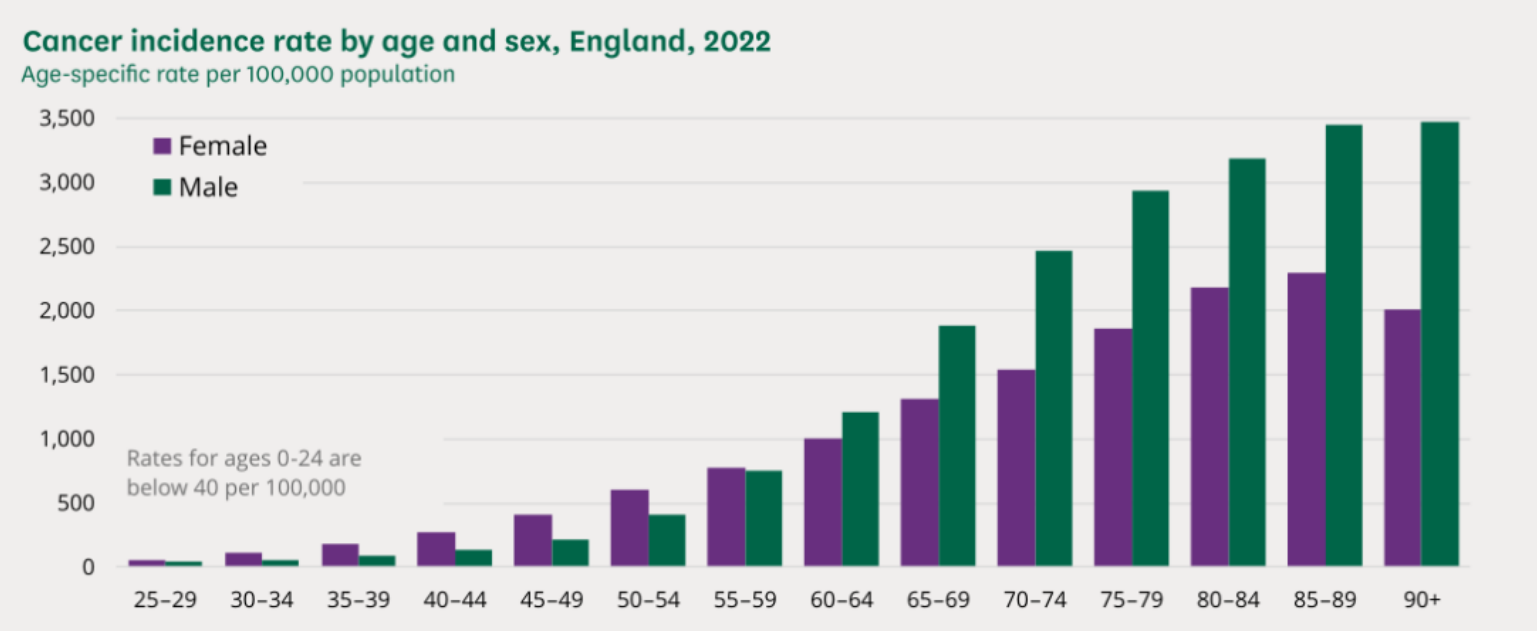
Survival rates:

- Lowest rates and numbers are for cancers with low survival rates (pancreas, liver, stomach, oesophagus, unknown primary); between one and two thousand patients were alive for each across London. Just over 7,000 people in London were alive with a diagnosis of lung cancer
- Service needs for patients with poor prognosis will be different from those who have cancers with better survival but potentially longer-term consequences of their disease and treatment.

[7]A Cancer Prevalence Dashboard for London Guidance to inform strategy and service planning, Transforming Cancer Services Team for London and Public Health England, December 2017

Population Health Demand – Incidence of Cancer

- Overall incidence of cancer was 21% higher in men that women in 2020. Over half of people newly diagnosed with cancer are aged over 70. Among people aged 25 to 59, incidence rates are higher in women than in men. Among people aged over 65, incidence rates are around 50% higher in men than in women.



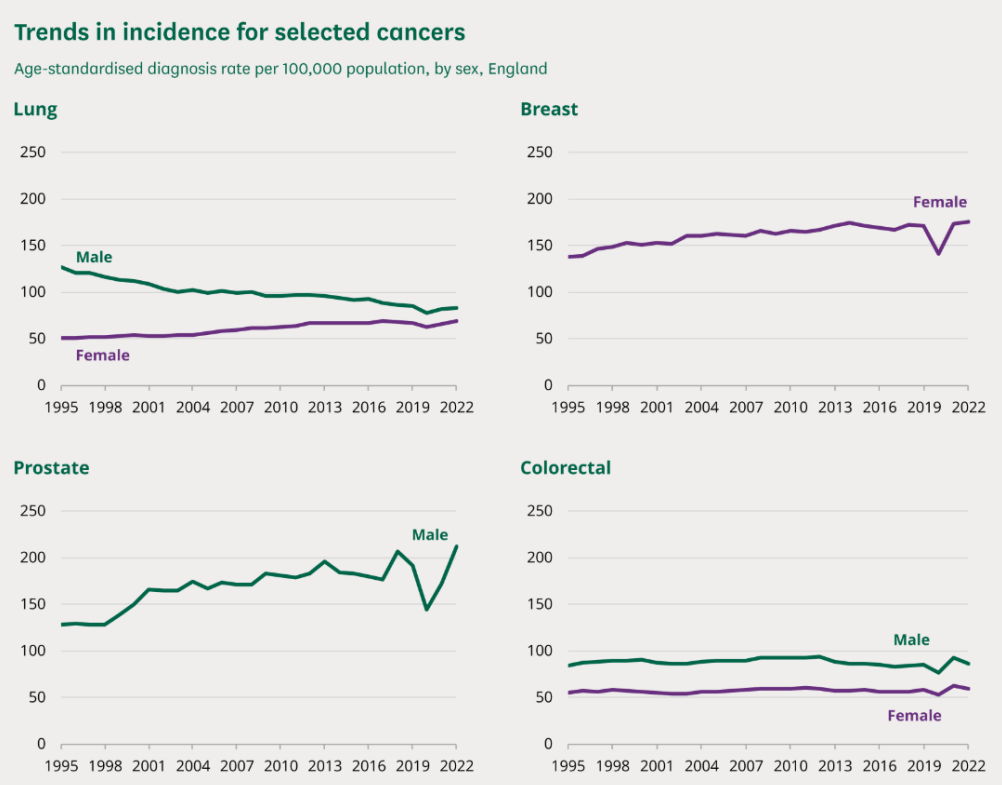
- National incidence of cancer is an indicator of how overall patterns of cancer are changing as a disease. In 2022, there were 346,217 new cases of cancer diagnosed in England. The number of cancer diagnoses increased each year since 1995, except for 2020 – a decrease which is likely to be due to the disruption of cancer diagnostic pathways during the coronavirus pandemic.
- The generally increasing trend in diagnoses can be partly explained by population change. Incidence rates (the number of new diagnoses per 100,000 population) rose slowly between 1995 and 2013 and have since broadly levelled out – apart from a fall in 2020 coinciding with the coronavirus pandemic[8].

health dynamics

[8]Cancer Registration Statistics for England 2022,

Population Health Demand – Incidence of Cancer

Cancer Type	Gender	Incidence per 100k
Bowel	Males	77
Bowel	Females	57
Breast	Females	151
Lung	Males	85
Lung	Females	63
Prostate	Males	251



- Over half of cancers fall into four types: prostate, breast, lung, and colorectal. However, as the graphs below indicate, demand over time varies for these four types, with a decrease in male incidence of lung cancer particularly.[9]
- Cancer is the cause of just over a quarter of all deaths in England in a typical year. In 2022 in England, 138,579 people died from cancer.
- Deaths have increased but rates have fallen. The number of deaths has increased by 9% since 2001. But after accounting for the fact that England's population is both growing and ageing, the rate of cancer deaths has fallen[10].
- Cancer survival rates vary between types of cancer. Over 95% of people diagnosed with breast, prostate or skin cancer between 2016 and 2020 survived for one year after their diagnosis. However, less than half of people with lung, liver, and pancreatic cancer survived for one year after their diagnosis[11].
- The 2022 data for North East London showed that both Lung and Colorectal were broadly in line with the National trends, however incidence of Prostate Cancer was higher (251 per 100k compared with c.210). The incidence of Breast Cancer in North East London was slightly below the National trend (150 per 100k compared with c.175).

[9]Commons Library - https://commonslibrary.parliament.uk/research-briefings/sn06887/2022. [10]ONS NOMIS, Mortality statistics
[11]https://digital.nhs.uk/data-and-information/publications/statistical/cancer-survival-in-england/cancers-diagnosed-2015-to-2019-followed-up-to-2020

Health Inequalities

Cancer stage 1 and 2 diagnosis by gender:

Gender	Early-Stage Proportion
Male	51.3%
Female	61.8%
Average	**55.9%**

Cancer stage 1 and 2 diagnosis by age:

Age	Early-Stage Proportion
0-49	67.2%
50-59	64.2%
60-69	59.2%
70-79	50.0%
80+	41.4%
Average	**55.9%**

Cancer stage 1 and 2 diagnosis by deprivation:

Deprivation	Early-Stage Proportion
1 (most deprived)	55.9%
2	54.8%
3	56.4%
4	58.0%
5 (least deprived)	57.2%
Average	**55.9%**

Cancer stage 1 and 2 diagnosis by ethnicity:

Ethnicity	Early Stage Proportion
Asian	57.2%
Black	60.7%
Mixed and Other	60.3%
Unknown	67.5%
White	53.6%
Average	**55.9%**

Cancer Diagnosis

- The most recent data on early cancer diagnosis is included in in Appendix 2. It echoes the findings of NHS North East London's latest Annual Health Inequalities report, but provides more detail on recent system performance per month at the different stages of the cancer pathway. To understand Health Inequalities fully, these two data sources will be examined starting with the overall picture for North East London.
- The North-East London Annual Health Inequalities report examines whether age, gender, deprivation and ethnicity create a variance in early stage diagnosis:
- For deprivation, there is a small social gradient where the least deprived quintile has a higher proportion of cancers diagnosed at stage 1 and 2 and a lower proportion the more deprived the quintile. The variation is 2-3% of the population.
- For ethnicity, the results are relatively similar across the board with little variation, although the white and Asian ethnic groups lag relatively at 54% and 57% respectively compared with black, mixed and other which are all above 60%.
- For gender, men getting diagnosis at stage 1 and 2 are a full 10% lower than females. By age, people at younger ages are far more likely to get diagnosed at stage 1 and 2 than older people.
- *Report Date: 12 months from December 2022 – November 2023*[12]

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[12]Annual Health Inequalities Information for NHS North East London Data Summary, NHS North East London ICB - July 2024

Health Inequalities

Personalised Care, Patient Experience and Quality of Life

- A Macmillan Cancer Support report – Mind the Gap: Cancer Inequalities in London (2017) – identified three key findings in relation to inequalities in cancer patient experience[13] –
  1. Overall, London cancer experience is good, although worse than in the rest of England
  2. Patients from the most deprived areas report worse experience than those from the least deprived areas in practically all aspects of care
  3. Minority ethnic cancer patients have poorer experiences of cancer services than those who identify as white, on nearly all dimensions of care
- Initial findings from the Macmillan Quality of Live and Personalised Care Community Reach Programme (2024), a pan-London programme currently being delivered by the Transforming Cancer Services Team for London, summarises findings from a range of data sources on quality of life and patient experience.
- National NHS Cancer Quality of Life (QoL) Survey (May 2024)
  - London had the lowest response rate to the survey – 35% compared to 44% nationally
  - Responses from patients from Black, Asian and mixed ethnicity were significantly lower than those from white ethnicity – Black 20.3%, Asian 22.7%, Mixed 22.8% compared to white 40%
  - Younger adults (25-50) and older adults (80+) had the lowest response rates
  - Those living in the most deprived area had a lower response rate (24.4%) to those in the least deprived (46.6%)
- National Cancer Patient Experience Survey (2021)
  - In 33% of the 12 personalised care questions London's ethnic minorities scored significantly lower than London's white population
  - Black and Asian patients reported significantly worse experience compared to their white counterparts
  - Older patients report a poorer experience compared to the younger age groups, and older patients in London scored significantly lower than England

[13] Mind the Gap: Cancer Inequalities in London (2017), data relates to National Cancer Patient Experience Survey 2016

Health Inequalities

Summary

- When comparing indices of multiple deprivation across England and Wales, North East London has a greater concentration of the most deprived areas than any other part of greater London. In 2021, Newham had the highest proportion of households experiencing at least one dimension of deprivation in all local authorities in England and Wales.
- Breast and prostate cancer are the most prevalent cancers within the North East London population. Overall incidence of cancer was 21% higher in men that women in 2020. Over half of people newly diagnosed with cancer are aged over 70. Among people aged 25 to 59, incidence rates are higher in women than in men. Among people aged over 65, incidence rates are around 50% higher in men than in women.
- Cancer survival rates vary between types of cancer. Over 95% of people diagnosed with breast, prostate or skin cancer between 2016 and 2020 survived for one year after their diagnosis. However, less than half of people with lung, liver, and pancreatic cancer survived for one year after their diagnosis. The overall pattern is of improved survival rates – by 2030, it is estimated that the number of people living with cancer and beyond in North East London is expected to rise from 43,204 in 2017 to 65,900 in 2030 – a rise of 53% over those 13 years.
- Health inequalities show some variation by ethnic group in terms of stage of diagnosis. The greatest variation in health inequalities is in patient experiences and in personalised cancer care. The Macmillan Cancer Support report – Mind the Gap: Cancer Inequalities in London (2017) showed that patients from the most deprived areas report worse experience than those from the least deprived areas in practically all aspects of care and that minority ethnic cancer patients have poorer experiences of cancer services than those who identify as white, on nearly all dimensions of care.

Performance

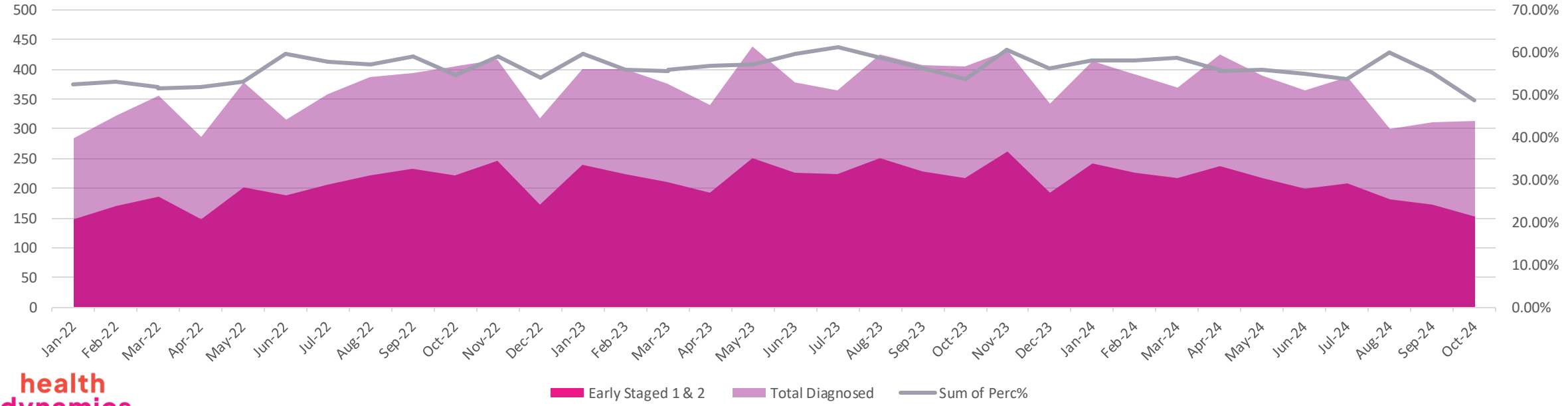
Performance – Early Diagnosis

- Performance reports provide data about activity and the achievement of targets, not directly about workforce. However, the information they provide can help formulate key lines of enquiry about workforce or skills shortages, which will be considered further when this report considers the challenges facing each professional group. A summary of early diagnosis performance is provided below, with more detailed data provided in Appendix 5.

Early Diagnosis Performance

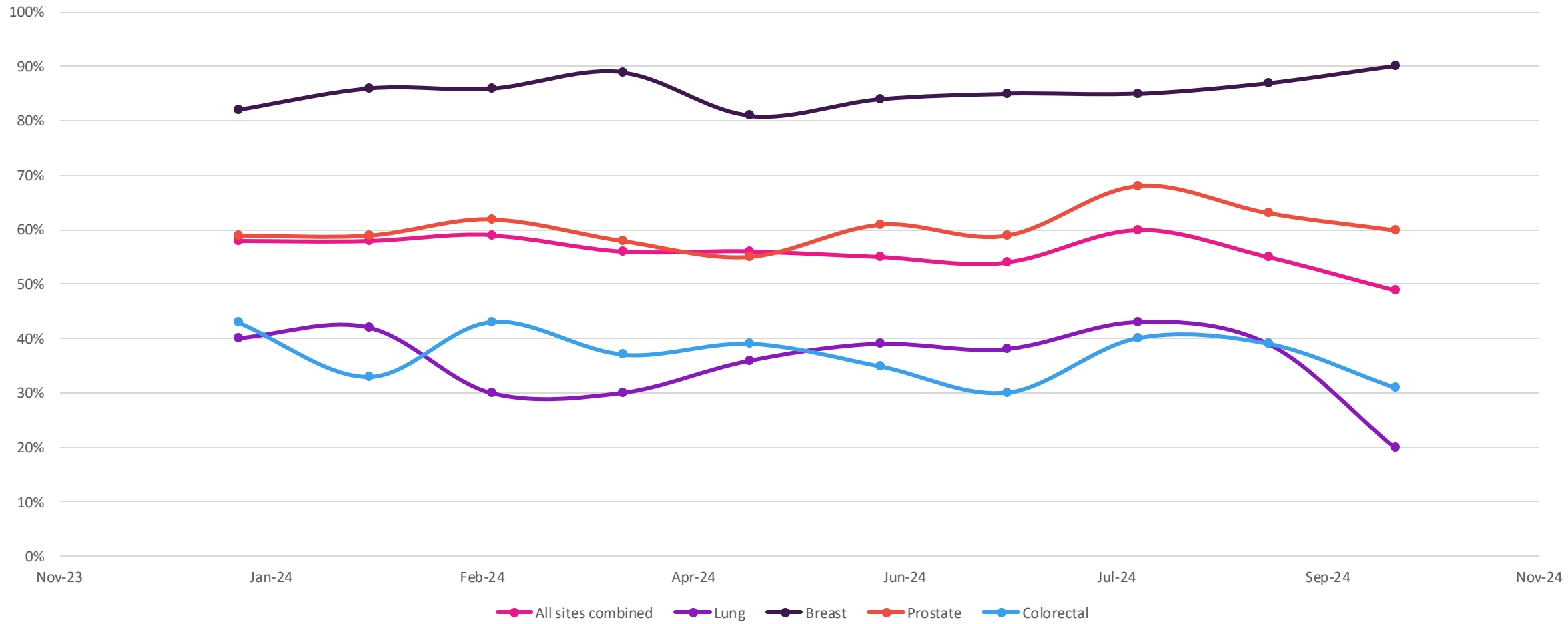
- Early diagnosis of cancer is one of five clinical priorities within the NHS's Core20PLUS5 approach, and the NHS Cancer Plan Deliverables.
- NELCA tracks ED performance against the following targets/indicators –

75% of cancer diagnosis at stage 1 and 2



Performance – Early Diagnosis

Early Diagnosis by Tumour Group – Top 4 & All sites combined



Performance – Early diagnosis

Early Diagnosis by Tumour Group – All sites

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
All sites combined	58%	58%	59%	56%	56%	55%	54%	60%	55%	49%
Bladder	100%	100%	71%	83%	50%	67%	29%	50%	33%	50%
Breast	82%	86%	86%	89%	81%	84%	85%	85%	87%	90%
Colorectal	43%	33%	43%	37%	39%	35%	30%	40%	39%	31%
Gynaecological	79%	68%	74%	80%	70%	70%	76%	73%	60%	53%
Haematological	33%	44%	36%	31%	71%	18%	40%	10%	39%	44%
Hodgkin lymphoma	0%	0%	33%	50%	50%	0%	60%	0%	57%	0%
Kidney	52%	87%	86%	92%	83%	79%	63%	70%	75%	75%
Lung	40%	42%	30%	30%	36%	39%	38%	43%	39%	20%
Melanoma	82%	82%	94%	93%	86%	100%	77%	100%	96%	100%
Non-Hodgkin lymphoma	27%	50%	29%	30%	75%	20%	30%	17%	33%	57%
Oesophageal	29%	30%	11%	14%	9%	33%	50%	0%	9%	17%
Oesophago-gastric	38%	47%	40%	29%	12%	38%	43%	11%	24%	33%
Ovarian	40%	43%	63%	100%	25%	29%	60%	75%	33%	14%
Pancreatic	31%	0%	25%	13%	33%	29%	23%	45%	25%	20%
Prostate	59%	59%	62%	58%	55%	61%	59%	68%	63%	60%
Stomach	50%	71%	83%	100%	17%	40%	33%	33%	50%	67%
Upper GI excl OG	31%	0%	25%	13%	33%	29%	23%	45%	25%	20%
Urological excl prostate	62%	88%	83%	89%	80%	76%	47%	64%	57%	67%
Uterine	89%	80%	80%	70%	81%	88%	83%	71%	71%	80%

Performance – MDT discussions and reporting

80% of cases discussed at MDT and reported with a full stage

NHS Trust	Numerator	Denominator	Staged (%)
Homerton	160	177	90.4
Barking, Havering and Redbridge University	561	740	75.8
Barts	382	825	46.3

