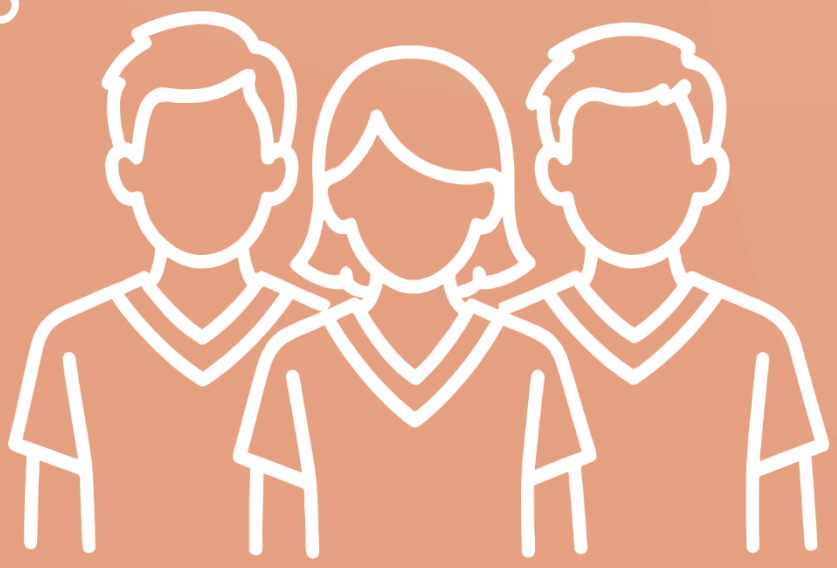
WORKFORCE

NHS
North East London
Cancer Alliance



North East London Cancer Alliance

Workforce Strategy

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Executive Summary

This workforce strategy is the culmination of a year-long workforce programme addressing issues of supply and improvement across the whole cancer pathway. At the end of May 2025, a Mapping and Scoping document was produced which looked at workforce supply within the context of population health demand. This identified the key workforce risks. Deep dives were then undertaken over the summer focussed on the nursing, AHP and support workforces. Since the autumn the priority has been to understand the longer-term solutions which will enable the cancer workforce in North East London to be more sustainable.

The purpose of this workforce strategy is to provide a comprehensive workforce planning framework that aligns with North East London Cancer Alliance's goals and strategic priorities. It looks at the drivers for service and workforce change (national and local) to understand the overall strategic framework. It then encompasses an in-depth analysis of the current workforce supply challenges, demographic and service model shifts, policy and regulatory changes and technological advancements that impact workforce planning. The report identifies key findings and offers actionable recommendations to address workforce challenges and leverage opportunities.

The strategy starts with consideration of the wider national and local strategic workforce planning framework. After a review of the current workforce, it then travels a journey that starts with understanding national supply before considering the workforce implications of addressing the North East London 'structural deficit' in the professions which can be benchmarked. This analysis demonstrates that, in several key pathway areas, future workforce sustainability will depend less on expanding medical capacity and more on strengthening nursing, AHP and support roles, supported by appropriate governance, training, and career structures. Deep dives have been undertaken for both the Nursing and the Allied Health Professional workforce which help to identify the minimum forecast growth in these professional groups.

The strategy then looks at future drivers for change – from service models to digital transformation. It then looks at how these might change workforce plans - future recruitment and retention programmes, alongside investment in upskilling and continuous professional development and whilst adapting to technology changes to drive efficiency in both clinical and administrative work areas. And where relevant it also considers the development and integration of new roles to meet evolving healthcare demands.

An action plan recommends main thematic priorities on a year-by-year basis. This helps identify priorities to inform annual plans and progressively move the Alliance towards a more sustainable cancer workforce.

To encapsulate the findings of the strategy and the action plan, future workforce modelling starts with consideration of the specific shortages by professional group. The impact of these shortages has then been brought together in a heat map, which

prioritises by risk which shortages need to be addressed first. A comparison has been undertaken of shortage professions based on population served, to understand how North East London would address its deficits in funded posts compared with the rest of London and nationally. The numbers required for the highest risk (red) roles are included in our overall future workforce modelling.

Lastly, a series of annual workforce change scenarios bring together the impact of turnover during the five year-period, fill of vacancies, and known efficiency and productivity requirements. Workforce change interventions are worked through annually in order to provide the five-year aggregate position.