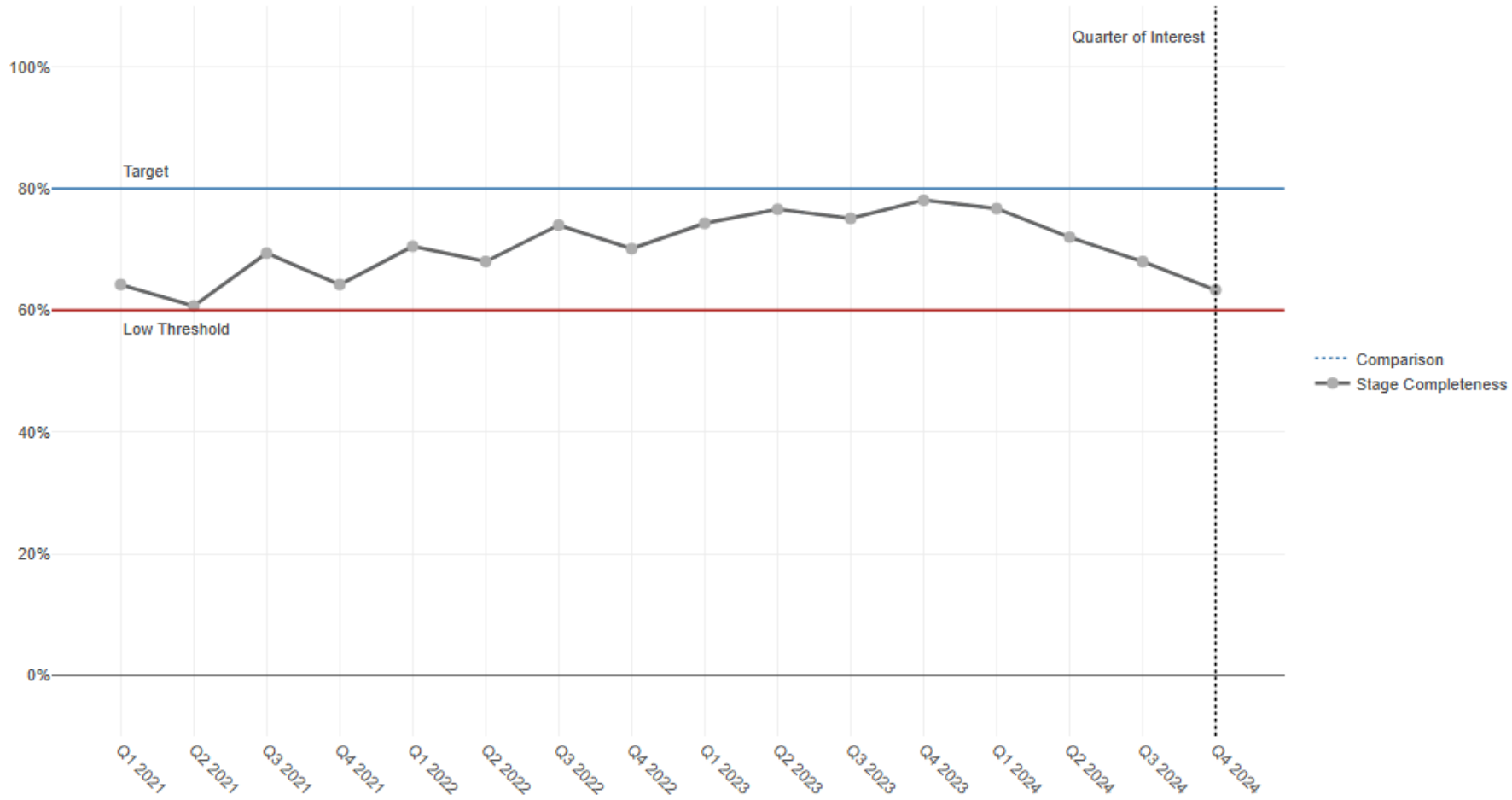
Performance - MDT discussions and reporting

80% of cases discussed at MDT and reported with a full stage

Cancer Group	Numerator	Denominator	Staged (%)
Bone and Soft Tissue	4	6	66.7
Breast	129	275	46.9
Cardiothoracic	1	9	11.1
CLL	8	11	72.7
Endocrine	16	28	57.1
Gynaecological	104	172	60.5
Head and Neck	58	62	93.5
HPB and Gall Bladder	50	62	80.6
Lower GI	207	227	91.2
Lung	205	218	94
Lymphoma	41	76	53.9
Melanoma Skin	31	70	44.3
Myeloma	11	27	40.7
Oesophagogastric	44	60	73.3
Pancreatic	43	50	86
Prostate	113	263	43
Urological	38	126	30.2

Performance – Stage Completeness over Time

- The diagram shows the proportion of cancer cases for which complete and accurate staging information is documented at diagnosis, tracked across different time intervals (e.g., quarterly or annually).
- Cancer stage at diagnosis (Stage I–IV) is critical for:
- Treatment decisions
- Prognosis estimation
- Clinical trial eligibility
- Evaluating outcomes (e.g., survival rates)
- Incomplete staging data limits the ability to monitor quality of care, compare outcomes, and improve patient management.



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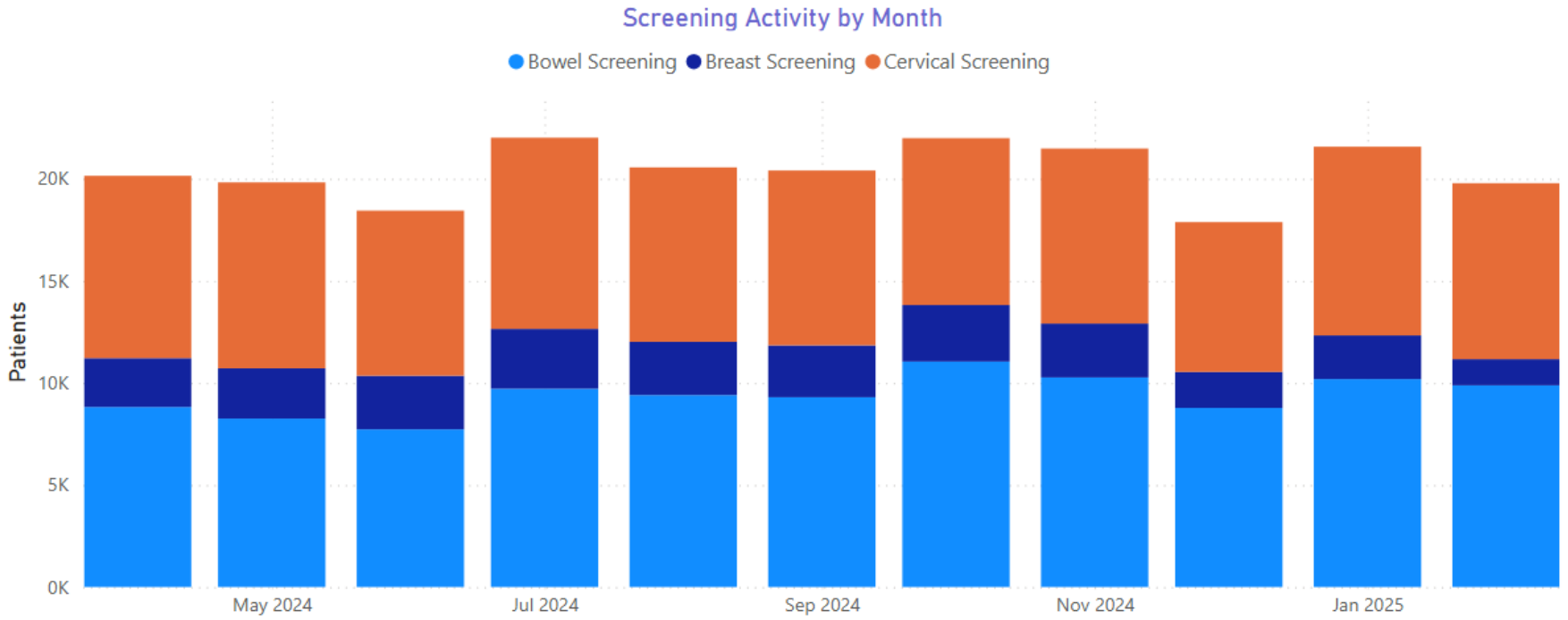
Performance - Screening

- We have data on the number of people screened, but unfortunately no denominator data on how many should have been screened.



Screening Performance

- Bowel: 60%
- Breast: 70%
- Cervical: 80%

SCREENING_TYPE	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	**Total**
Bowel Screening	8,818	8,249	7,725	9,713	9,400	9,293	11,043	10,264	8,768	10,187	9,877	**103,337**
Breast Screening	2,390	2,463	2,622	2,929	2,606	2,545	2,769	2,639	1,764	2,136	1,280	**26,143**
Cervical Screening	8,932	9,104	8,088	9,364	8,546	8,562	8,174	8,572	7,343	9,244	8,622	**94,551**
Total	**20,140**	**19,816**	**18,435**	**22,006**	**20,552**	**20,400**	**21,986**	**21,475**	**17,875**	**21,567**	**19,779**	**224,031**

Performance – Cancer Waiting Times

System Performance

- NELCA has concerns about Cancer Waiting Times performance across the three standards: Faster Diagnosis, 31-day Decision to Treat to Treatment and 62-day Urgent Referral to First Treatment Standards.
- The particular focus is on improvement plans for tumour types where an ICBs 62-day performance is in the bottom quartile compared to other systems, in Q3 2024/25, (or below 50%). This will translate into actions to address where >25% of patients are waiting more than 31 days for treatment on a pathway at a provider (e.g. Prostate Surgery) using Q3 2024/25 as a baseline. The main 62-day performance concern is lung, including the staging and treatment phases of the pathway.
- NELCA has concerns about seasonality, and its 2025-26 plan includes interventions to support more consistent performance across the year. These include a continued focus on skin performance in providers where FDS skin performance was below 75% within individual providers in 2024/25 (from April to September 2024)

Performance – Cancer Waiting Times

Acute Performance by Tumour Site

- The Cancer Alliance Data, Evidence and Analysis Service (CADEAS) is a partnership between NHS England and the National Disease Registration Service (NDRS). CADEAS provides cancer alliances with data and analysis to support their decision making. Performance data is collected across all tumour sites at the three Acute Trusts within North East London Cancer Alliance – Barts Health NHS Trust, Barking Havering and Redbridge University Hospitals NHS Trust and Homerton Healthcare. The data is then broken down by tumour site, before a deep dive is undertaken into the 28, 31 and 62 day waits.
- Details of performance by tumour site are included at Appendix 3 from June 2023 to end of November 2024. Difficulties meeting cancer targets often, but not always, indicate workforce shortages.
- The data shows substantial progress in meeting cancer targets within some of the most challenging areas over the period. However, areas experiencing either intermittent or last calendar year and current challenges include:
  - Haematology
  - Lung
  - Skin
  - Upper GI
  - 'other'
- Breast was experiencing challenges during 2023, but the position has improved since February 2024. According to the CADEAS dashboard Urology has met targets every month with one exception – May 2024. However, since November 2024 Urology has again struggled to meet targets at both Trusts.

Performance – Personalised Cancer Care

- The NHS Long-term plan states that every person diagnosed with cancer will have access to personalised care, and that where appropriate patients should have a follow-up that is personalised to them (Personalised Stratified Follow-Up). These deliverables are monitored against the following –
- Personalised Care Interventions –
  - Holistic needs assessments and support plans that address a patient's physical, practical, emotional and social needs. Completed at time of diagnosis and end of treatment (usually within an acute setting with the patient's key worker).
  - End of treatment summaries shared with the patient and the patient's GP including summary of treatment, potential side effects, signs and symptoms of recurrence.
  - Cancer care reviews completed in primary care with the patient, completed within three and 12 months of diagnosis.
  - Health and wellbeing information and support events/activities that facilitate a patient to self-manage and access available support to improve their health and wellbeing following a cancer diagnosis and subsequent treatment
- Personalised Stratified Follow up – number of patients on a personalised stratified follow up pathway (particular focus on breast, prostate, colorectal and endometrial).
- The NEL PCC dashboard records these metrics reported by acute Trust, and can be broken down further against a number of variables such as tumour site, team/role, population demographic e.g. age, postcode, ethnicity, etc. The 'one-page' dashboard providing an overall summary of this data from Q1 2019-20 to the end of Q2 2024-25 is included in Appendix 4.
- Again, difficulties in meeting targets can be an indication of either a workforce shortage or a skills issue. London targets for PCC interventions are set at 70%. National deliverables for PSFU are prioritised for Breast, Prostate, and Colorectal, and targets are set at 70% for breast and 40% for prostate and colorectal. The PSFU targets in these tumour sites has not been met in the last five years apart from in Breast in 2023/24. The delivery of PCC interventions - receiving a holistic needs assessment at diagnosis and then at end of treatment and a treatment summary - could also all be higher

Performance – Personalised Cancer Care

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- Whilst GP reporting of CCRs is very good, the quality and patient experience of the reviews could be improved. The CCR QOF was retired as a requirement in February 2025, which puts at risk both robust reporting and quality improvements in CCRs.
- The workforce primarily responsible for conducting, actioning and recording personalised care and PSFU interventions (other than CCRs) are predominantly acute cancer CNSs with support provided by the acute assistive/supportive workforce (there are some small-scale pilot projects where primary and community care services deliver PCC interventions). CCRs are completed in primary care, usually by a GP or practice nurse with support provided by the assistive/supportive workforce such as social prescribers/cancer co-ordinators.
- **Overall Performance Summary**
- A further analysis of NELCA activity will be undertaken at the start of Phase 2 to enable a more in-depth understanding of the link between performance and workforce challenges. Meanwhile, during the stakeholder interviews, each ERG chair or Clinical Lead was asked how, where and why workforce issues were impacting performance. The most straightforward answers were in areas where activity can be easily quantified and measured – for example, in radiology where the Royal College of Radiologists already understands the impact of workforce shortages on MRI and CT waits. The waiting list issues were consistently attributed to workforce shortages in the diagnostic part of the pathway (radiology, histopathology, endoscopy etc). The more complex answers varied but the strongest single theme was that increasing population health demand combined with changes in service model from patients living longer had created an upsurge in workforce demand which was unaffordable. In these circumstances, it is important to understand whether there is any room for service or skills mix change to enable better use of resource – so to examine benchmarking.

National Census and Benchmarking Data

National Census and Benchmarking Data - Oncology

- Workforce benchmarking data helps each area understand how their workforce compares either with other cancer centres or by resource per head of population. Consistently poor benchmarking scores indicate an 'infrastructure deficit' i.e. less resources to meet the same or higher identified need.
- The professional associations representing clinical oncologists (The Royal College of Radiologists, RCR), therapeutic radiographers (Society and College of Radiographers) and the physics workforce (Institute for Physics and Engineering in Medicine) each undertake an annual workforce census to provide national data. Findings of their workforce benchmarking are included below.
- Macmillan Cancer Support have produced a series of Cancer Nursing Censuses (latest October 2017) and an overall cancer workforce report (September 2022). Sadly, there is no clear benchmarking for some of the smaller professional groups or the administrative and clinical support groups who work within cancer services.

National Census and Benchmarking Data - Oncology

Clinical and Medical Oncology

- The Royal College of Radiologists produces workforce data on the numbers of clinical and medical oncologists in each Cancer Centre and then analyses the numbers of these consultants per head of population[14]. This provides robust data for benchmarking of NELCA cancer consultant workforce compared to the rest of the UK.
- Barts Cancer Centre ranks 60 out of 61 in the league table for number of Clinical Oncology (CO) consultants per head of population in 2022. This reflects the same position as the Trust was in the previous workforce survey in 2020[15]. Benchmarking data from 2022 – shown on the updated RCR workforce data from 2023 shows that Barts Clinical Oncologists rank 59 out of 59 cancer centres in terms of number of consultants per head of population
- The CO census data on 2022 was worked out based on a current funded establishment of 9.2 WTE Clinical Oncologists. At present Barts Healthcare has 6.6 WTEs; new substantives starting shortly will move the team to 8.4 WTEs. To begin to move towards the national position, two additional substantive posts are shortly out to advert – that would bring the Trust to 10.2 WTEs.
- Matching the top 10 Cancer Centres in the country would require 23 WTEs (an additional 13), to reach the top 20 we would need 21 (an additional 11) and to reach mid table we would need 19 (an additional 9).
- The issue is more in clinical than medical oncology. When Barts ranks the data by number of oncologists in total (clinical oncologists and medical oncologists combined) it is then 31 out of 61, so mid table. However, in this table, Royal Free is number 1, UCLH is number 2, Guy's and St Thomas' number 3, Cambridge is 7th and Royal Marsden is 10th. Barts would expect, as a major Cancer Centre, to rank similarly to both their neighbours and to other comparable centres.

[14] https://www.rcr.ac.uk/clinical-oncology/rcr-clinical-oncology-workforce-census-2022
[15] Royal College of Radiologists *Clinical oncology- UK workforce census report 2020* : Clinical oncology UK workforce census 2020 report | The Royal College of Radiologists (rcr.ac.uk).

National Census and Benchmarking Data - Radiography

- As the table below shows, Barts Therapeutic Radiographers workforce ranks 13/16 among its comparator centres:

	population	WTE 2021	No. per million population/2021	WTE 2022	No. per million population/2022	Rank
Barts	1.2	43.6	36.1	52.6	43.8	13
Guys & St Thomas'	1.9	107.73	56.7	105.23	55.4	7
Imperial	1.0	50.8	50.8	56.9	56.9	5
Kent	1.8	84.9	47.16	87.03	48.4	11
Mount Vernon	2.2	70.52	32.05	72.2	32.8	15
North Middlesex	0.6	27.9	46.5	27.9	46.5	12
Royal Free	0.5	21.11	42.22	21.6	43.2	14
Royal Marsden	2.3	110.8	48.17	131.6	57.2	4
Royal Surrey	1.4	85.09	65.4	88.85	63.5	3
Royal Sussex	1.1	60.39	54.9		0.0	8
Queens Hospital	0.7	24.7	39.6	22.7	32.4	16
University College London	1.3	98.7	75.9	119.4	91.8	1
Bristol	1.2	58.83	49.01	60.58	50.5	10
Nottingham	1.3	70.05	53.88	70.05	53.9	9
Hull	1.1	53.12	48.29	61.31	55.7	6
Southampton	1.3	72.02	55.4	87.7	67.5	2

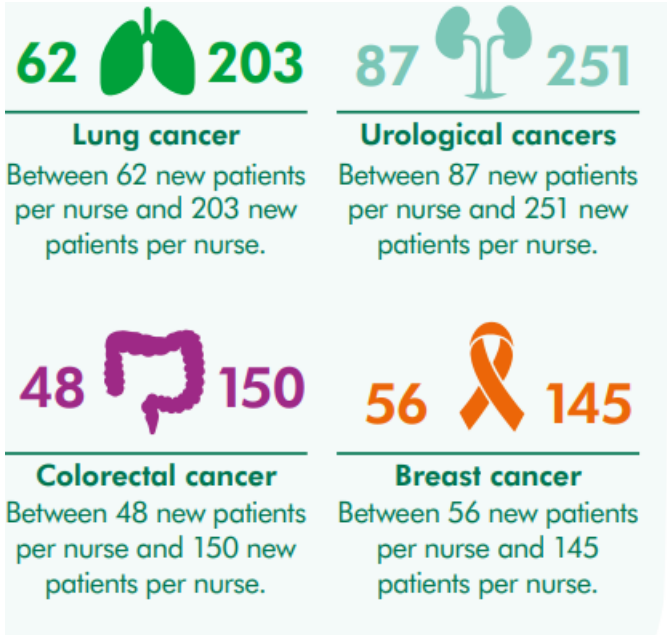
National Census and Benchmarking Data – Radiotherapy Physics

- The Radiotherapy Physics Census of November 2023 shows Barts ranks 11/13 of the comparator centres which provided data. 3/16 did not provide data:

	population	WTE Nov 2023	No. per million population/2023	Rank
Barts	1.2	27.1	22.6	11
Guys & St Thomas'	1.9			No data
Imperial	1.0	32.2	31.9	4
Kent	1.8	54.2	29.9	6
Mount Vernon	2.2	55	25.3	9
North Middlesex	0.6	18.1	31.2	5
Royal Free	0.5	11.6	22.3	12
Royal Marsden	2.3			No data
Royal Surrey	1.4	37.2	26.2	7
Royal Sussex	1.1			No data
Queens Hospital	0.7	14	19.2	13
University College London*	1.3	70	53.8	1
Bristol	1.2	25.3	22.8	10
Nottingham	1.3	32	25.4	8
Hull	1.1	34.2	32	3
Southampton	1.3	52.3	41.5	2

National Census and Benchmarking Data – Cancer Nursing

- Macmillan have produced both a series of Cancer Nursing Censuses, and an overall cancer workforce report. The most recent cancer nursing census in England was 2017 (census was taken on October 9th 2017). It provided information about four different aspects of the cancer nursing workforce identifying 4020 specialist cancer nurses in England, 2,686 adult chemotherapy nurse posts, 635 cancer support workers and 978 specialist palliative care nurses. Compared to the previous 2014 census, the workforce age profile recorded more nurses over 50 (33% of that workforce in 2014, 37% in 2017). Helpfully the report looked at the numbers of newly diagnosed patients per specialist cancer nurse and showed the variation between four cancer types[16] :



- A 2019 report produced by the Macmillan London Lead Cancer Nurse Forum identified a number of key challenges for the London nursing workforce including the increasing number of people living with cancer, particularly those living with the consequences of newer, more complex and aggressive treatment; defining and protecting the CNS role and skills alongside other specialist nursing and supportive roles; the need for a clear career pathway and competency framework; collaboration with primary care; and opportunities and exposure to cancer care for pre-registration student nurses.

- The Discovery Phase (2021-22) of the London Cancer CNS Workforce Project[17] identified the following issues in the London cancer nursing workforce - high vacancy rates (15% in London vs 12% nationally); low retention rates, significantly older workforce nearing retirement (37% over 50) creating a substantial risk of retirement; retiring CNSs being replaced by less experienced nurses who need a higher level of support to reach full professional autonomy; low morale and resilience; low entry rates into cancer nursing roles; and challenges in navigating career progression. In addition, it was predicated that at any one time approximately 22 cancer CNS vacancies being advertised across London, and in a 12month period 75 CNSs are in their first year as a cancer CNS.

[16] Cancer Workforce in England, Macmillan, 2017, [17] London CNS Development Project/CDL project documentation, North London Cancer Alliance -2022

National Census and Benchmarking Data – Cancer Nursing

- The London Lead Cancer Nurse Forum and the North Central Cancer Alliance have proposed a project looking at CNS benchmarking across London/NCL and this may be helpful to support local benchmarking of the CNS workforce but is currently in its infancy. However, there are a number of limitations related to CNS benchmarking which it would be important to consider when using any available data. It would be important not to consider the data in isolation, but to review alongside things like increasing numbers of patients on follow up pathways, increasing complexity of treatments and patient needs and variation between cancer types, increasing number of treatable but not curable patients and those on surveillance pathways, existing skill mix within teams for example the inclusion or not of support workers, cancer care navigators, triage services etc.

Wider Cancer Workforce

- The report on the overall cancer workforce was produced based on September 2022 ESR data[18]. Using their data definitions, Macmillan identified around 37,000 headcount as belonging to the England cancer workforce in September 2022, with 88% identified as working full time. The data shows the leaver rate in the year to September 2022 was 12.1% (4,378 staff), the highest rate recorded within the period studied. Additionally, almost one in five (19.7%) staff were aged 55 or over as of September 2022.

[18] Using the Electronic Staff Record (ESR) to Describe the NHS Cancer Workforce, Macmillan Cancer Support, September 2022

National Census and Benchmarking Data

Overall Summary

- Benchmarking data is not available across all professional groups. Where it is available, there is a strong indication that North East London is particularly challenged in terms of workforce provision:
- Barts Cancer Centre ranks 60 out of 61 in the league table for number of Clinical Oncology (CO) consultants per head of population in 2022. Matching the top 10 Cancer Centres in the country would require 23 WTEs (an additional 13), to reach the top 20 we would need 21 (an additional 11) and to reach mid table we would need 19 (an additional 9).
- Barts Therapeutic Radiographers workforce ranks 13/16 among its comparator centres
- The Radiotherapy Physics Census of November 2023 shows Barts ranks 11/13 of the comparator centres which provided data.
- The Discovery Phase (2021-22) of the London Cancer CNS Workforce Project[19] identified specific issues in London - high vacancy rates (15% in London vs 12% nationally); low retention rates, significantly older workforce nearing retirement (37% over 50)
- Although the secondary workforce data provided below underestimates the NELCA workforce, it is collected against the same criteria and data protocols nationally as that of the other cancer centres, During Phase 2 of this strategic workforce programme, further benchmarking will be undertaken providing comparisons for other professional groups and across key elements of the cancer workforce.

[19] London CNS Development Project/CDL project documentation, North London Cancer Alliance -2022

Analysis of Available Workforce Data

Analysis of Available Workforce Data – Acute Workforce

Methodology

- Due to timescales of the project, it is proposed that existing published NHS data on Primary Care, Hospital & Community workforce is utilised. This does not include primary care which is dealt with separately below. Full details of the ESR and Primary Care workforce data are being shared for use for validation with providers, with a narrative provided to explain the differences from the national workforce data collection.

Acute Workforce

- The acute workforce data is taken from the national ESR data collection. When this dataset is considered across NEL ICB and multiple areas of work associated with Cancer pathways, it provides an initial draft of a baseline of 1,371.78 WTE across the 3 organisations listed below.
- This summary data is currently provided in the same categories as Trusts' operating plan submissions. More detail of the split between the different Allied Health Professions, or the nature of support staff, will be examined during the deep dives recommended by this report. Professionals whose work includes, but not solely, cancer, may not be included. Admin and PA support may also not be recorded in this data.

Organisation	Central functions	Medical Staff	Managers	Nurses & health visitors	Scientific, therapeutic & technical staff	Support to doctors, nurses & midwives	Support to ST&T staff	Grand Total
Barking, Havering and Redbridge University Hospitals NHS Trust		58.38	3.00	67.03	106.32	93.33	37.18	365.23
Barts Health NHS Trust	54.35	184.41	1.00	240.88	271.92	93.93	109.53	956.01
Homerton Healthcare NHS Foundation Trust		5.00	2.00	26.27		17.28		50.55
Grand Total	54.35	247.78	6.00	334.17	378.24	204.54	146.71	1371.78

Analysis of Available Workforce Data – Acute Workforce

Barking, Havering and Redbridge University Hospitals Trust additional posts

- Validation of the data above with the Lead Cancer Nurse and the Cancer Lead at BHRUT suggested the number of medical staff were approximately correct in terms of consultant numbers but failed to identify the resident medical workforce. The breakdown of consultants was discussed: 11 oncologists, 5 haematologists, 5 Breast, 8 Urology and 3 Gynaecology consultants; 3 Upper GI, 4 Gastroenterology and 5 Lower GI consultants, 2 Head & Neck, 3-4 Skin and 2 Brain consultants.
- The data shown underestimated the full numbers of nurses and health visitors. The Trust has 40.75 WTE nursing staff in their Chemotherapy service, and 36.00 WTE ward nurses. As the data represents a nursing workforce which is mostly based in Medical Oncology the data above is likely to be missing at least 50 nursing staff including a proportion of their CNSs. Trainee Nurse Associates and Nurse Associates will both be included in the support numbers, which may be more accurate.
- The three managers identified is correct as are the scientific, therapeutic and technical staff and the support staff. The staff from the Cancer Referral office appear to be missing – another 7 Band 3 & 4 WTEs.

Barts Healthcare additional posts

- Validation of the data with the Lead Cancer Nurse again suggested that the number of medical staff only reflected consultant posts and not medical residents. Beyond the Cancer specialists identified above, there is realistically a number of general surgeons who will be operating across cancer and other surgical interventions.
- The nursing numbers appear to reflect the cancer nursing workforce operating within the various cancer teams and clinics. Barts has five specialist cancer wards, but all of the other sites have general wards. The data does not reflect an appropriate proportion of ward staff as many cancer patients are on general wards post-surgery.
- The Allied Health Professional workforce will be under-estimated as many support both cancer and non-cancer patients. Psychology posts are all missing – both Psychosocial support and those involved in supporting palliative care. Pharmacy is also a considerable under-estimate. Conversations have now been undertaken with both Pharmacy and Psycho-Oncology Leads. Details of those two workforces are therefore included in the professional groups section.

Analysis of Available Workforce Data – Acute & Primary Care

Homerton Healthcare additional posts

- Validation of the data above with the Lead Cancer Nurse and the Cancer Performance and Patient Experience Manager began with the low numbers of medical staff identified from national data. As 80% of the work of the medical workforce in Urology, Colorectal and Breast provide cancer services, this proportion of those staff should be added to the medical workforce.
- The nursing numbers were affirmed as being correct, as were the support staff numbers except a Band 6 Information and Support Manager. However, these numbers did not reflect those managers leading the Division – 3 WTE – and potentially did not include those working on cervical cancer screening – 1.6 WTE. The numbers also did not include the 0.8 Band 7 AHP and the Band 4 Exercise Technician who form the Prehab team. There is also a 0.2 WTE Dietician currently supporting Prehab. Community teams from UCH currently support Head and Neck and these would also be additional posts involved in the care of North-East London cancer patients.

Primary Care Workforce

- The approach to identifying the Primary Care workforce is to utilise published Primary Care workforce data[20]. A quick survey has been sent out to GPs to ask them to attribute a % of Primary Care activity (and therefore workforce) to the baseline workforce data for primary care. Several responses were received, but the % of primary care activity proved to be highly variable. So, a Primary Care Lead suggested a case study approach.
- Included below are three graphs showing the numbers and breakdown of medical staff, of nursing and then of all other direct patient care staff. In addition to the numbers on each slide, there are 2,305 FTE involved in non-clinical management and administration. The data provided in February 2025 therefore indicates there were a total of 4,303 FTE primary care staff in North-East London. An age profile by role across North-East London is also included below with commentary on the workforce risks.

[20] NHS Digital - https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services , 31st March 2025 data.

Analysis of Available Workforce Data – Primary Care

Case Study to understand Primary Care resource usage:

Dr Tania Anastasiadis talked through how she saw her role as a GP in managing cancer patients in more detail. She's clear that in Tower Hamlets, about 70% of the patients diagnosed with cancer have co-morbidities – she thinks therefore that much of the contact with these patients is multi-faceted.

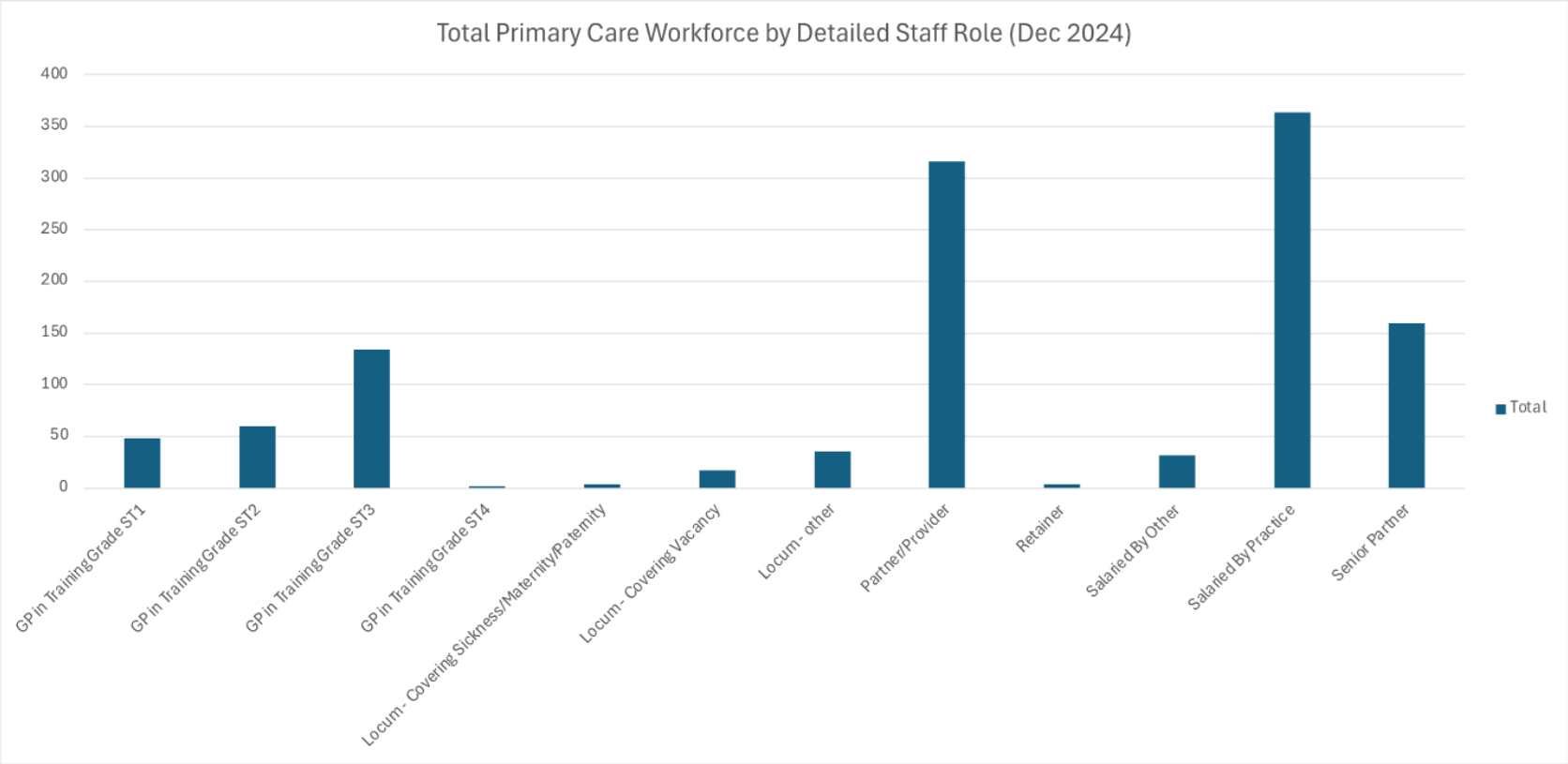
Estimating current cancer resource needed is potentially more difficult than understanding future need as the primary care role within the pathway for cancer specific interventions is progressively changing. With more patients living longer, the length of time during which patients need to be monitored after risk stratification is changing on several pathways. If this change is formalised for primary care, then it should be possible to understand additional capacity needed, for example, to do PSA and CS follow up in prostrate. The only easy way to describe current primary care resource usage is to base it on need.

The case study provided concerns a Stage 4 diagnosis patient who presents with a high palliative care need. The patient could need a weekly phone call to change prescribing and more detailed monthly consultations; primary care support needed carries with it a substantial administrative load to ensure other elements of care maintain the patient's end of life care pathway. A cancer diagnosis does tend to mean a higher number of contacts per patient than the majority of other long-term conditions; there are more primary care tasks overall for cancer.

It is important to understand the overall primary care workforce to understand, for example, how many experienced practice nurses are likely to retire in the next few years. But a numeric allocation of time for specific primary care resources is probably less helpful than patient-centred thinking about resourcing. Co-morbidities and stage of cancer are probably the two clearest drivers of resource need. Please see the section on population health which provides further analysis.

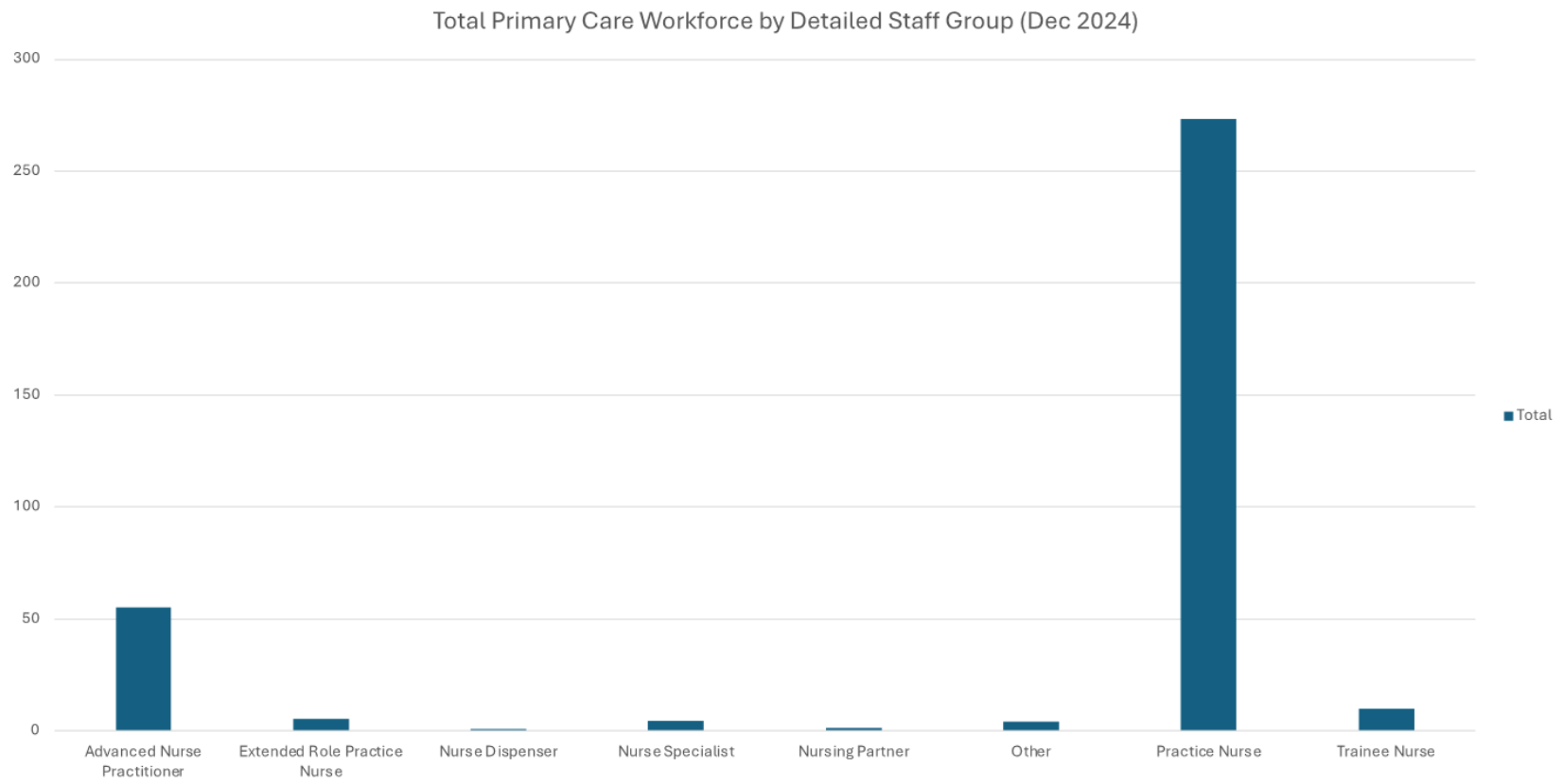
Analysis of Available Workforce Data – Primary Care

GP / Medical Staff – 1,171 FTE



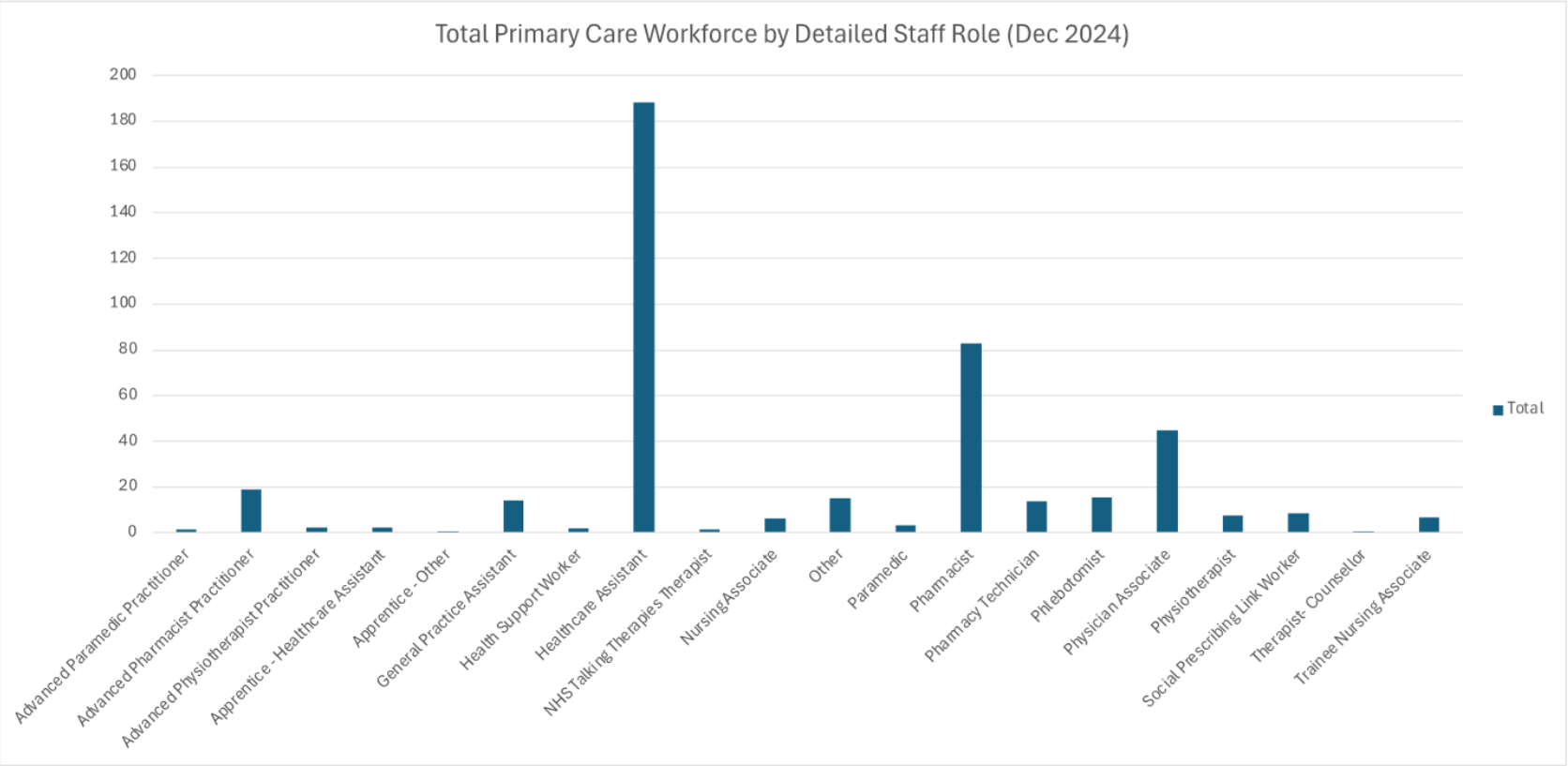
Analysis of Available Workforce Data – Primary Care

Nurses - 355 FTE



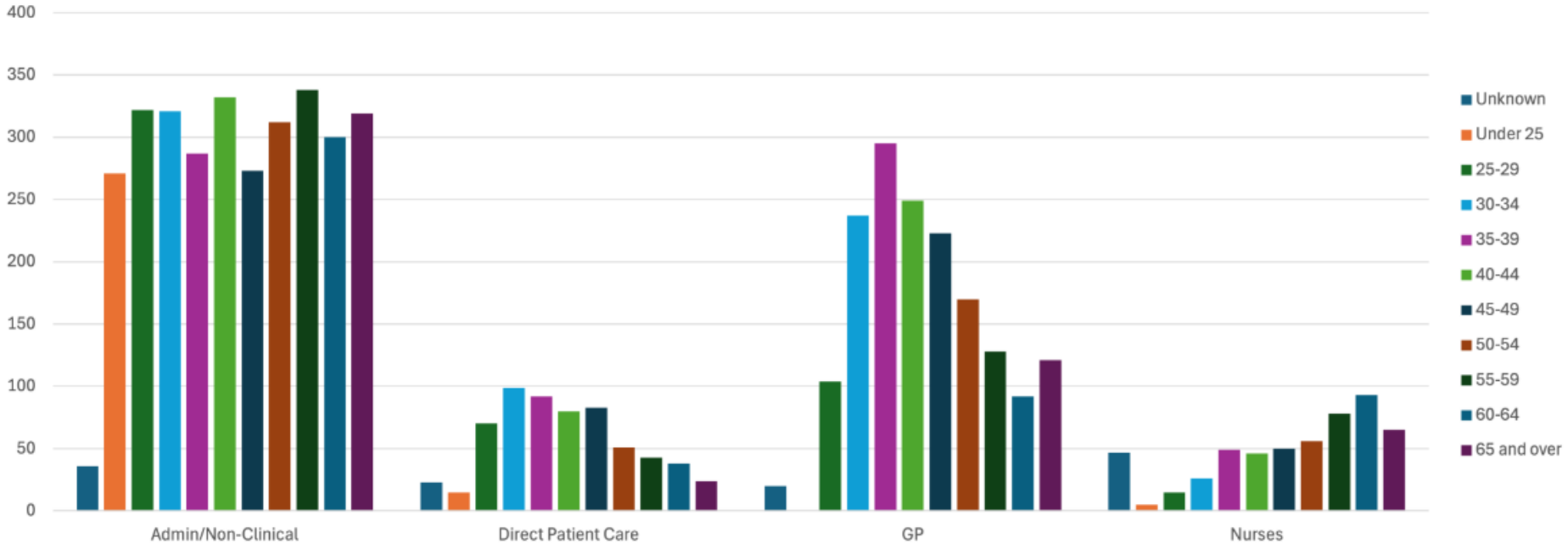
Analysis of Available Workforce Data – Primary Care

Direct Patient Care – 437 FTE



Analysis of Available Workforce Data – Primary Care

- The age profile analysis of the primary care workforce included above shows a relatively healthy distribution across age groups for administrative and clerical staff, direct patient care and the GP workforce. The nursing workforce shows a high risk of retirement, with a high proportion of nurses being over 50. Addressing this issue should be considered when undertaking more detailed nursing career pathway planning. Too many practice nursing vacancies would create substantial gaps in both long-term condition management and in cervical screening.



Insights and Challenges for each Professional Group

Insights and Challenges – Clinical & Medical Oncology

- There are 1,078 Clinical Oncology consultants across the UK (988 WTE), and 77 Specialty, Associate Specialist and Specialist (SAS) doctors. 8% of the consultant workforce are locum staff.
- 184 whole time equivalent (WTE) consultants, or nearly one in five of the current Clinical Oncology workforce, are expected to retire within the next 5 years. Over the next 10 years, 40% of the CO workforce are forecast to retire. Considering projected retirements and the impact of LTFT working, the UK has a 15% shortfall of CO consultants. By 2027, the shortfall of CO consultants is projected to grow to 25%.
- In 2022, 73% of those leaving the workforce were aged below 60 years compared to 53% in 2018. The median age of leavers was 54; this is slightly lower than the five-year average of 55 years.
- 33% of Clinical Oncologists are working less than full time contracts (LTFT), compared to 28% in 2018. This represents an 8% capacity loss.
- 31% of those aged between 55-59 are working LTFT.
- Considering projected retirements and the impact of LTFT working, the UK has a 15% shortfall of CO consultants. By 2027, the shortfall of CO consultants is projected to grow to 25%. The UK needs to hire 175 additional consultants immediately to deliver services in a way which is safe, provides a good patient experience and reduces stress and burnout. Clinical Oncologist consultants should be managing 150-200 new patients annually over no more than 2 cancer subsites and should not be working more than 10PAs.
- Expansion of the workforce needs to fill vacancies, remove reliance on doctors working excess PAs *and* increase in line with a rising cancer prevalence of at least 3% and the need to be able to deliver more complex treatments – overall an anticipated increase in demand of 5% per year. The number of oncologists per 100,000 population varies significantly by region throughout the UK, ranging from 0.8 to 6.1. In areas that have a lower number of oncologists per 100,000 older population, there is a correlation between this figure and waiting times, which has a direct impact on patient care and outcomes.

Insights and Challenges – Cancer Nursing

- As identified in the National Census and Benchmarking section national census data and London research identifies worrying issues in the cancer nursing workforce. Increasing numbers of nurses nearing retirement age, one in five over 55 nationally with an even older workforce in London and increasing leaver rates and vacancy rates, again higher in London (15% in London v 12% nationally). As CNSs are retiring, they are being replaced by less experienced nurses who need a higher level of support and approximately 18 months to reach full professional autonomy [21].
- The future position is concerning. There are low entry rates into cancer nursing roles. This is due to a lack of awareness of the CNS role and limited exposure to cancer nursing in undergraduate curriculums. As there has traditionally been no nationally agreed career pathway nor levels of practice, the new national ACCEND programme now provides guidance on the knowledge, skills and capabilities required by cancer nurses. However, there will be need to engage, implement and localise this to ensure CNSs are developing their skills and capabilities against this positive framework.
- Caseloads for some Cancer Nurse Specialists have doubled in the last 3 years – for example, in Lung. This is largely for positive reasons as patients are living longer, but with limited national guidance or benchmarking for CNSs, the impact is significantly challenging the workforce capacity and quality of care. The pan-London LCN Forum, with support from the London Alliances, is exploring the possibility of developing some capacity planning guidance/benchmarking, which may provide some future insight and review of CNS caseloads in NEL.
- Similar to the issues reported in the cancer nursing workforce, primary care nursing is facing similar challenges – recruitment, retention and an aging workforce. This is particularly impacting practice nurses where succession planning in needed. This will impact screening, for example cervical screening. As patients are living longer following a cancer diagnosis the knowledge and support needed from primary and community care also changes. Increasingly cancer should be managed as a long-term condition, and often alongside a number of co-morbidities, all of which require support and review in primacy care. There is a need to educate and upskill the primary and community nursing workforce, alongside other primary and community care roles, to increase and improve the support provided to people living with cancer in primary and community care. There are good practice pilots and projects, at place base, system level and pan-London that North East London could learn from and utilise in supporting their primary care nursing workforce, as well as opportunities to link more closely with ICB primary care workforce plans.

[21] London CNS Development Project/CDL project documentation, North London Cancer Alliance -2022

Insights and Challenges – Allied Health Professionals

- In December 2018, Macmillan published the first ever survey of AHPs working in cancer[22]. The largest proportion of patients seen by AHPs were in hospital settings; little involvement in prehabilitation was reported (only 3-14% of AHPs seeing patients before treatment had begun). The report covered four types of AHPs – Dieticians, Occupational Therapists, Physiotherapists and Speech and Language Therapists. Across the four AHPs a range of tumour types were reported as being seen including brain and central nervous system, breast, colorectal, lung, head and neck and upper gastrointestinal cancer. There was a clear indication of shortage of AHP resource, as 7 – 13% of respondents reported working 20% more than contracted hours. Between 63% and 75% of respondents felt more AHPs were needed to support people living with cancer with between 14% and 22% reporting they felt there were the right number of AHPs.
- There are limited Prehabilitation and Rehabilitation services in North East London, with further detail provided in the below section on Speciality Specific Services.

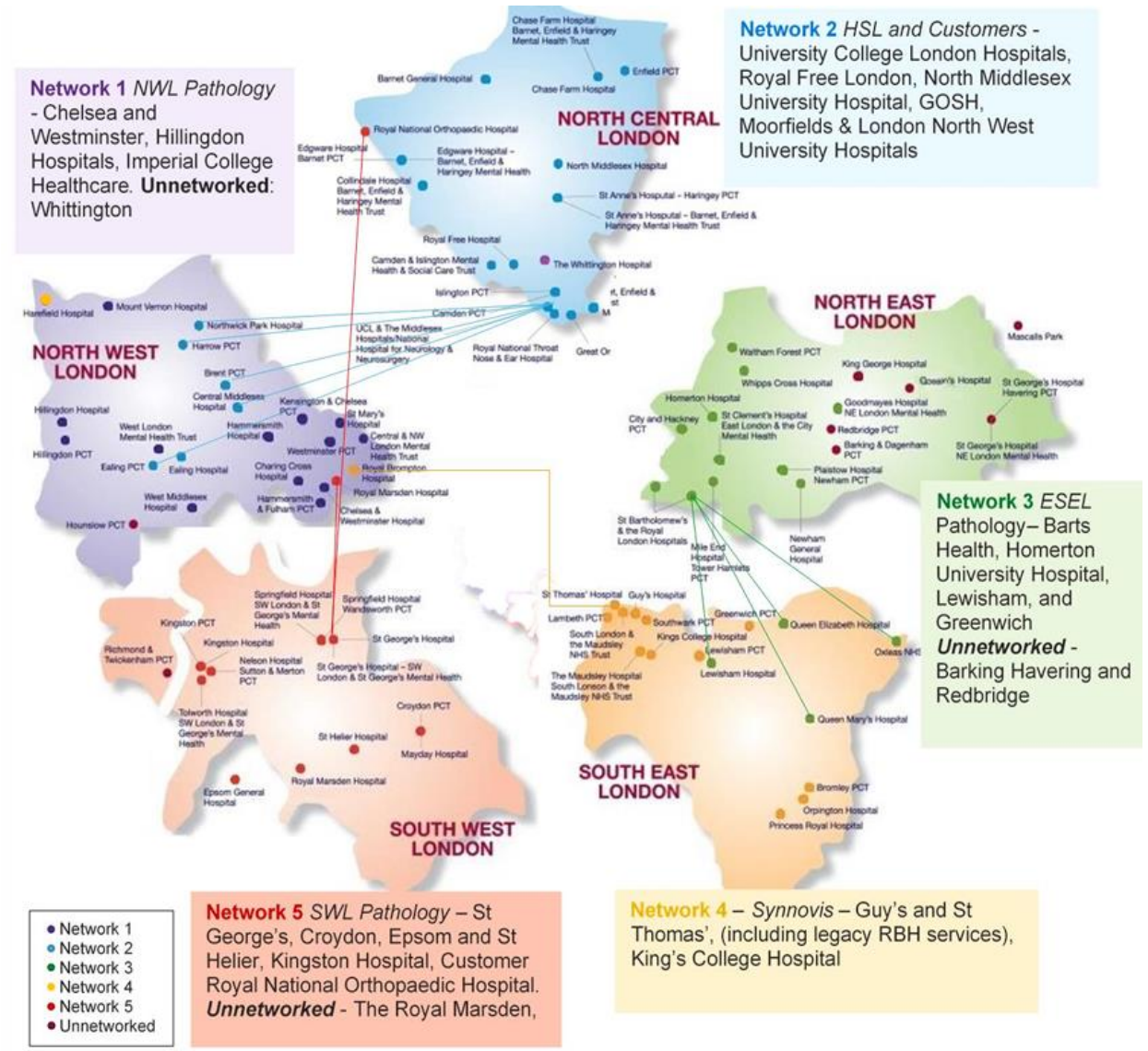
[22] Allied Health Professional Workforce Report, Macmillan Cancer Support, December 2018.

Insights and Challenges – Histopathology

- Current turnaround times for histopathology across London are contributing to the delays in diagnoses. Since April 2018, Patient Requests but specifically, corresponding activity within the laboratory and its complexity has increased workload by 21%. Scientific advances (offering improvements in personalised medicine) have compounded this further.
- Workforce has not increased in line with activity. Consultant workforce has only increased by 2% as compared to a 21% increase in activity. This is important as histopathology workflows are highly manual. The automation of processes remains a new technology. Services across London are provided from multiple sites with different models for delivery. Turnaround times for results across London are highly variable.
- London's pathology services are not aligned to ICB footprints – see map below. Data shows that no service in London has been able to regularly meet the target of 80% of reports within 7 days or 90% within 10 days. Performance has deteriorated since 2021 albeit, in recent months, some services have started to address this with local improvement initiatives. There is wide variation in turnaround times by speciality and pathology network, some of which may be warranted, some not. High volume specialities are particularly impacted. In NEL, both BHRUT and the Royal London Lab have been challenged to meet turnaround times over the 4-year period covered by the Review. Performance has declined since the pandemic.
- Since 2016 the number of Histopathologists in London has only grown by 2% with an activity increase of 21%. Relative to the size of the population that each Pathology Network serves, the number of laboratory staff and histopathologists per head of population appears variable. This may indicate that establishment levels may need to change, particularly in areas which have the most challenged turnaround times. HEE workforce data (ESR) shows that growth in staff in post (WTE %) has been lowest in NEL compared with London ICBs over the period since 2016.

Insights and Challenges – Histopathology

- By way of background, this map shows the extent to which Pathology Networks align to ICBs.
- In all cases, more than one Pathology Network is responsible for providing services to patients across the ICB footprint.
- This makes it harder for ICBs to be assured their pathology service meets the needs of their population, and are providing, equitable access to all. To help address this, some ICBs are establishing pathology groups to bring stakeholders together and provide governance.
- Additionally, there are a few acute and specialist trusts which are not currently part of Pathology Networks.



Insights and Challenges – Histopathology

- A pan-London pathology programme reported on an initial discovery phase with specific workforce findings – 'opportunities'. For all labs, the skill mix seems to be broadly consistent with other Network Laboratories, but is significantly affected by vacancies, which are the highest across London and expected to be a significant driver of challenged performance. The key opportunities identified by this 'discovery' project are:
- Extension of Laboratory hours to increase capacity – with associated increase in staffing
- Build and strengthen the workforce strategy, with a focus on recruitment and retention and staffing planning
- Support increase in biomedical scientist cut up and reporting
- Releasing consultant time through streamlining MDTs and improving admin support
- Workflows in lab to reduce time to transfer/cut up and reduce overall TAT
- Reduction in unwarranted variation in speciality TATs, including provider improvements to manage demand alongside strategies to address in-lab workforce gaps
- Recent work in Histopathology in NELCA has focussed on improving performance, with a detailed analysis of efficiency across the pathway. Although this has alleviated performance issues, it does not deal with ever-increasing demand for Histopathology services, nor the resulting under-investment in workforce relative to activity requirements. A two-year demand management workstream has therefore been established to work collaboratively with other cancer specialties.
- A skills mix solution is proposed to address the national shortage of histopathologists. Scientists need to take on tasks currently or historically performed by medical staff. In a pilot, backlogs were improved due to scientists taking on dissection previously performed by medics, but this was only a short-term option and there is currently no funding available to sustain the model. NELCA funding has been provided up to end of March 2025 for agency scientific staffing, which is now improving performance back to previous levels. In the longer-term, a business case addresses scientific staff training to take on roles performed by medics, as recommended by NHSE and in line with other UK peers.

Insights and Challenges – Pharmacy

- The key challenge for the pharmacy workforce is growth and changes in cancer medicine. One example of the growth in cancer medicines is the increased use of immunotherapies. In 2011 the first immunotherapy Ipilimumab was approved for use in melanoma. As on 1st February 2022, there are seven immunotherapies in utilised in nine different tumour sites and over 20 different indications. The benefits from these treatments can been in direct patient outcomes but the differences in toxicities and duration of time patient remain in treatments in comparison to traditional chemotherapy has caused challenges, not least within oncology pharmacy services. This is particularly seen within aseptic service compounding capacity (which is already insufficient to meet demand) and increased role of the PIP in clinics to review immunotherapy patients. The further expansion of immunotherapy into the adjuvant setting will only increase these challenges further. Advanced therapy medicinal products (ATMP's) including CAR-T therapy also pose a huge burden on NHS pharmacist resource due to the complex nature of these therapies.
- In May 2023, the British Oncology Pharmacy Association (BOPA) published results of a workforce survey. This revealed vacancy rates of 20.6% (176/854) in technical services staff and 19.0% (135/711) in clinical services staff across the 69 respondents — 31.7% and 16.6% of these vacancies, respectively, had been advertised at least once without successful recruitment. In BOPA's written evidence submitted to parliamentary committee in January 2022, the national overall oncology pharmacy shortage was estimated to be 17%[23].

[23] Written evidence submitted by the British Oncology Pharmacy Association (ECS0031) to parliamentary committee, January 2022

Insights and Challenges – Pharmacy (Continued)

- There is a designated Oncology Pharmacy team at Barts. This team includes a 0.5 Band 8c Consultant Pharmacist, a Band 8b Service Lead and a Band 8b Specialist Haematology Pharmacist, 5 Band 8as who are Specialist Oncology Pharmacists, and who work on a rotational basis supporting different specialty teams each 9 months and about 15 Band 7 Pharmacists with one Band 6 Specialist Pharmacy Technician. These are all supported by appropriate numbers of Pharmacy Technicians.
- Volume is the main issue, with the number of patients constantly increasing. Each year the Chief Pharmacist submits a proposal based on capacity for increased investment to match the workforce against demand trends. The current pharmacy service is meeting current demand, but if the investment is not agreed, then fairly soon there would be issues about capacity. The current request for investment Is for 2 more Band 7 staff and an increase in staff for the manufacturing unit.
- Pharmacy rarely has capacity to attend MDTs. The manufacturing unit is growing at the same rate as the prescribing team. A separate team deals with clinical trials. Their workload has increased by c. 25% but the research projects bring with them funding which should pay for additional posts. There are some resolvable issues with both chair space and office space on the Barts site; when the teams need to visit the other sites, there is increased complexity.

Insights and Challenges – Radiotherapy Physics

- In this professional group nationally there are 950 WTE clinical scientists, 640 WTE clinical technologists (physics) and 350 WTE clinical technologists (engineering). There are approximately 65 WTE 'Other staff' in Radiotherapy Physics, who include computer scientists, clinical pathway co-ordinators, administrative staff and quality managers. Dosimetrists are made up of both clinical technologist and therapeutic radiographers, so it is not currently possible to provide exact numbers of dosimetrists in post.
- 9% of clinical scientists and 20% of clinical technologists are expected to retire within the next 5 years. There is a particular risk around linac engineers, 34% of whom are expected to retire within the next five years. Approximately 10% of Clinical Scientists leave the profession within five years of HCPC registration.
- There is currently a clinical scientist shortfall of 7% and a clinical technologist shortfall of 9%. By 2026, the shortfall of clinical scientists is projected to grow to 10%. There are currently only 27 clinical technologists registered on IPEM's Technologist Training Scheme.
- Radiotherapy Physics includes three main staff groups – Clinical Scientists, Engineers and Therapeutic Radiographers. The issues facing the NELCA Therapeutic Radiography workforce are dealt with separately below. The Clinical Scientists and Engineers staff groups within North-East London both face supply problems. The national training scheme for Medical Physicists does not provide a national framework for career development, new roles or research. The national training scheme rarely provides candidates who are ready for autonomous clinical work; the academic background might be appropriate but the lead time to create a fully effective clinical scientists can be up to 2 years. There is also a lack of training places on the Science and Technology Programme, which limits the national recruitment. Locally recruited and trained candidates would improve this challenging position.

Insights and Challenges – Radiotherapy Physics

- Similarly there is no training scheme for engineers. Previous feeder roles came from TV repair shops or the military – both sources no longer provide entrants with some relevant experience – so there is a real need for an apprenticeship for engineers to address this gap.
- BHRUT has as gap for 1 Engineer as this individual is on long-term secondment as Staff-Side Chair; the team also has 4 radiographers and 2 physicists. The team there can undertake basic diagnostics, and basic fixes – but more complex work goes to Barts. BHRUT as 3 Linax machines; Barts has 5 and an additional specialist machine.
- The work is very highly regulated by both the Health and Safety Executive and the Care Quality Commission. CQC is the regulatory body for the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- There are specific challenges in recruiting to more senior roles across London. The recent Institute of Physics and Engineering in Medicine (IPEM) Workforce Survey – available to members - gave minimum staffing recommendations and then shows the % of current establishment against recommended establishment. BHRUT was at 69% of the staffing required by patient numbers. The minimum staffing at BHRUT should be 10 WTE; they currently have seven.

Insights and Challenges – Systemic Anti-Cancer Therapy

Barking and Havering University Hospitals Trust (BHRUT)

- The Sunflower Suite at BHRUT delivers around 10,000 SACT treatment cycles each year. The Trust also has a 15-bed haematology-oncology (haem-oncology) mixed ward. New patients are seen as soon as practicable within the 2-week wait, discussed at MDT and if confirmed as cancer, bad news broken to patient. Patient case is dealt within the relevant tumour groups and a decision to treat as out-patient. The patient is scoped, history is taken, treatment plan is explained, patient consented, blood tests ordered, CDF forms completed, chemotherapy is prescribed. Any dose adjustments or treatment proposals are made depending on histopathology. All or most of the above is undertaken by the oncologists. With the acute shortage of medical oncologists, clinical oncologists undertake both the SACT prescribing and Radiotherapy prescribing. There are 10 clinical oncologists and 2 medical oncologists in the Trust; approximately 50% are part-time. See Figure 2 below for workforce overview.
- The service does not have enough support staff, and so consultants undertake pre-SACT reviews, which has an impact on clinic capacity and ability to initiate new treatments. Patients are sometimes seen at decision point due to the capacity limitation. Ideally, pre-SACT reviews can be undertaken by nursing or pharmacy staff with appropriate qualification. Due to limited pharmacy resource, there is no dedicated oncology pharmacist involved in the process of prescribing SACT. There is no dedicated oncology pharmacist for clinics or screening SACT prescriptions of new patients for contradictions. However, there is a clinical pharmacy service provided to the 15-bed capacity in-patient ward. This member of staff also supports the Chemotherapy Production Unit.
- There are 2 Nurse-led clinics per week, seeing an average of 38 patients a week. There is also one virtual clinic a week, (utilising an app-based system - Noona and questionnaire) for Pre SACT-Toxicity Assessment and prescribing at BHRUT. There is an inadequate number of nurse-led clinics with the service requiring an estimated minimum of 20 clinics per week. There is also an additional nurse who reviews but does not prescribe. There are no dedicated clinical nurse specialist (CNS) within the oncology service as their roles mainly sit within the divisions.

Insights and Challenges – Systemic Anti-Cancer Therapy

Barts Healthcare

- There are 127 individual outpatient clinic lists at the site, covering the specialties including Breast, GI, GU, Renal, Melanoma, Neuro, Lung, Head & Neck and Gynaecology. The medical oncology outpatient clinics see roughly 600 patients per week. There are 18 medical oncologists at Barts with a projected 30% increase year-on-year in activity.
- The set-up at Barts has a visible oncology pharmacists' input into the SACT pathway. There are dedicated oncology pharmacists for screening SACT prescriptions of patients for dose modifications, protocols, medicines reviews, contradictions etc. However, there is a limited input from prescribing pathway in the clinics. The majority of the clinics are run by medical consultants with clear distinction from clinical oncologists' roles in terms of prescribing SACT.
- There are 5 oncology inpatient wards. 3 wards provide care for Medical Oncology patients with a total of 44 beds. In terms of throughput it is difficult to quantify in terms of total number of patients, but the site runs at 100% occupancy the majority of the time. In addition, there is a satellite chemotherapy day unit at Whipps Cross and the Barts also deliver chemotherapy at Newham Hospital two days a week.
- Based on the available figures, approximately 29,000 SACT prescriptions are screened per annum. However, noting the dates and accounting for missing data from submission, this is expected to be higher. The pharmacy team generally screen around 130-140 prescriptions per day which would amount to around 35,000 per annum[24].

[24] Information on both hospital's service models is taken from NELCA Oncology Scoping Review, December 2023.

Insights and Challenges – Systemic Anti-Cancer Therapy

Homerton Healthcare

- Homerton has 5 WTE Clinical and Medical oncologists, but much of their cancer surgery is undertaken alongside general surgery in the bigger specialties. Approximately 80% of the work in Urology, Colorectal and Breast is cancer-related; the medical workforce in these specialties therefore supplements dedicated oncology resource. A significant challenge is shared pathways – with University College Hospitals and Royal Free or Barts Healthcare – ensuring continuity of care for the patient can sometimes become challenging.
- The radiology team has substantial vacancies and is limited by equipment capacity – for example, Homerton only has two MRIs. The Trust is also reliant on the pathology partnership for all its pathology, which can cause delays when there is pressure in the wider health system.

Insights and Challenges – Therapeutic Radiography

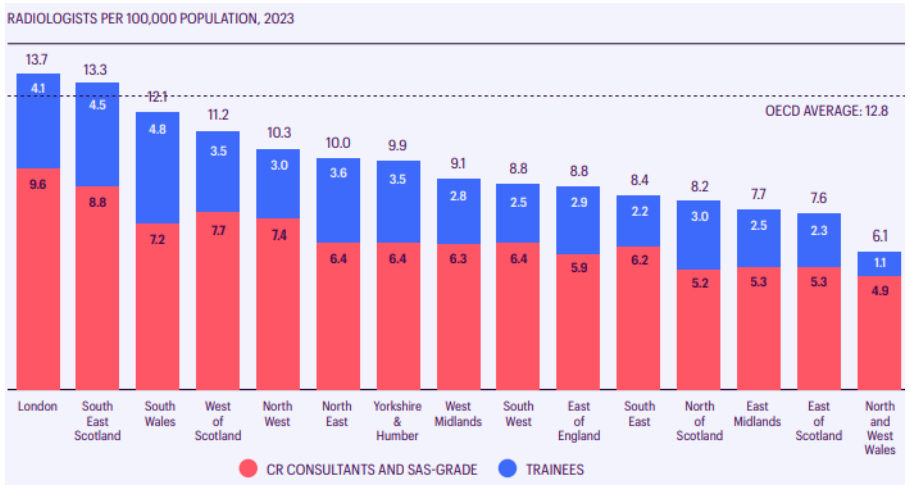
- The total NHS radiotherapy radiographic workforce is 3903 WTE. There are 3746.1 WTE therapeutic radiographers, 63.3 WTE assistant practitioners/trainee assistant practitioners (APs/TAPs) and 93.6 WTE clinical support workers. Within the next five years, it is anticipated that around 5% of therapeutic radiographers will retire.
- In 2022, 45% of those who departed from the workforce chose to pursue careers outside of the health service, indicating a significant rise compared to the previous year's data, where only 16% left for the same reason.
- The highest turnover rates based on AfC bands are observed in Band 3, representing clinical support workers, and Band 5, encompassing therapeutic radiographers. The turnover rates for Band 3 and Band 5 are 17.4% and 20.2% respectively.
- The vast majority of therapeutic radiographers are educated and trained by a traditional undergraduate programme. The numbers trained by region varies, so some services do not have access to newly qualified staff, many of whom choose to take up employment where they were trained or in centres with particular expertise (e.g. proton centres).
- Student attrition from pre-registration therapeutic radiography degree programmes has always been relatively high when compared to other healthcare programmes. Student retention is improving but approximately one fifth of the cohorts do not complete their degree.

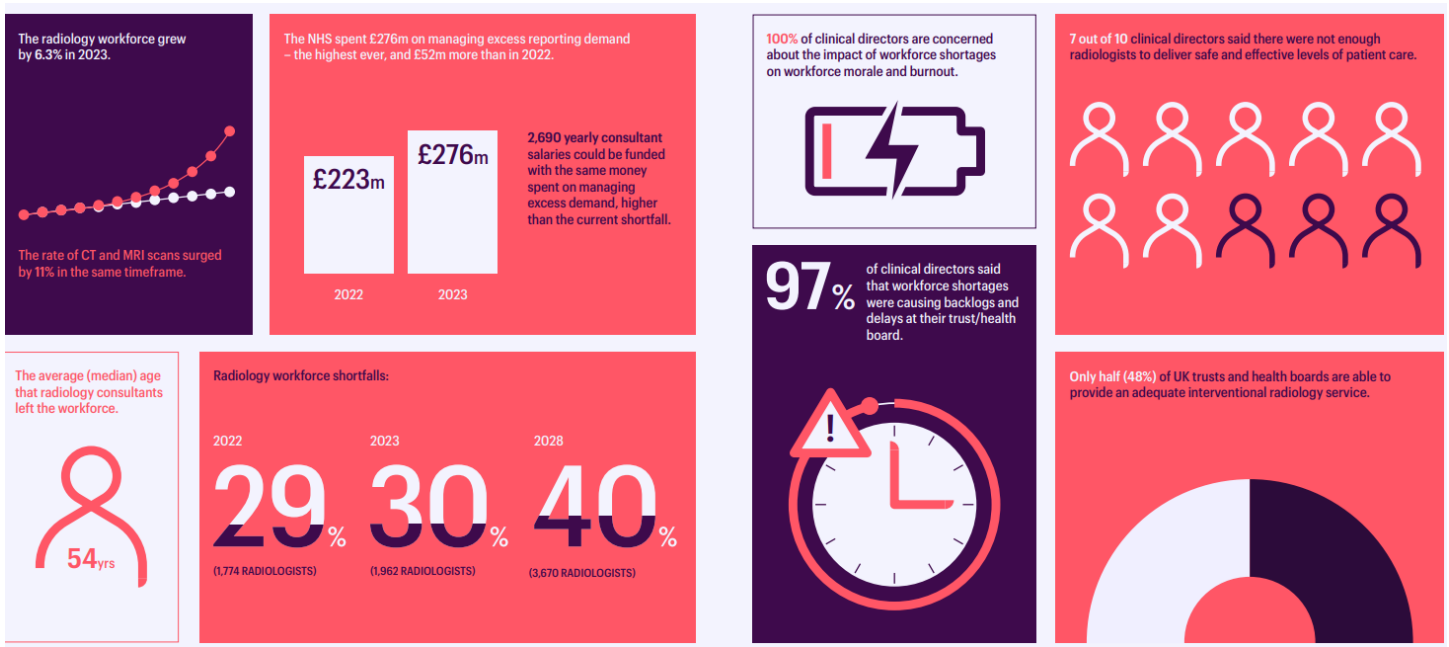
Insights and Challenges – Therapeutic Radiography

- There is currently a therapeutic radiographer shortfall within the NHS of 10%. There are circumstances where the funded operational establishment does not meet safe staffing levels and therefore the shortfall figure will be higher. By 2026, the shortfall of therapeutic radiographers will increase. The rate of increase is dependent on the expansion of Advanced Practitioners to fill roles in other workforce areas. At Barts, this impacts on the available operational workforce which will also need to increase due to increased demand. The rollout of the apprenticeship programme will help to offset the shortfall, but these posts need to be funded appropriately. BHRUT does not have Advanced Clinical Practitioners but struggles to recruit. There would be mileage in understanding whether a collaborative model would strengthen both services.
- NHSE workforce improvement workstreams focus on the triumvirate workforce of Radiographers, Oncologists and Physicists. Therapeutic Radiographers are encouraged to take development roles; once an Advanced Clinical Practitioner, they can cover for Consultant Oncologists. This makes the day-by-day operational end of the service less stable – staff are still needed to cover Linax, CT scanners etc. Diagnostic Radiology has had national investment to resolve its workforce issues – a similar level of focus is now needed in Radiotherapy. A workforce plan including the development of apprenticeships, radiotherapy dosimetrists and overseas recruitment to meet short, medium and long-term shortfalls is needed. This should potentially also include the creation of a late affects team similar to that being established at UCLH.
- A Safer Staffing document is about to be published along with a modelling spreadsheet which will enable both Trusts to collect data. Once this process has been completed, a deep dive into the service and workforce model should be undertaken. This is included amongst the recommendations at the end of the report.

Insights and Challenges – Radiology

- In 2023, the UK had a 30% shortfall of clinical radiologists; the four nations were 1,962 radiologists short of providing an adequate radiology service. This is forecast to rise to 40% by 2028. This means, without meaningful action, by that date the UK will have a shortfall of 3,670 radiologists[25].
- London is better supplied with Clinical Radiologists than the rest of the UK. However, nowhere in the UK meets the OECD average of 12.8 consultants.





[25] Royal College of Radiologists Clinical Radiology Workforce Census 2023

Insights and Challenges – Radiology

- The radiology workforce is growing but is not keeping pace with demand. The first image above shows the rate of growth in demand for CT and MRI scans compared with growth of the workforce. Backlogs are the inevitable result. On the Royal College of Radiologists' (RCR) website, a section is given to 'state of the wait'[26]. Month by month, the RCR analyses diagnostic imaging and cancer treatment waiting times, showing how many radiologists it would take to clear the imaging backlog in England. The calculation is based on CT scans and MRI scans taking an average 15 and 20 minutes respectively to report. The current calculation (December 2024) suggests 346 radiologists would need to be hired overnight – equivalent to just under 10% of the workforce.
- Radiology colleagues in NELCA report that their biggest issue for Imaging is the reporting backlog (currently approx. 2500 for cross sectional Imaging across RLH/SBH) and their Reporting Turnaround Times (TATs) for reporting which are substandard for Cancer Imaging. The deficit in the local radiology workforce (which parallels the national shortage) is a major contributing factor, but the other big problem is the lack of administerial staff dedicated to supporting reporting flows and pathways. All existing radiology administerial staff have designated roles and are stretched to the limit. Radiology would therefore need a dedicated 'Imaging Navigator' whose key role is to triage/prioritise/direct cancer Imaging reporting, so Radiologists are able to focus on meeting KPIs for reporting and meeting TATs for Cancer scans. There is one in post at Guy's and St Thomas's, who has significantly streamlined their workflow. The addition of this type of dedicated staff member could potentially be transformative to the current service.

[26] https://www.rcr.ac.uk/news-policy/policy-reports-initiatives/state-of-the-wait/

Specialty Specific Service and Workforce Issues

Specialty Specific Service and Workforce Issues

Gynaecological Oncology

- Patients are diagnosed at Queens, Homerton and Whipps Cross as well as the Royal London; the more complex cases might be transferred for surgery to Royal London before receiving chemotherapy or radiotherapy at either Barts or Queens. Currently there is a gap in the radiotherapy workforce at Queens which means almost all treatment is at Barts. Histopathology remains a pervasive concern although a recent recruitment drive has begun to address the shortage of biomedical scientists. There is still a backlog, and the number of cut-up benches still limits capacity.
- The units have strong medical staffing with the exception of Queens. Queens has a Clinical Oncologist gap which is proving difficult to fill. The high population need and lack of funding both make Queens a challenging work environment. The position is more positive for Gynaecological Surgeons – there are six in post at Royal London and a 7th is being developed to address the current gap. There is a good pool of Junior Clinical Fellows, an Academic Clinical Fellow and an ESCO Fellow (European School of Oncology) at Barts Healthcare, providing a feeder for consultant posts and the current vacancy for the sub-specialty vacant post.
- There is a need to train a second nurse hysterscopist to ensure stability for the 5 nurse-run clinics. This process could take up to 18 months. Clinical Nurse Specialists are now in post or recruited to establishment. Recent gaps have meant that the ward staff have not received all the training normally provided but this is expected to improve. There is definitely a need to succession plan key nursing skills given the likelihood of retirement of some of the more highly specialist workforce.

Specialty Specific Service and Workforce Issues (Continued)

Haemato-Oncology

- The recently appointed Clinical Director highlighted that the Outpatient model in her specialty needs an overhaul. More patient-initiated follow-up (PIFU) and increased remote monitoring would improve the use of current capacity. A junior doctor is currently doing a feasibility study to look at and size these key changes.
- Haematology-Oncology is consultant-led – there are no CNS-led clinics currently. A CAR-T clinic was requested 5 months ago and still has not been approved internally. There is potential for 2-3 nurse-led clinics as there are 2-3 Advanced Clinical Practitioners with appropriate backgrounds. Skills mix could change over a period of time – less consultant-led and more use of ACPs and prescribing pharmacists with appropriate administrative support.
- There is an issue about clinic capacity in terms of clinical space – but this is resolvable. The shift to remote monitoring might create some flexibility if a different clinic model was planned. The team would appreciate help with planning these service changes if the Alliance is able to provide some support.

Specialty Specific Service and Workforce Issues

Breast

- Breast is responsible for 46% of chemotherapy undertaken at Barts. Chemo is under-resourced – the current NELCA analysis of demand and capacity indicates that there are insufficient pharmacists and CNSs. There are also clear shortages in Breast radiologists – this is a national problem – this impacts on the symptomatic and 2 week wait pathways. On a good day, all three Trusts can just keep up but only by overtime; the pathways struggle to perform as soon as there is any leave or sickness absence.
- The complexity of treatments for breast cancer have increased exponentially with a knock-on impact on the need for oncology resource. Follow-up periods are much longer than 3-5 years ago – this can be a 3-year period once per month for some patients – and the patterns of treatment have also changed. Chemo is often given both before and after surgery now, whereas before it was almost always a post-surgery treatment. For each patient, the workload has probably therefore increased 40 or 50% over the last three years.
- Barts has responded by recruiting 4 new oncologists in the last 3 years. Patient outcomes are still improving, but to maintain this trajectory, there will need to be continuous growth in the workforce, which is now not affordable. The challenge is the speed at which new successful treatments are being developed. As each new treatment in mainstreamed, the team has to adjust capacity according to demand. The most recent business case internally was to resource more treatments for early breast cancers.
- Clinics are now overbooked by 2 hours minimum. Each oncology appointment is 20 minutes. Assuming 2 sessions with 4 hours each, this means an oncologist can see 24 patients a day. Most clinics are booked for 30 patients – if they all attend, the consultants have no choice but to work the extra hours. The work intensity and complexity are leading to burnout.

Specialty Specific Service and Workforce Issues

Breast (Continued).

- Administrative support would help. The resourcing levels for administration are low, meaning oncologists and CNSs are involved in booking, filling in forms, etc. The current administrators are not paid well compared with competing industry sectors; turnover is high. As a result, clinic bookings can sometimes be chaotic.
- The Breast ERG Chair identified three priorities for Breast – in priority order:

1. Some solution to oncology demand – this continues to grow over proportionately to surgical demand with the availability of new treatments.
2. A Specialist Nursing Team – appropriately resourced, some clinics could be nurse-led, releasing pressure on the oncologists
3. Finding a solution to the lack of Breast radiologist shortages.

- Ensuring that there is a sufficient stream of mammographers coming through to replace turnover is also important. The current workforce often get RSI given the nature of breast cancer screening procedures. The profession does not currently have a high profile nationally and it might help to address this issue locally.

Specialty Specific Service and Workforce Issues

Colorectal

- Colorectal has high volumes of tumours, and substantial workforce challenges. Services are provided at Whipps Cross, Newham and Royal London for Barts; this means three MDTs although Royal London and Whipps Cross do work together. The biggest issues facing this specialty are endoscopy and histopathology. The histopathology issue only affects Barts, but there delays in diagnoses hold up the rest of the pathway. Histopathology does not have capacity to attend the MDTs. The NELCA Colorectal Lead is focusing currently on Histopathology improvement – there are currently 7 unfilled new consultant posts in Histopathology and the gap in the current establishment is another 3 WTE, including an Upper GI Histopathologist.
- Endoscopy has a large backlog despite the increased capacity of the community diagnostic centres; rooms remained closed for a variety of reasons (some workforce) and the backlog grows. Faster Diagnosis Standard nurses have been tried in Lower GI but only on short-term contracts which means that the workforce does not remain stable. Retention of FDS nurses is difficult as there is no clear career pathway and the work may not stretch capabilities as much as CNS roles on other parts of the pathway. If FDS nurse roles were seen as development posts, where do the next cohort come from?

Specialty Specific Service and Workforce Issues

Dermatology/Skin

- Skin has some of the highest referral rates of all the tumour groups, with a 10% year on year growth from 2020 onwards. Meanwhile the consultant workforce is reducing. NELCA is therefore seeking to empower primary care to decrease secondary referrals. Teledermatology and medical photography will be used to enable GPs to communicate with consultants at both Barts and BHRUT; Homerton will receive GP photos to enable rapid diagnosis. Training is being provided for GPs in the use of dermatoscopes; each practice is being encouraged to have a tele-dermatology lead. The use of AI is being scoped, and the cancer assessment unit is extending hours in an endeavour to avoid A & E.
- The planned pathway change is currently being scoped. A survey has gone out to find out if any GPs with Special Interests or a diploma or are teaching; the aim is to find any experience of community dermatology good practice to support peer review, or peer triage.
- Meanwhile the ERG Chair is piloting the new way of working. At his practice, each GP proposes a referral that then comes through him for peer review. He is logging the extra work required for the reviews, to estimate the time commitment for other GPs who volunteer.
- The time taken is approximately 8-10 minutes a month for the c. 10 referrals he reviews and triages. There are some risks from GP triage – but these are limited and could be mitigated further by good ongoing training.
- There is no national register of those who have special interests in this specialty. Using a network of the knowledgeable, the hope is to create a hub and spoke type model – once this is understood, some help with the resultant pathway redesign would be appreciated Once the survey to GPs has been completed and analysed, support with pathway redesign would be appreciated. .

Specialty Specific Service and Workforce Issues

Head and Neck

- Head and Neck cancer treatments are split between Ear Nose and Throat (ENT) teams and Oral Maxio-Facial Surgery teams (OMFS). The ENT teams within NELCA would diagnose cancer and provide any post-operative care, but a pan-London agreement means that the surgery is split currently between the Royal London and University College London Hospital. A recent GIRFT report on outcomes suggested that patient care would be improved if this current split of pathways was removed, and that all care took place at one or other hospital. A dialogue is therefore underway to 'repatriate' NELCA patients with Royal London becoming the main centre for care. Speech and Language and Dietetics support is already available at the Royal London; low risk of cancer referrals are currently seen by Speech and Language Therapists, but thresholds for referrals for therapeutic support are likely to be re-evaluated if the service model overall changes.
- Barts Health ENT diagnoses are undertaken at both Royal London and Whipps Cross sites. The one-stop clinic at Royal London is effective; Whipps Cross cannot provide rapid on-site reporting. BHRUT have both a one-stop clinic and an oral lesion 2 week wait service. This latter service uses combined medical photography to stratify patients.
- Improving Dietetic support is an urgent need. At the moment, there is variation in access – Waltham Forest has 2 weeks of follow-up when guidance recommends 6. A proposal is being produced to ask for pump priming for a new role to increase capacity. The restorative dental service is also over-stretched; only 60% of patients who need this support can currently access the service. The current 2 dentists would at minimum benefit from improved administrative support. Ideally an assessment should then be made as to whether additional prosthetic sessions are needed.
- Overall, given changes in the model of care, the most important outstanding need is probably updated pathway mapping

Specialty Specific Service and Workforce Issues

Lung

- The GIRFT (Get It Right First Time) studies on Respiratory and Lung Cancer provide two different windows on the workforce in Lung. The team at Barts has about 400 new diagnoses per year; the team has 12 PAs increasing to 15 shortly but the ratios recommend 20 PAs for this level of caseload. The recommendation for nurse ratios to patients in Lung is currently 80:1; nursing ratios across Barts as a whole are c. 55:1 so this level is met. However, the increases in complexity mean that the nurse-to-patient ratio is likely to be changed to 40:1 which will leave Barts short. There are also some individual clinics which are only staffed by one nurse, making them vulnerable to cancellation during leave periods – for example an outpatient clinic at Royal London.
- Delays in radiology are the single largest barrier to the Lung pathway – there is an overall shortage of diagnostic radiologists, but also a national shortage of specialist thoracic radiologists. The surgical pathway is also increasingly slow – the reasons for this are being investigated.
- The current consultants are all over job-planned – the team are trying to create a further joint post with acute medicine, but the current financial challenges may make this difficult. Pleural disease currently falls within the team's remit, but there is no specialist in this area. At minimum, the Trust should have a Pleural Nurse Specialist.
- A pathway navigator could free up consultant time if investment in the medical and nursing workforce is not forthcoming. Please see the case study below to explain this navigator could improve flows.

Specialty Specific Service and Workforce Issues

Lung

Improving patient care with a pathway co-ordinator and better use of diagnostic capacity

- There are administrative problems in the first part of the Lung pathway. If the episode of care is not assigned to a consultant at the outset, then Cerner Millenium does not automatically update the consultant with the different stages of diagnosis and treatment. Most referrals are then taken to triage – the office then books at the end of the 2 week wait, not the next available slot. The episode of care entry drives the scheduling for CTs automatically. If the CT scheduler is on leave, this then waits for the approval of the radiologist. At least some patients could be triaged by X-ray, which would lead to a faster diagnosis. The date of the clinic appointment currently defines the scheduling of the CT; it would be better if a CNS and a navigator make the decision that those with a normal CT do not need to come to clinic.
- The next part of the pathway requires a PET scan – 1.5 PET scanners are currently needed, and Barts only have 1 and contract out in 'batches' to InHealth for use of the second. If a PET scanner at Queens was available, this could solve capacity issues.
- Biopsies, mostly be endoscopic ultrasound, take about a week but the consultants tend to schedule these given the lack of a pathway navigator. 1 consultant does nearly 50% of these so better cross-cover would ensure less vulnerability.
- The pathology laboratory is challenged for both resources and space. Small biopsy samples are turned around within a week – but biomarkers take longer. Large surgical samples have a 2-3 week turnaround time. Diagnostic surgical samples need to be categorised as 'small samples' to ensure timeframes are met – again, a need for a navigator to ensure compliance.
- Radiology might also benefit from a pathway co-ordinator – perhaps a shared team of 2-3 with the Lung pathway? A specialist pharmacists might also help unlock current delays in chemotherapy prescribing.

Specialty Specific Service and Workforce Issues

Urology

- Urology is responsible for five cancer groups – prostate, bladder, renal, testes, penile. The number of CNSs in Urology at Barts does not benchmark well against other specialties. The sub-specialty coverage of the medical workforce also has significant gaps. The gaps are most significant in bladder cancer – Barts receives 2,000 referrals p.a. but does not currently have a specialist.
- Ten years ago, pelvic and renal cancers were centralised across London – North East London patients are therefore sent after localised diagnosis to either the Royal Free Hospital or University College London Hospital for treatment. This has created difficulties for the surrounding hospitals including Barts recruiting both medical and nursing workforce. Some improvement has come from developing joint posts with these two hospitals – BHRUT has 1 post and Barts 3. However, the non-medical PAs to those joint posts are still undertaken at the centralised hospitals – meaning the allocation to BHRUT and Barts is approximately 3.5 PAs per week. The waiting lists at UCLH are now a cause for concern, with extra capacity being bought from the private sector.
- There are issues in the speed of diagnostic and follow-up monitoring test support. Pathology and Radiology are both workforce shortage professions and often run with high vacancies. Outsourcing of scans has been tried, but it leads to over-reporting of cancer or suspicion of cancer. A particular pressure point is MRIs – Barts undertakes 1,500 prostate MRIs p.a. but only has 6-7 radiologists who understand this area. Urology differs from other specialties in how long the patient needs to be monitored after treatment, The average period for Breast patients might be 2 years – for Urology it could be 5.

Specialty Specific Service and Workforce Issues

Genomics

- Recent developments in Genomics are undoubtedly of benefit to patients and their relatives. Family history screening for Breast cancer and Lynch syndrome has been undertaken at Barts Health for a while. Recently widening the Family history service to include Gynaecological and Colorectal cancers is being discussed. As Barts is the only London hospital offering family history screening, they may yet be asked to provide this across other London areas. The key challenge is that it is difficult to predict the resource needed; at the moment, Specialist Nurses are expected to 'absorb' the extra workload once equipped with suitable training.
- There are also ethical risks if the service is widened beyond the current provision. Even if it was only ever widened to cover other treatable cancers, there conversation about having a 'gene for cancer' requires very careful handling.
- An evaluation of the workforce resources currently required for screening for Lynch syndrome might help assess the future workforce requirements to cover Gynaecological and Colorectal cancers.

Specialty Specific Service and Workforce Issues

Personalised Cancer Care

- CNSs are responsible for co-ordinating and providing the bulk of personalised care interventions and support to cancer patients. We describe in other sections the challenges in the CNS workforce.
- In addition, to CNSs, who predominantly sit within specialities, all three Trusts have additional dedicated support staff who are crucial to the efficient, effective, and safe delivery of co-ordinated and personalised care. These include Cancer Support Workers, Personalised Stratified Follow-Up (PSFU) support teams/roles and MDT coordinators who usually work within specialities. In addition, there are roles and teams that work across specialities to deliver and improve personalised and coordinated care including Macmillan Information and Support staff, Personalised Care Leads, Living With and Beyond Cancer teams. Continuous upskilling, training and supervision for this patient facing largely non-registered workforce is vital.
- The number of patients remaining on the pathway has increased despite personalised stratified follow-up planning – this creates capacity pressures on already over-stretched staff. The complexity of some pathways and number of professionals involved in treatment and care requires careful co-ordination and communication. And with the introduction of new treatments and drugs this adds to the complexity of patient needs.
- For example, cancer support workers work closely with the CNS teams to deliver personalised care interventions, address low level needs, triage patient enquiries, and support patients with signposting, navigation and care co-ordination. As the number and complexity of patients increases support workers are crucial in enabling CNSs to focus their time on more complex patients and patient needs.

Specialty Specific Service and Workforce Issues

Personalised Cancer Care - Barking and Havering University Hospitals Trust (BHRUT)

- At BHRUT there is a Living With and Beyond Cancer team which leads on delivering personalised care including personalised stratified follow up and Macmillan information and support services. The team comprises of a Macmillan Personalised Care Lead, a Macmillan Information and Support Manager, two Personalised Cancer Care support workers, a Personalised Cancer Care data manager, a PSFU Team Lead, a PSFU CNS, a PSFU support worker and a PSFU data manager . The intention is to achieve a good standard of wrap around care – including links with prehab.
- Staffing is probably sufficient but there is a space issue. All the team works out of the Macmillan Information room at the hospital which is much too small. Workshops are held at Hornchurch, again limited by space constraints. Some quality and post-treatment wellbeing events are also virtual.
- The team signposts to Havering, Barking and Dagenham social prescribers; they have links with District Nurses particularly if there are complex co-morbidities. They work closely with the NELFT psycho-oncology team – both referrals and shared workshops. They also link into NELFT and other partners for Talking Therapies.
- In addition to the support workers in the Living with and Beyond Cancer team there are 7.4 wte support workers working with lung, head and neck, neuro-oncology, haematology, AOS, metastatic breast and metastatic urology. There is a desperate need for additional support workers in breast, urology, colorectal, skin, gynaecology and UGI.

Specialty Specific Service and Workforce Issues

Personalised Cancer Care - Barts Healthcare

- At Barts there is a Personalised Cancer Care Lead who leads on development, progress, monitoring and support for the Personalised Cancer Care interventions and PSFU. There are PSFU/RMS support workers/administrators covering Breast, Prostate, Colorectal and Gynaecology. Sustainability of these pump prime funded roles has been challenging despite the impact the roles have on the safe co-ordination and digital tracking (RMS) of patients.
- There are 15 support workers across all four hospital sites and specialities. Two support the gynae and colorectal PSFU patients, 8 are based in the following specialities – breast, head and neck, urology, haematology (2), AOS and an additional one in gynae. There are a further 3.5 support workers working in the Macmillan Information and Support Centres, and a support worker working with the radiotherapy team.

Personalised Cancer Care - Homerton Hospital

- Up until the end of March 2025 there was a Macmillan Information and Support Manager, who also covered Personalised Care and Patient Experience. There is currently uncertainty about the continuation and re-recruitment of this role due to challenging financial decisions regarding personalised care services at the Trust.
- There is one band 5 PSFU/RMS co-ordinator and four wte band 4 support workers (some of which are currently grant funded and will therefore need approved business cases to sustain). The support workers cover lung, colorectal, breast, head and neck, skin, urology, AOS and haematology.
- The personalised care team facilitates a regular patient-led community cancer drop in that is well attended by a range of patients and covers things like advice on LA services, housing, welfare benefits, art therapy, physical activity including yoga, dancing, and walking football. The team also link with community social prescribing services including a Macmillan funded cancer specific service delivered by Family Action.

Specialty Specific Service and Workforce Issues

Personalised Cancer Care - Macmillan Information and Support Services Teams

- There are Macmillan Information Teams at every hospital where cancer treatment is provided. Staff are employed by their host Trust with initial pump prime funding followed by ongoing service and professional engagement and support from Macmillan. The teams do the same work but with different activities to suit their population's needs. A drop-in centre provides information on pathways, individual cancers, treatments, psycho-social support and wellbeing. The teams work closely with welfare benefits services, as finances are usually a substantial issue for patients. Some teams work with palliative care teams more than others – partly depending on co-location. The teams support the CNSs with Holistic Needs Assessments; they run wellbeing offers such as complementary therapies. Travel costs are also an issue as most treatment for Barts patients is done at the main Barts site – help is therefore offered with the process of fare re-imbursement. The teams prepare 'newly diagnosed' packs and can provide information in other languages as needed. The patients served work in borough but serve patients beyond the borough when needed.
- Most teams have a support worker and a manager plus volunteers. Volunteers are recruited and initially trained centrally by the Trust/hospital. Signposting to other organisations will depend on what is available and sufficiently robust in terms of support offered. Recently specific ethnic minority cancer groups have been established to help with living with and beyond cancer - examples are a prostrate group in Whipps Cross and Bengali and Pakistani groups for Breast. Housing and immigration support is also needed for some ethnic minorities – working with local Authority services. Tower Hamlets and Newham has neighbourhood teams linking voluntary services – this has yet to develop in Waltham Forest where work is largely with social prescribers. The teams meet bi-monthly to share good practice, and at least once a year to network with other Macmillan Information teams across and outside London.

Specialty Specific Service and Workforce Issues

Personalised Cancer Care – Macmillan (Continued)

- A Cancer Information Nurse Specialist (a job share) at Barts manages their team, and works with the Tertiary Referral Centre. They work closely with the Clinical Nurse Specialists and Consultants, supplementing the advice, information and guidance provided during diagnosis or treatment. Their key focus is to enable the patient to understand better what has been said in medical consultations; they visit patients on the wards (about a 100 patients on the Barts site plus the chemotherapy day wards). This role also contributes to Cancer Nuse Development days, and provides some input to both health and wellbeing events and awareness initiatives. Links into social prescribing would be made for in-area patients; out of area patients would be referred back to their GPs to access more local services. A support worker helps with workload issues three days per week; the workload potentially requires a full-time support resource. In terms of onward referrals, a good network is in place although social worker support is definitely particularly stretched.

Personalised Cancer Care – Maggie's

- Maggie's is a registered charity, providing cancer support. Their premises is on the Barts site and they work closely with cancer services here 16,500 visits per annum are handled by 3 WTE oncology clinicians, 1 Psychologist, 2 Fundraisers and 1.5 Benefits Advisors; volunteers provide hospitality and a wider programme of activities. Their support services include friends and families – providing links to the nearest Maggie's centre for relatives if they do not live close to the patient. Maggie's is involved with the Psychosocial Support Team in linking with trainees. The staff also undertake bereavement work. There are 25 Maggie's centres across the country, with 4 in London (the other three are at the Royal Marsden, the Royal Free and Hammersmith). Surveys are regularly undertaken to understand the balance of patient needs. The last one showed that 3 out of 4 patients were more worried about their financial position than their cancer – an indicator of the impact of the cost of living crisis?

Specialty Specific Service and Workforce Issues

Psycho-Social Support

- The Transforming Cancer Services Team commissioning guidance for London in 2020-21 calculates that 25% of cancer patients require L3/4 psychological support, 10% requiring L4 specialist psychological/psychiatric services and 15% requiring L3 interventions from psychologically trained health care professionals. The guidance recommends that this L3/4 support for cancer patients is provided by psychologists that specialise in cancer and work as part of the cancer MDT (psycho-oncology), alongside providing psycho-social training and supervision to the cancer workforce delivering L1/2 psychosocial support to cancer patients.
- Each of the three hospitals has a psycho-oncology team:
- Barts has 0.7 clinical time of the NELCA Consultant Lead Psychologist and 4 full-time psychologists plus one working 0.9 and one working 0.6 WTE (6.2 WTE in all). It currently has a 0.6 WTE vacancy. There is substantive funding for 5.6 FTE and the remaining posts are funded on a fixed term basis by other organisations.
- BHRUT has access to 5 NELFT psychologists who between them cover approximately 4 x WTE. This includes a Lead Consultant Psychologist, (Band 8b 0.5WTE) , a Band 8a 1.3WTE Psychologist (0.5WTE is fixed term funding), and 1.4 WTE Band 7 Psychologists (1.0WTE is fixed term funding).
- Homerton has 2 psychologists, who each work 0.8 WTE so 1.6 in total. These individuals cover both psycho-oncology and palliative care.

Specialty Specific Service and Workforce Issues

Psycho-Social Support (Continued)

- Additional palliative care psychological support is available – 1.5 WTE at Barts, Whipps Cross has 1 WTE, and there are paid posts to provide psychological therapies at both Hospices.
- Additionally, there are trainees who are supernumerary – 4 at Barts, 2 at BHRUT and 1 at Homerton.
- There is also a 0.4 wte NEL Liaison Psychiatrist supported by two years of Macmillan funding.
- The services currently provide for patients in the first year of diagnosis and treatment but is challenged to support patients living with and beyond treatment (which is often when psychological needs present), and cannot provide any form of family support (another recommendation in the commissioning guidance). Geographically, much of the Barts support is based on the St Bartholemew's site, whereas need seems to be concentrated in the more deprived areas (City and Hackney, Newham and Tower Hamlets). More advanced stage cancers often need home visits, which the service can only provide in two boroughs. Care is therefore sub-optimal given shortage of resource. Links have been made with community talking therapies although their ability and training to support psycho-social needs related to cancer requires improvement.

Specialty Specific Service and Workforce Issues

Pre-habiliation and Rehabilitation

- There are small prehabilitation teams, pump prime funded by NELCA, at BRHUT, Barts and Homerton. Recent evaluation of the services, alongside Maggie's patient activation scheme, shows clear improvements in patient outcomes across a range of categories (from mobility to self-care and nutrition). Sustainable funding has been confirmed for the BHR and Barts service and awaiting an outcome on the Homerton service.
- The rehabilitation offer overall is more limited, with current initiatives being targeted to Head and Neck and Upper GI.
- Prehab services consist of the following roles:

Barts

- Barts started with 1 WTE Physiotherapist and 4 Exercise Technicians; the team has now expanded to include a dietician.

BHRUT

- BHRUT have 1 Physiotherapist, 1 Dietician, 1 Personalised Care Cancer Nurse Specialist, and it has recently expanded to include an Occupational Therapist, an Exercise Psychologist and a Data Co-ordinator

Homerton

- Homerton has a smaller team who offer both prehabilitation and rehabilitation and delivers the service in the community. Prehab posts – a 0.8 WTE Allied Health Professional and a Band 7 Exercise Technician. There is 0.2 WTE dietetics support for this team – the only dietetics resource currently designated for cancer patients. Substantive funding needs to be secured for this service.

Specialty Specific Service and Workforce Issues

Palliative, End of Life and Enhanced Supportive Care

- We have presented the BHRUT services in more detail, with a summary of the services at Barts and Homerton.

BHRUT

- BHRUT has two Enhanced Supportive Care Leads who are Clinical Nurse Specialists. Their team was established under a CQUIN to the Trust to enable earlier intervention, to manage down crisis and avoid emergency admissions. The service is nurse-led and provides palliative care at point of diagnosis of an incurable cancer. The team meet with patients while they are still well, and help manage appropriate treatments, contacting them every 2 months.
- Treatment for palliative care patients have changed – there are many more drugs, and immunotherapy now plays a large part. Many patients live longer with an incurable cancer. The only other enhanced supportive care team in London is at UCLH – and this is consultant-led.
- The caseload numbers have remained stable during the past five years at around 760 patients per annum. The team started by covering three tumour groups, then expanded to 5. A service review enabled them to lower the intensity of input for some patients and provide specific capacity for breast and urology caseloads; this led to the decision a month ago to open to all tumour groups.
- The team numbers 4.4 WTE Clinical Nurse Specialists (Band 8a and Band 7); one Macmillan funded Band 7; one fixed term Metastatic Breast CNS (until September 2025), 2 Macmillan Support Workers (Band 4) and 0.8 Admin. It is not yet known whether this will be sufficient to address the increased caseload from opening to all tumour groups. The team would appreciate a check-in in 6 months-time to evaluate how the new service change is faring.
- The BHR Hospital has a Palliative Care Advisory Service. The team there works closely with St Francis' Hospice, who have both inpatients and a community palliative team. Since 2008, palliative care has been extended to cover non-malignant patients. The team has about 50:50 cancer to non-cancer patients.

Specialty Specific Service and Workforce Issues

Palliative, End of Life and Enhanced Supportive Care

- BHRUT runs a specialist service, so there are criteria and thresholds – the team does not see everyone who dies in hospital. As well as the Lead, the team includes:
  - 2 palliative care facilitators – one per site – both Band 7 – originally CQUIN funded, 1 per borough, now Trust funded.
  - 1 ACP
  - 6 CNSs
  - 1 OT
  - 1 Social Workers
  - 1 Discharge Facilitator.
- In terms of medical workforce, at prime they had 4.5 consultants but at the moment these are all vacancies. They therefore use the virtual advice call – Supportive Care UK – who provide palliative care consultants. One new consultant is joining in May – meanwhile they have 2 GPs who work in the team – 1 also works at the Hospice. Joint teaching sessions with the GPs are very successful in helping other non-palliative care staff understand how to approach dying. This helps generalists to engage with tools to recognise dying, to equip them to deal with the wider cultural and family issues.
- The team does have one Associate Specialist (0.6 WTE). They have a Registrar post on hold and will recruit to this in September once the consultant embeds. This will lead to a 2nd consultant in 18-24 months.
- Winter pressure moneys last year enabled a palliative care paramedic on the front door – turning patients around and enabling feedback in real time to GPs and Care Homes. Funding from the consultant vacancies is now enabling this post to become substantive alongside a CNS on the admitting ward. The CNS reviews all patients on day 3 and day 5 – by day 5, patients have normally died or are able to go home with appropriate support. This CNS pilot is about to be written up and evaluated.

Specialty Specific Service and Workforce Issues

Palliative, End of Life and Enhanced Supportive Care

- St Francis Hospice – the Hospice struggles to recruit to its community palliative care teams, and to CNS roles in inpatients as they do not pay NHS terms and conditions. Ideally, Band 6 rotational development posts could be established which would be feeder roles into Band 7 for both the Hospice and BHRUT. The aim would be to rotate through being a District Nurse, a Hospital Nurse and a Palliative Care Nurse – 6 months each. The current group of CNSs has a cohort who may retire soon, so this needs to happen before valuable experience is lost.
- Bereavement services - the Chaplaincy is within the BHRUT Lead's remit. The Chaplaincy team run one informal bereavement group per borough each month. The Hospice also run something similar for their patients. There is also a coffee morning at BHRUT once a month for the recently bereaved and this is well attended. The team is about to start a 7-week course based on watching a video and then a discussion. Some patients genuinely need a 1:1 service for (those with high or complex needs) but there is currently no funding. BHRUT have established a befriending service for staff – 'Bereavement First Aiders' – which helps BHRUT be a compassionate community.
- Main risks - the Lead's main concern is advocacy for more specialist support for palliative care and bereavement at Executive level given the financial constraints. The high number of complex patients, and the increasing numbers of younger patients are creating extra demand,
- The social worker is particularly stretched, Ideally the team could do with a second social worker, in order to provide one per site.

Specialty Specific Service and Workforce Issues

Palliative, End of Life and Enhanced Supportive Care

Barts

- There are Macmillan palliative care services at Newham Hospital, The Royal London Hospital, and St Barts Hospital. The palliative care services at Whips Cross Hospital are based at the Maragaret Centre which is a Gold Standards Framework accredited 11 bedded specialist palliative care unit with day room and peaceful garden for patients, loved ones and visitors. Services run from the Margaret Centre include the Macmillan Hospital Palliative Care Team and the Waltham Forest Community Palliative Care team. As well as working directly with patients and families, the community palliative care team provides advice and support to other professionals in the community including GPs and district nurses, and work closely with patients GP or hospital consultants who remain primarily responsible for their care.

Homerton

- The palliative care team at the Homerton provides specialist palliative and end of life care to any adult patient living with serious or life-limiting illness (this includes patients with cancer and non-cancer diagnoses) and offers support to families and carers. The team manages complex symptoms such as pain, nausea, breathing difficulties, and fatigue, as well as providing personalised holistic support for spiritual, emotional, psychological, and practical needs. The service is an advisory service and covers all areas of the hospital, and Mary Seacole Nursing Home. All patients seen remain under the care of their referring medical or ward team. The service works closely with other health and social care professionals including GPs, community nurses, hospital doctors, and other local hospitals and hospices to support patients and their friends and family.
- The team consists of medical consultants, nurse consultant, team leader, clinical nurse specialists, social worker, clinical psychologists, and an end-of-life care facilitator.

Impact of Current Workforce Projects

Impact of Current Workforce Projects

National Initiatives

- NELCA has several current workforce projects which are described below. Before considering these, it is worth recognising that some workforce shortages are now being addressed at national level. Key national initiatives include:
- The development of apprenticeships in the radiotherapeutic and physics workforce areas, across a variety of roles, grades and academic levels, to build a locally committed workforce that is more likely to be retained over time, ideally through the creation of supernumerary apprenticeship posts.
- An expansion in training places, particularly through apprenticeships, though variation in funding of additional training places across the professions and lack of capacity to support clinical education are key barriers.
- National profile-raising campaigns to encourage more people to consider careers in cancer care.
- Exploration of global recruitment and learn-earn-return initiatives.
- Development of Specialist posts for Clinical Oncology and Medical Oncology to provide development opportunities for specialty and associate specialist grade doctors who do not pursue consultant roles.
- Development of Advanced Practice and Consultant roles in the therapeutic radiographer and radiotherapy physics workforce.

Impact of Current Workforce Projects

Aspirant Cancer Career and Education Development programme (ACCEND)

- ACCEND has been established by NHSE/HEE to provide guidance on the knowledge, skills and capabilities required by all cancer support workers, nurses and allied health professionals who care for people living with cancer in non-oncology and specialist cancer services and roles as part of multi-professional teams.
- The ACCEND programme is a cancer career and education development programme that supports aspirant cancer nurses and allied health professionals towards increasing their knowledge, skills and capability. The intention is to increase and improve the supply of the cancer health care professional workforce in the future. Using a range of learning opportunities, ACCEND provides a definitive career and development pathway for those aspiring to work in cancer care. ACCEND is underpinned by learning related to the four pillars of professional practice - clinical practice; leadership and management; research/evidence-based practice and quality improvement; and specialist cancer focused education.
- The theoretical framework of ACCEND and a standard approach nationally are both positive steps but given the infancy of the framework significant time and resources at an operational level are required to support the engagement of the local workforce and successful implementation. It will also be reliant on both national and local programmes to ensure the accompanying learning and development are kept updated and relevant. For ACCEND to have impact in the long-term, effort is required locally to support on-going engagement, implementation, usability and availability of relevant training and education.

Impact of Current Workforce Projects

Pan-London Cancer CNS Development Lead (CDL) Pilot Project

- Macmillan and NHSE are currently funding a 3-year London Cancer CNS Development Project which Is a regional project to support ACCEND implementation. The aim of the project is to improve the recruitment, retention and career development of cancer CNSs, as well as increase general awareness and understanding of the CNS role. The project is overseen by a London project team hosted by North Central London Cancer Alliance (NCLCA) on behalf of all London Cancer Alliances. There is a pan-London Steering Group which provides governance to the project, attended by all stakeholders including Alliance representatives, Trust representatives, Macmillan and NHSE representatives. The project will also support regional implementation of the ACCEND framework for the CNS workforce.
- The pilot involves recruitment of innovative Cancer CNS Development Lead (CDL) roles across the capital who will deliver three main functions – an enhanced support offer to new and development CNSs (B6/7s), a universal training and education offer to all CNSs, and comms and engagement activity to champion the role of the CNS. In total, five CDL posts, working in Trust clusters aligned to the five London ICS geographies, have been recruited. The CDLs will be supported and managed by a host organisation within the Cluster but will work across all hospitals and with all CNSs within the Cluster. A Cluster steering group will provide local governance and assurance and report into the pan-London steering group. Evaluation has been commissioned and is being delivered by an external agency, MEL Research. The evaluation has been designed to assess the impact of the CDL role, share learning, and to support sustainability/legacy of the project.
- The CDL for North East London was one of the last of the cohort to take up post and started November 2024. Initially she has focused on establishing the enhanced support to a cohort of new/development CNSs, as well as engaging with all CNS teams across NEL about the project. The NEL CDL has discovered a disparity of what CNSs do, how they do it, and indeed how they feel about the job. Standardisation of competency and grading is needed to create a meaningful system-wide career pathway across NEL. Rotational posts would also help this endeavour. Universal educational sessions are now being planned to strengthen competencies and networking, bringing together more experienced cohorts alongside the new recruits. Another focus is aspiring CNSs – educational events are being provided in the day units and in huddles – the impact of these will be measured in due course.

Impact of Current Workforce Projects

Faster Diagnosis Programme

- This programme was designed to meet the faster diagnosis standard and focussed on clinical improvement and the early stages of the diagnostic pathway. Initiatives are being undertaken across Urology, Head & Neck, Gynaecology and Skin to speed up diagnosis as part of the national drive to meet the Faster Diagnosis Standard. Pathways are being streamlined as far as possible to reduce entry points and enable faster results and patient communication. Progress has been made in pathology with designated resource; imaging might need a similar approach to address the current delays.
- A programme report in 2023 focussed on performance for cancer diagnosis for those referred with non-specific symptoms. The economic impact within the report asked what resources were required to develop new NSS pathways and improve existing pathways for FDS compliance as part of the FD Programme, but did not resolve whether there were any specific additional workforce skills or resources needed. FDS nurses are currently supporting achievement of the Faster Diagnosis Standard on fixed term contracts; this will be reviewed once the funding period is completed.
- The main Faster Diagnosis challenges are at Barts. There are workforce challenges in the 2 week wait office, and the staff shortages mean there are delays in scheduling 1st appointments. Then there are also delays in Radiology, although the hospital is working up AI programmes currently to improve flow and times.

Impact of Current Workforce Projects

Faster Diagnosis Programme Continued

- The delays are particularly in Urology, Gynaecology, Skin and Head and Neck. In Gynaecology, requests for GA/Hysto rather than OPH's require use of endoscopists. Endoscopy is particularly challenged at Whipps Cross, where there are staff shortages. There is a clash between the needs of Urgent and Emergency Care and Cancer on a team which is under pressure.
- In terms of treatment, process mapping and prioritisation will improve matters (the 18 week pathway patients can be scheduled later) but this will not improve things in all specialties. An example is skin, where there is a limit of physical space too, and therefore scheduling is delayed.
- Head & Neck at Homerton has specific problems – a consultant is off on long-term sick. This has considerable impact as numbers and therefore the team are small. The hospital are therefore converting some ENT slots to accommodate the patient backlog. The issues in Colorectal in Barts are almost entirely endoscopist-shortage driven – the delay in diagnosis has a knock-on effect on the timeframes for treatment.
- Ultimately, the only game changer is to smooth the front-end of the pathway. Having allocated close-down slots on Cerner would help immensely – this would clearly prioritise cancer diagnoses.

Impact of Current Workforce Projects

Multi-Disciplinary Team (MDT) Project

- The requirement for Multi-Disciplinary Teams to review all patients can cause delay; work has recently been undertaken with risk stratification tools to prioritise and streamline. Band 4 & 5 MDT coordinators provide vital administrative support keeping to momentum going for each patient – but sadly the turnover amongst this cohort of staff is high. Training is being provided alongside peer support to help address retention issues.

Oncology Workforce Scoping Exercise

- A system-wide approach looking at alternate workforce for oncology, and possible workforce strategies across NEL was undertaken in 2023. The report written in December 2023 shared examples and practical resources for implementing skill mix across the oncology workforce. It produced a series of workforce recommendations with a clear focus on improving the SACT pathway:
- Upskilling to increase the number of Pharmacy Independent Prescribers
- A small increase in WTE prescribing pharmacist and consultant pharmacist resource at both Barts Healthcare and BHRUT
- A 1 WTE increase in nurse prescriber resource
- Increase in the number of Cancer Nurse Specialists

Impact of Current Workforce Projects

Systemic Anti-Cancer Therapy (SACT) Capacity Project

- The current SACT project is concentrating on efficiency, patient flow and patient experience. A combination of time and motion studies and data collection is building up a detailed picture of capacity in the current pharmacy workforce. The capacity insight dashboard which forms a major part of this project will provide information and analysis of those parts of the wider cancer workforce who deliver directly alongside pharmacy – for example, the WTE ratio of nurses supporting the chemotherapy chairs. The supporting administrative workforce is also being analysed as part of the same capacity documentation process.
- This project has now gathered together the data from Barts Healthcare which is being analysed; the results should be available by the end of March and scenarios therefore can be considered for this Trust in early April. The BHRUT data collection is being completed currently, and analysis and scenarios should be completed by end of April. Ideally a deep dive into the SACT workforce should then use this data to find opportunities for improvement from Q2 2025-26 onwards.

The North-East London Cancer Academy

- The vision for the cancer academy was originally wider than its current scope. The hope initially was 4 facets - to cover general public education, administrative and clerical staff, nursing and practice staff and other clinicians and doctors. The general education focus has not yet been developed and the NEL Cancer Academy focusses on primary care.
- Much of the Academy's current work is with the Early Diagnosis team and with Primary Care to improve the quality of referrals, processes and pathways (including the use of direct access diagnostics).
- *What does the Cancer Academy provide?* A website – which has pulled together the excellent virtual learning resources already available – e.g. from NHSE, the National Disease Registration Service etc. The Academy has been running for a year, and has held 5 live webinars updating pathways etc. It signposts to other reputable providers and helpful partnerships – for example Gateway C. The Academy is part of the wider NEL Training Hub – the two share content.
- There is an ambition to develop the Academy further to include specialist training and education beyond early diagnosis and primary care but there is currently uncertainty as to how these plans will be taken forward without an Alliance lead for the programme.

Current and Future Workforce Risks

Current and Future Workforce Risks

1. Workforce Shortages Across Multiple Specialties

The report reveals significant workforce shortages across various specialties, including:

- **Histopathology:** A widespread concern with unfilled consultant posts and limited capacity due to a shortage of biomedical scientists and cut-up benches
- **Endoscopy:** A large backlog exists despite increased capacity in community diagnostic centres, partly due to workforce-related room closures
- **Radiology:** Colleagues across North East London are concerned about a reporting backlog – e.g. currently approx. 2500 for cross sectional Imaging across RLH/SBH
- **Therapeutic Radiographers:** A 10% national shortfall, projected to worsen by 2026, with challenges in student retention and safe staffing levels
- **Oncology:** Shortages of oncologists, particularly at Queens Hospital, impacting service stability. The report also notes a need for more pharmacy independent prescribers, consultant pharmacists, nurse prescribers, and cancer nurse specialists.
- **Nursing:** Underestimation of nursing staff numbers in the initial data, with additional needs in chemotherapy, ward nursing, and clinical nurse specialists (CNS) roles. Succession planning is also needed due to anticipated retirements of highly specialised nurses. Practice Nursing is also very challenged given the very high number of elderly cancer patients with co-morbidities, management of cancer as a long term condition, and delivery of screening activities.

2. Challenges in Recruitment and Retention:

The report emphasizes difficulties in recruiting and retaining staff across multiple specialties. Factors contributing to this include:

- High vacancy rates, particularly in histopathology, across London.
- Lack of clear career pathways, especially for Faster Diagnosis Standard (FDS) nurses and support workers, leading to poor retention.
- Challenging work environments due to high population needs and limited funding (e.g., Queens Hospital).
- High student attrition rates in pre-registration therapeutic radiography programs.

Current and Future Workforce Risks

3. Impact of Health Inequalities: The report acknowledges health inequalities, noting that psychosocial support is geographically concentrated in less deprived areas, leading to suboptimal care in more deprived boroughs. There are clear inequalities by ethnic group in personalised care – The National Cancer Patient Experience Survey (2021) showed that in 33% of the 12 personalised care questions London's ethnic minorities scored significantly lower than London's white population. The increasing prevalence of cancer, particularly among older people with comorbidities, further exacerbates these challenges.

4. Performance Issues and Delays: Difficulties in meeting cancer targets, particularly in haematology, lung, skin, upper GI, and other areas, often indicate workforce shortages. Delays in diagnosis due to histopathology or imaging reporting backlogs impact the entire cancer pathway.

5. Need for Workforce Transformation: The report emphasises the need for a comprehensive workforce transformation strategy to address the identified risks and shortages. This includes exploring various solutions such as:

- International recruitment
- Upskilling existing staff
- Changing skills mix where appropriate
- Creating new career pathways
- Developing apprenticeships
- Improving collaboration between services
- Streamlining workflows and administrative support using AI and technology

Current and Future Workforce Risks

Category	Risk/Issue/Concern
Oncology Workforce	Shortage of oncologists, particularly at Queens Hospital, impacting service stability.
	High reliance on clinical oncologists for both SACT and radiotherapy due to medical oncologist shortages.
	Need for additional consultant posts to align with national benchmarks.
Nursing and AHP Workforce	High vacancy rates in London (15% vs. 12% nationally).
	Low retention due to experienced CNSs retiring and being replaced by less experienced staff. Increased caseloads for CNSs, doubling in some areas over the last three years.
	Lack of clear career pathways and limited exposure in undergraduate training.
	Specific shortages in some of the AHP professional groups which are impacting on the quality of patient care.
Therapeutic Radiography	National 10% workforce shortfall, projected to worsen by 2026.
	High turnover in Band 3 and Band 5 staff (17.4% and 20.2% respectively).
	Student attrition from pre-registration therapeutic radiography degree programmes remains high.
Radiotherapy Physics	7% national clinical scientist shortfall, projected to grow to 10% by 2026.
	34% of linac engineers expected to retire within five years.
	20% of clinical technologists expected to retire within five years.
Histopathology	Workforce growth (2%) has not kept pace with activity increase (21%).
	Seven unfilled consultant histopathology posts in NEL.
	High backlog causing delays in cancer diagnosis and treatment pathways.
Pharmacy	Vacancy rates of 20.6% (technical services) and 19.0% (clinical services).
	Increasing complexity and workload due to growth in immunotherapy and advanced therapies.
	Aseptic service compounding capacity is insufficient to meet demand.
Primary Care Workforce	Shortage of trained staff to deliver cancer care reviews and manage patients as a long-term condition
	Workforce estimates may underrepresent primary care contributions to cancer pathways.
Endoscopy	Large backlog despite increased community diagnostic centre capacity.
	Workforce-related room closures limiting capacity.

Current and Future Workforce Risks

Category	Risk/Issue/Concern
Colorectal Workforce	Shortage of Faster Diagnosis Standard (FDS) nurses, leading to high turnover due to lack of career progression.
Gynaecological Oncology	Clinical oncologist gap at Queens Hospital is difficult to fill.
	Need for an additional nurse hysteroscopist to ensure stability of nurse-led clinics.
	Lack of succession planning for key nursing skills.
Psycho-Social Support	Current workforce cannot provide family support.
	Home visit capacity is limited to only two boroughs.
	Services are concentrated in areas with lower deprivation, leaving high-need areas underserved – this should hopefully be addressed with the recruitment of an additional psychiatrist.
Multi-Disciplinary Teams (MDTs)	High turnover among Band 4 & 5 MDT coordinators due to demanding roles.
	Workforce shortages in histopathology and radiology affecting MDT efficiency.
Urology	Shortage of specialist medical and nursing workforce, especially in bladder cancer.
	Centralisation of pelvic and renal cancer services has created recruitment challenges.
Radiology	Workforce shortages are leading to Imaging reporting delays, impacting across multiple cancer pathways
Increases in demand for services	Rising cancer prevalence among older populations with comorbidities increasing demand for services. Increases in cancer in the younger population are creating different needs.
	Substantial rise in those living with and beyond cancer.
Health Inequalities Impact	Ethnically diverse population of NEL may attribute to deprivation and poor outcomes for patients.
	Disproportionate staffing distribution across deprived areas, impacting access to care.

Recommendations

Summary of Recommendations

- The overall recommendations of this report are based on the level of risks articulated by key stakeholders plus the information gathered about performance and population health. The second phase of NELCA's workforce strategy programme is focussed on planning those system-level workforce planning or transformation interventions which will best reduce the overall workforce risks. Some initial conversations have been held to help initiate Phase 2 which are aimed both at identifying any recent progress on workforce plans, and on gaining more specific information to aid with prioritising Phase 2 workforce planning support.
- During the 2025-26 financial year, the focus will be on key improvement priorities. To prioritise areas for workforce interventions, the following criteria have been used:
- **Urgency: How urgent is the problem**? Is it impacting on current performance? Is it impacting on patient safety and care? Is there a work-around / mitigation in place? What is the risk if we do nothing?
- **Feasibility: Is it within our influence or outside our control? Can we make a difference?** Does it require a change somewhere else that we do not have the ability or capacity to impact or influence?
- **Alignment to population health:** Are the challenges specifically related to the demographics of our North East London population? Would we widen health inequalities, or not close the gap, if we do nothing?
- **Potential impact:** Is the return in terms of patient quality and system performance improvement commensurate with the scale of change, work and commitment required to achieve it?

Summary of Recommendations

Known supply issues: Where there is already known issues in certain areas of the workforce, and potential solutions available, but the challenge is in local implementation.

- The most critical workforce risk is a national shortage of a specific skill or professional group. This means that even if funding is available, it is unlikely that NELCA employers can fill all their current vacancies, stretching those who hold substantive posts to the limit of their ability to deliver. All the recommendations of this report have been framed around these shortages. Longer-term workforce plans to address these shortages will be developed in Phase 2 – particularly in Nursing, Allied Health Professions and in those diagnostic professions which are experiencing national shortages and which do not currently have a plan. Each of these areas will require a deep dive or hackathon approach to involve stakeholders in identifying the 'art of the possible'. It is recommended that the Nursing and AHP deep dives take place before other deep dives, in the hope that these two deep dives may help resolve some of the issues relating to shortages of clinical and medical oncologists.

- Requests from other areas have been logged. They vary from specific help with pathway redesign to help rethinking system workforce resource. These requests will be met if possible, and if not, then the log will be revisited during the 2026-27 planning round to identify a second set of priorities.

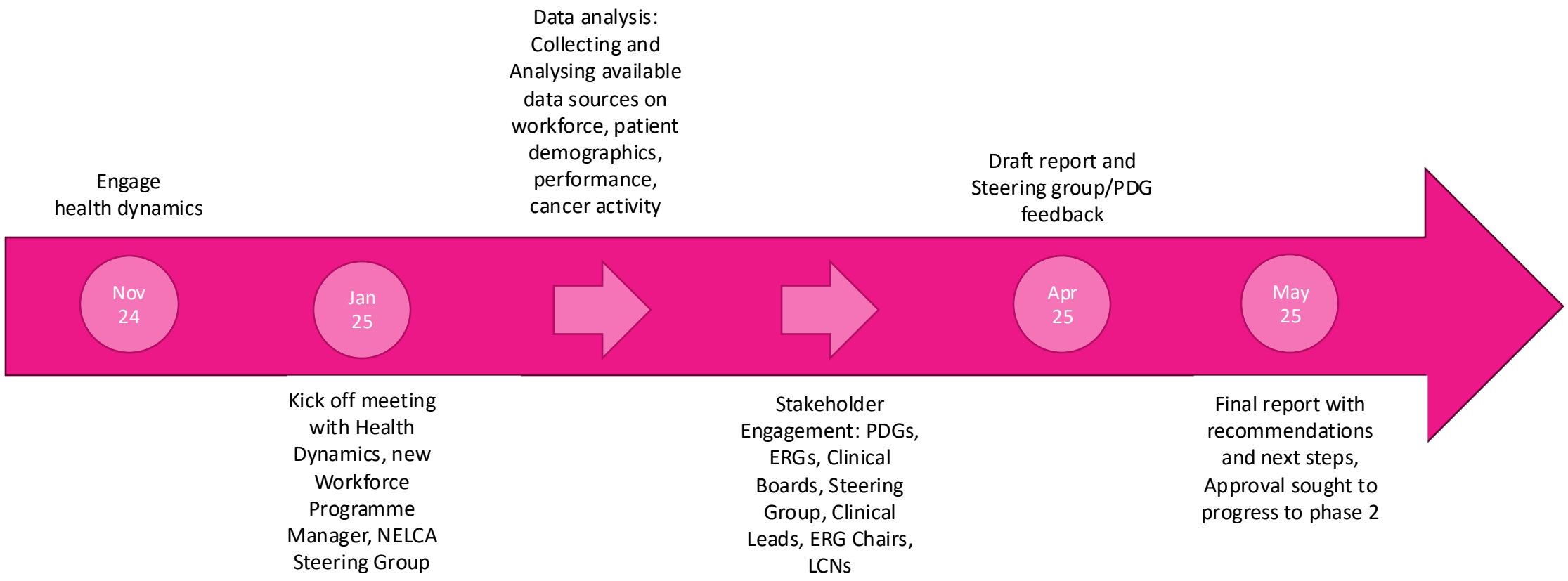
- The workforce projects underway include helpful capacity modelling which will need to be included as relevant in any strategic workforce planning. An example is the work currently being undertaken in chemotherapy capacity – this could naturally fit into the nursing deep dive but has some implications for pharmacy capacity which would need to be considered separately under oncology. As many of the current projects are improvement based, it is not possible to map their numeric impact on workforce numbers, but information has been gathered to ensure that no learning is lost as this workforce strategy moves into its next phase. Some of these projects have developed specific requests to support a series of 'quick wins' – these will be scheduled in flexibly around the other workforce planning activities in Phase 2.

- Lastly it is also recommended that this scoping and mapping document becomes a 'living document' capturing for the NELCA team any useful workforce or service information gathered that does not naturally fit into the outputs of deep dives or professional workforce planning. This would entail updating per quarter and setting up a shared website as a document and data repository.

Appendices

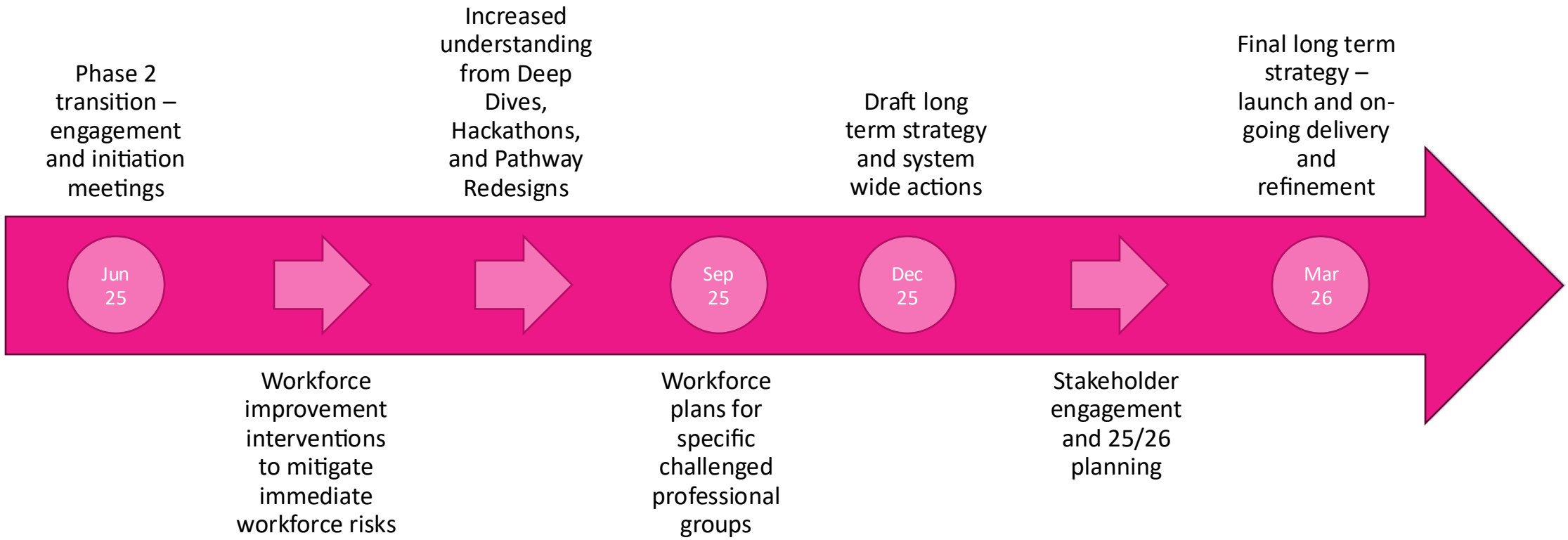
Appendix 1:
NELCA Strategic Workforce Programme Timelines

Phase 1 Timelines: Scoping and Mapping



Appendix 1:
NELCA Strategic Workforce Programme Timelines

Phase 2 & 3 Timelines: Deep dives, quick wins and longer-term strategy development



Appendix 2:
NEL Staging/ED Data by Population Demographics

North East London		All sites combined	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Age-group	0-49	Numerator	34	34	35	29	29	25	36	33	28	13
Age-group	0-49	Denominator	59	50	50	39	42	38	60	43	39	25
Age-group	0-49	Performance	58%	68%	70%	74%	69%	66%	60%	77%	72%	52%
Age-group	50-59	Numerator	55	42	52	49	43	55	38	30	33	36
Age-group	50-59	Denominator	89	65	74	80	73	84	62	44	54	55
Age-group	50-59	Performance	62%	65%	70%	61%	59%	65%	61%	68%	61%	65%
Age-group	60-69	Numerator	80	78	53	68	73	55	56	65	53	49
Age-group	60-69	Denominator	131	113	97	122	129	102	104	105	88	82
Age-group	60-69	Performance	61%	69%	55%	56%	57%	54%	54%	62%	60%	60%
Age-group	70-79	Numerator	46	49	55	68	49	49	63	36	33	28
Age-group	70-79	Denominator	81	101	95	133	98	90	114	63	79	91
Age-group	70-79	Performance	57%	49%	58%	51%	50%	54%	55%	57%	42%	31%
Age-group	80+	Numerator	26	24	22	24	24	16	15	17	25	26
Age-group	80+	Denominator	55	62	53	52	47	50	47	46	51	60
Age-group	80+	Performance	47%	39%	42%	46%	51%	32%	32%	37%	49%	43%
Deprivation	1 - most deprived	Numerator	54	52	44	48	54	49	45	49	39	23
Deprivation	1 - most deprived	Denominator	94	90	81	82	100	96	92	77	78	69
Deprivation	1 - most deprived	Performance	57%	58%	54%	59%	54%	51%	49%	64%	50%	33%
Deprivation	2	Numerator	96	90	92	95	81	73	84	56	62	58
Deprivation	2	Denominator	183	140	148	169	148	133	145	106	109	117
Deprivation	2	Performance	52%	64%	62%	56%	55%	55%	58%	53%	57%	50%
Deprivation	3	Numerator	49	44	38	54	51	46	31	40	35	43
Deprivation	3	Denominator	75	76	67	94	77	73	67	61	64	72
Deprivation	3	Performance	65%	58%	57%	57%	66%	63%	46%	66%	55%	60%

Appendix 2:
NEL Staging/ED Data by Population Demographics

North East London		All sites combined	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Deprivation	4	Numerator	28	21	29	20	19	21	28	22	17	14
Deprivation	4	Denominator	39	47	49	43	41	41	49	31	30	32
Deprivation	4	Performance	72%	45%	59%	47%	46%	51%	57%	71%	57%	44%
Deprivation	5 - least deprived	Numerator	14	20	14	21	13	11	20	14	19	14
Deprivation	5 - least deprived	Denominator	24	38	24	38	23	21	34	26	30	23
Deprivation	5 - least deprived	Performance	58%	53%	58%	55%	57%	52%	59%	54%	63%	61%
Ethnicity	Asian	Numerator	38	23	30	30	37	34	29	29	23	24
Ethnicity	Asian	Denominator	64	52	52	54	59	57	56	52	41	44
Ethnicity	Asian	Performance	59%	44%	58%	56%	63%	60%	52%	56%	56%	55%
Ethnicity	Black	Numerator	36	33	32	39	29	29	34	25	23	23
Ethnicity	Black	Denominator	65	49	49	60	59	58	67	42	47	42
Ethnicity	Black	Performance	55%	67%	65%	65%	49%	50%	51%	60%	49%	55%
Ethnicity	Mixed and Other	Numerator	14	27	17	25	16	12	18	23	16	15
Ethnicity	Mixed and Other	Denominator	33	36	29	44	28	20	25	33	22	24
Ethnicity	Mixed and Other	Performance	42%	75%	59%	57%	57%	60%	72%	70%	73%	63%
Ethnicity	Unknown	Numerator	8	2	5	7	7	8	8	5	11	14
Ethnicity	Unknown	Denominator	11	8	6	8	7	10	10	7	14	24
Ethnicity	Unknown	Performance	73%	25%	83%	88%	100%	80%	80%	71%	79%	58%
Ethnicity	White	Numerator	145	142	133	137	129	117	119	99	99	76
Ethnicity	White	Denominator	242	246	233	260	236	219	229	167	187	179
Ethnicity	White	Performance	60%	58%	57%	53%	55%	53%	52%	59%	53%	42%
Gender	Female	Numerator	127	112	110	103	112	102	114	99	86	82
Gender	Female	Denominator	199	177	177	164	181	173	186	151	148	148
Gender	Female	Performance	64%	63%	62%	63%	62%	59%	61%	66%	58%	55%
Gender	Male	Numerator	114	115	107	135	106	98	94	82	86	70
Gender	Male	Denominator	216	214	192	262	208	191	201	150	163	165
Gender	Male	Performance	53%	54%	56%	52%	51%	51%	47%	55%	53%	42%

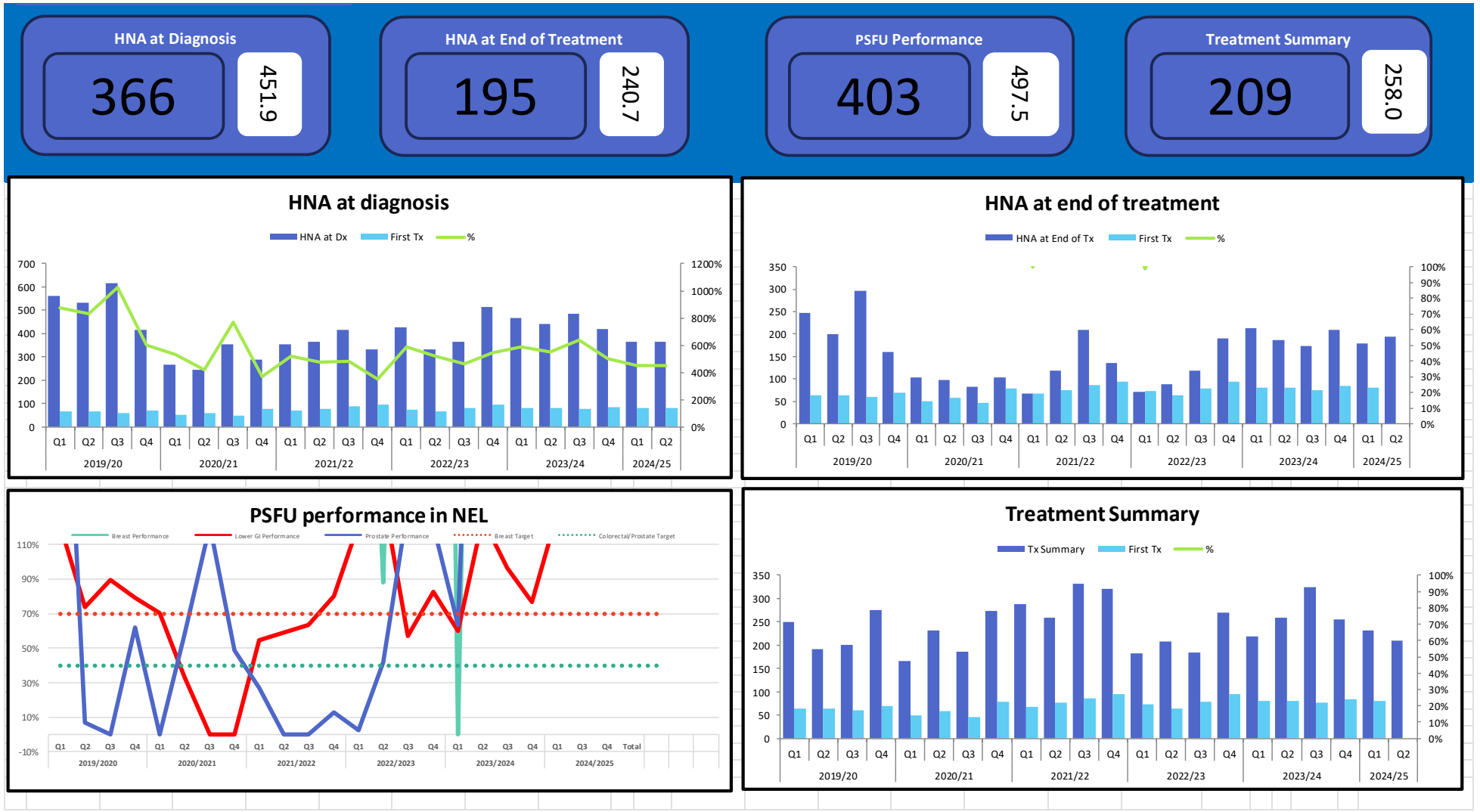
Appendix 2:
NEL Staging/ED Data by Population Demographics

North East London		All sites combined	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Route to Diagnosis	DCO	Performance	0	0	0	0	0	0	0	0	0	0
Route to Diagnosis	Emergency presentation	Numerator	23	18	21	19	12	16	17	15	0	0
Route to Diagnosis	Emergency presentation	Denominator	69	59	60	66	55	63	64	49	13	0
Route to Diagnosis	Emergency presentation	Performance	33%	31%	35%	29%	22%	25%	27%	31%	0%	0
Route to Diagnosis	GP referral	Numerator	74	66	75	81	78	69	57	52	24	0
Route to Diagnosis	GP referral	Denominator	112	106	108	119	117	102	96	66	36	0
Route to Diagnosis	GP referral	Performance	66%	62%	69%	68%	67%	68%	59%	79%	67%	0
Route to Diagnosis	Inpatient elective	Numerator	0	1	4	1	2	3	4	9	1	0
Route to Diagnosis	Inpatient elective	Denominator	2	3	7	4	7	7	9	17	6	0
Route to Diagnosis	Inpatient elective	Performance	0%	33%	57%	25%	29%	43%	44%	53%	17%	0
Route to Diagnosis	Other outpatient	Numerator	17	18	15	17	15	18	20	7	10	0
Route to Diagnosis	Other outpatient	Denominator	37	28	29	28	26	32	35	13	20	0
Route to Diagnosis	Other outpatient	Performance	46%	64%	52%	61%	58%	56%	57%	54%	50%	0
Route to Diagnosis	Screening	Numerator	19	24	23	21	23	17	23	22	15	0
Route to Diagnosis	Screening	Denominator	26	27	28	27	29	24	25	25	18	0
Route to Diagnosis	Screening	Performance	73%	89%	82%	78%	79%	71%	92%	88%	83%	0
Route to Diagnosis	Unknown	Numerator	6	5	1	3	4	2	3	8	73	0
Route to Diagnosis	Unknown	Denominator	7	8	6	8	7	7	5	20	122	0
Route to Diagnosis	Unknown	Performance	86%	63%	17%	38%	57%	29%	60%	40%	60%	0
Route to Diagnosis	USC	Numerator	102	95	78	96	84	75	84	68	49	0
Route to Diagnosis	USC	Denominator	162	160	131	174	148	129	153	111	96	0
Route to Diagnosis	USC	Performance	63%	59%	60%	55%	57%	58%	55%	61%	51%	0
Total	Total	Numerator	241	227	217	238	218	200	208	181	172	152
Total	Total	Denominator	415	391	369	426	389	364	387	301	311	313
Total	Total	Performance	58%	58%	59%	56%	56%	55%	54%	60%	55%	49%

Appendix 3:
NEL CADEAS Activity and Performance by Tumour Site

14 Day		Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Barts Health NHS Trust	All Tumour Groups	4133	3887	3872	3643	3812	4087	3174	3604	3836	3812	3573	4282	3961	4266	3636	3642	4156	4030
		3226	3607	3637	3391	3425	3321	2812	3103	3624	3568	3092	3728	3521	3852	3328	3399	3864	3572
		78%	93%	94%	93%	90%	81%	89%	86%	94%	94%	87%	87%	89%	90%	92%	93%	93%	89%
	Haematology	20	27	31	20	30	32	21	29	26	19	21	23	18	19	20	24	28	18
		20	26	31	18	29	32	21	29	25	19	21	22	16	16	18	23	28	18
		100%	96%	100%	90%	97%	100%	100%	100%	96%	100%	100%	96%	89%	84%	90%	96%	100%	100%
	Breast	1064	949	866	876	909	914	796	877	971	952	948	959	864	890	790	868	947	933
		573	851	852	827	789	477	572	689	935	934	927	934	839	881	781	858	935	913
		54%	90%	98%	94%	87%	52%	72%	79%	96%	98%	98%	97%	97%	99%	99%	99%	99%	98%
Barking, Havering & Redbridge University Hospitals NHS Trust	Gynaecology	322	303	373	303	294	356	257	284	322	314	287	307	290	328	248	314	318	275
		291	259	344	301	291	335	245	221	289	308	283	298	282	321	242	296	304	256
		90%	85%	92%	99%	99%	94%	95%	78%	90%	98%	99%	97%	97%	98%	98%	94%	96%	93%
	Head & Neck	251	222	285	232	226	223	223	244	221	273	285	312	258	325	252	291	321	214
		235	211	269	221	214	206	208	229	216	260	275	301	251	312	244	284	318	209
		94%	95%	94%	95%	95%	92%	93%	94%	98%	95%	96%	96%	97%	96%	97%	98%	99%	98%
	Lower GI	539	447	475	418	450	438	331	413	387	406	406	456	408	477	430	519	451	422
		532	446	474	412	443	427	318	387	382	391	385	442	390	469	413	507	446	421
		99%	100%	100%	99%	98%	97%	96%	94%	99%	96%	95%	97%	96%	98%	96%	98%	99%	100%
Homerton University Hospital NHS Foundation Trust	Lung	25	29	29	15	23	30	29	17	29	30	17	22	21	31	26	26	21	21
		24	28	28	13	20	30	29	17	29	27	16	22	20	28	25	24	20	20
		96%	97%	97%	87%	87%	100%	100%	100%	100%	90%	94%	100%	95%	90%	96%	92%	95%	95%
	Skin	308	401	376	311	355	289	210	238	265	255	238	259	269	521	267	318	396	278
		280	365	333	265	278	248	179	218	231	225	154	153	77	110	112	75	90	38
		91%	91%	89%	85%	78%	86%	85%	92%	87%	88%	65%	59%	29%	21%	42%	24%	23%	14%
	Urology	109	93	89	88	88	111	87	94	111	107	107	114	86	112	107	129	112	109
		109	92	89	87	86	110	85	91	107	105	107	104	81	109	103	124	107	105
		100%	99%	100%	99%	98%	99%	98%	97%	96%	98%	100%	91%	94%	97%	96%	96%	96%	96%
All NEL Trusts	Upper GI	533	534	552	520	500	495	380	508	496	455	477	535	450	484	473	503	526	469
		494	516	535	506	487	475	363	463	466	438	432	508	400	452	420	467	499	450
		93%	97%	97%	97%	97%	96%	96%	91%	94%	96%	91%	95%	89%	93%	89%	93%	95%	96%
	Other	184	201	159	92	143	146	190	199	164	224	223	326	197	226	255	171	222	328
		174	192	130	89	125	132	185	197	161	172	133	167	106	119	147	119	129	146
		95%	96%	82%	97%	87%	90%	97%	99%	98%	77%	60%	51%	54%	53%	58%	70%	58%	45%
	All Tumour Groups	8660	8166	8238	7750	8036	8325	6771	7758	7775	7913	7886	8987	8157	9222	7854	7985	8931	8083
		7531	7697	7674	6981	7344	7300	6146	6929	7308	7290	6844	7806	7142	7998	7076	7217	7953	6941
		87%	94%	93%	90%	91%	88%	91%	89%	94%	92%	87%	87%	88%	87%	90%	90%	89%	86%

Appendix 4:
NEL PCC One-Page Dashboard



Appendix 5: Performance Statistics
75% of cancer diagnosis at stage 1 and 2

2022	January	February	March	April	May	June	July	August	September	October	November	December	Grand Total	Jan-Oct
Early Staged 1 & 2	149	171	185	149	201	188	207	222	233	222	246	172	2345	1927
Total Diagnosed	284	322	357	287	378	315	359	388	394	405	417	318	4224	3489
Sum of Perc%	52.50%	53.10%	51.80%	51.90%	53.20%	59.70%	57.70%	57.20%	59.10%	54.80%	59.00%	54.10%	55.50%	55.2%
2023														Jan-Oct
Early Staged 1 & 2	239	224	210	193	251	226	223	251	229	217	262	192	2717	2263
Total Diagnosed	400	400	376	340	439	378	365	426	408	404	432	342	4710	3936
Sum of Perc%	59.80%	56.00%	55.90%	56.80%	57.20%	59.80%	61.10%	58.90%	56.10%	53.70%	60.60%	56.10%	57.70%	57.5%
2024														Jan-Oct
Early Staged 1 & 2	241	227	217	238	218	200	208	181	172	152			2054	2054
Total Diagnosed	415	391	369	426	389	364	387	301	311	313			3666	3666
Sum of Perc%	58.10%	58.10%	58.80%	55.90%	56.00%	54.90%	53.70%	60.10%	55.30%	48.60%			56.00%	56.0%

Appendix 5: Performance Statistics

Early Diagnosis by Tumour Group

North East London	Total	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
All sites combined	Numerator	241	227	217	238	218	200	208	181	172	152
All sites combined	Denominator	415	391	369	426	389	364	387	301	311	313
All sites combined	Performance	58%	58%	59%	56%	56%	55%	54%	60%	55%	49%
Bladder	Numerator	5	2	5	5	1	4	2	2	1	1
Bladder	Denominator	5	2	7	6	2	6	7	4	3	2
Bladder	Performance	100%	100%	71%	83%	50%	67%	29%	50%	33%	50%
Breast	Numerator	58	65	55	58	57	41	52	45	39	43
Breast	Denominator	71	76	64	65	70	49	61	53	45	48
Breast	Performance	82%	86%	86%	89%	81%	84%	85%	85%	87%	90%
Colorectal	Numerator	24	15	20	19	18	23	17	16	19	18
Colorectal	Denominator	56	46	46	51	46	65	57	40	49	59
Colorectal	Performance	43%	33%	43%	37%	39%	35%	30%	40%	39%	31%
Gynaecological	Numerator	19	15	17	12	14	16	25	16	6	9
Gynaecological	Denominator	24	22	23	15	20	23	33	22	10	17
Gynaecological	Performance	79%	68%	74%	80%	70%	70%	76%	73%	60%	53%
Haematological	Numerator	5	8	4	4	10	3	6	1	7	4
Haematological	Denominator	15	18	11	13	14	17	15	10	18	9
Haematological	Performance	33%	44%	36%	31%	71%	18%	40%	10%	39%	44%
Hodgkin lymphoma	Numerator	0	0	1	1	2	0	3	0	4	0
Hodgkin lymphoma	Denominator	2	2	3	2	4	2	5	2	7	1
Hodgkin lymphoma	Performance	0%	0%	33%	50%	50%	0%	60%	0%	57%	0%
Kidney	Numerator	11	13	19	11	15	15	5	7	3	3
Kidney	Denominator	21	15	22	12	18	19	8	10	4	4
Kidney	Performance	52%	87%	86%	92%	83%	79%	63%	70%	75%	75%
Lung	Numerator	25	27	20	22	26	29	31	25	23	13
Lung	Denominator	62	65	66	73	73	74	81	58	59	65
Lung	Performance	40%	42%	30%	30%	36%	39%	38%	43%	39%	20%

Appendix 5: Performance Statistics

Early Diagnosis by Tumour Group

North East London	Total	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Melanoma	Numerator	18	9	17	13	19	13	10	18	23	10
Melanoma	Denominator	22	11	18	14	22	13	13	18	24	10
Melanoma	Performance	82%	82%	94%	93%	86%	100%	77%	100%	96%	100%
Non-Hodgkin lymphoma	Numerator	3	8	2	3	6	3	3	1	3	4
Non-Hodgkin lymphoma	Denominator	11	16	7	10	8	15	10	6	9	7
Non-Hodgkin lymphoma	Performance	27%	50%	29%	30%	75%	20%	30%	17%	33%	57%
Oesophageal	Numerator	2	3	1	2	1	1	2	0	1	1
Oesophageal	Denominator	7	10	9	14	11	3	4	6	11	6
Oesophageal	Performance	29%	30%	11%	14%	9%	33%	50%	0%	9%	17%
Oesophago-gastric	Numerator	5	8	6	5	2	3	3	1	4	3
Oesophago-gastric	Denominator	13	17	15	17	17	8	7	9	17	9
Oesophago-gastric	Performance	38%	47%	40%	29%	12%	38%	43%	11%	24%	33%
Ovarian	Numerator	2	3	5	5	1	2	6	6	1	1
Ovarian	Denominator	5	7	8	5	4	7	10	8	3	7
Ovarian	Performance	40%	43%	63%	100%	25%	29%	60%	75%	33%	14%
Pancreatic	Numerator	4	0	4	1	5	2	3	5	3	3
Pancreatic	Denominator	13	8	16	8	15	7	13	11	12	15
Pancreatic	Performance	31%	0%	25%	13%	33%	29%	23%	45%	25%	20%
Prostate	Numerator	67	65	50	88	51	51	54	45	44	45
Prostate	Denominator	113	111	81	152	92	83	92	66	70	75
Prostate	Performance	59%	59%	62%	58%	55%	61%	59%	68%	63%	60%
Stomach	Numerator	3	5	5	3	1	2	1	1	3	2
Stomach	Denominator	6	7	6	3	6	5	3	3	6	3
Stomach	Performance	50%	71%	83%	100%	17%	40%	33%	33%	50%	67%

Appendix 5: Performance Statistics
Early Diagnosis by Tumour Group

North East London	Total	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	2024-07	2024-08	2024-09	2024-10
Upper GI excl OG	Numerator	4	0	4	1	5	2	3	5	3	3
Upper GI excl OG	Denominator	13	8	16	8	15	7	13	11	12	15
Upper GI excl OG	Performance	31%	0%	25%	13%	33%	29%	23%	45%	25%	20%
Urological excl prostate	Numerator	16	15	24	16	16	19	7	9	4	4
Urological excl prostate	Denominator	26	17	29	18	20	25	15	14	7	6
Urological excl prostate	Performance	62%	88%	83%	89%	80%	76%	47%	64%	57%	67%
Uterine	Numerator	17	12	12	7	13	14	19	10	5	8
Uterine	Denominator	19	15	15	10	16	16	23	14	7	10
Uterine	Performance	89%	80%	80%	70%	81%	88%	83%	71%	71%	80%

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Key Team Members

Summary Profiles

Alison Alsbury
MA (Oxon)

Alison Alsbury

Chief Executive

Alison brings over 20 years of dedicated experience in health and social care, following a dynamic career that began in European strategic consulting and extended across utilities, regeneration, and public-private partnerships.

Her expertise includes senior roles within NHS England, the Department of Health, local authorities, and NHS Trust boards. She has led mergers across public and voluntary sectors and played a pivotal role in system-wide and acute service turnarounds. Her board-level experience spans national, regional and joint health and social care appointments.

Alison was Workforce Modelling Lead for the New Care Models programme, supporting the Vanguards across England. As a leader, Alison has guided our team in co-producing multiple practical integrated workforce plans. Her current focus is on system-level resource allocation where she continues to deliver transformative change in complex, multi-agency environments.

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