National Drivers for Strategic Change

'Fit for the Future: 10 year Health Plan for England' was published on 4th July 2025[1]. It was the NHS's strategic response to the Darzi Plan, which painted a clear but concerning assessment of the challenges facing the NHS. It describes clear ambitions for three shifts –

- from hospital to community: more care will be available on people's doorsteps and in their homes
- from analogue to digital: new technology will liberate staff from admin and allow people to manage their care as easily as they bank or shop online
- from sickness to prevention: reaching patients earlier and make the healthy choice the easy choice.

'Fit for the Future' included some welcome public health interventions that will help prevent cancers such as a recommitment to deliver on the Tobacco and Vapes Bill to move progressively to a society which is free from tobacco, but it did not describe in detail the changes sought in cancer service delivery. This will be outlined in due course in a National Cancer Plan (publication date still unknown at the time of writing). Meanwhile, the recommendations of the previous NHS Long Term Plan published in 2019 for cancer still apply.

The NHS Long Term Plan (LTP, 2019) sets out a 10-year programme with particularly stretching ambitions for cancer:

Earlier and faster diagnosis

- Diagnose 75% of cancers at stage I or II by 2028 endeavouring to significantly improve patient outcomes
- Deliver and maintain the Faster Diagnosis Standard (FDS) – patients to be told cancer is confirmed or ruled out within 28 days of urgent referral.
- Overhaul diagnostics through Rapid Diagnostic Centres (RDCs) and Community Diagnostic Centres (CDCs), building capacity in imaging, endoscopy, pathology and genomic testing.

[1] https://www.england.nhs.uk/long-term-plan/

Improved treatment access and outcomes

- Recovering the 62-day standard for starting treatment after urgent referral.
- Expand access to modern radiotherapy, surgery and systemic anti-cancer therapies (including genomics-informed treatments), and support participation in clinical trials.

Personalised and integrated cancer care

- All patients to receive personalised care interventions and care plans (including the provision of holistic needs assessments and support plans, health and wellbeing information, a cancer care review, and a treatment summary);
- To be supported as they enter follow-up pathways, underpinned by digital; remote monitoring
- Offered prehabilitation, rehabilitation, and psycho-social support to optimise treatment pathways and enhance recovery as they live with and beyond cancer.

Tackling inequalities

Cancer service providers were required to take targeted action where early-stage diagnosis and outcomes are worse, including more deprived and ethnically diverse populations – this is very relevant to North East London's demographics.

The LTP has had several profound impacts on the cancer workforce. Meeting its earlier and faster diagnosis targets required an expansion of diagnostic workforce, and of supporting diagnostic capacity in imaging, pathology, endoscopy, genomic labs. This endeavour was supported by both the Richards Review and the CDC/RDC rollout.

For North East London this created a need for more consultant radiologists, reporting radiographers, advanced/consultant radiographic practitioners. It meant an expansion of the endoscopy workforce (medical, surgical and non-medical endoscopists, nurses, decontamination teams) and the pathology workforce (consultant histopathologists, biomedical scientists, reporting advanced practitioners). This was accompanied by a growth in diagnostic support roles, e.g. imaging assistants, admin, booking and tracking staff.

A similar growth occurred in specialist cancer roles - oncologists, surgeons, clinical nurse specialists (CNS), specialist AHPs, cancer pharmacists and cancer support workers. The ACCEND programme (Aspirant Cancer Career and Education Development) now provides a structured career and education framework for nurses, AHPs, and assistive and supportive roles in cancer, supporting both supply and development.

Personalised care requirements meant a clear focus on both multi-professional team working and on Advanced Practice. The latter was particularly important in the management of those patients who presented with complex multimorbidity.

Lastly, the LTP emphasised digital and genomics: wider use of genomic testing, wider use of the NHS app, remote monitoring and AI-supported diagnostics. This meant that existing staff needed upskilling in digital tools, data literacy and genomic literacy.

The NHS Long Term Workforce Plan (2023) described how the LTP would be staffed over the next 15 years. Its numerical provisions have been scaled back or delayed due to recent financial constraints, but the ambition remains to reshape the workforce with an increase in the substitutional (replacement for turnover) domestic supply of nurses, doctors and AHPs; this means an expansion in both undergraduate training places and apprenticeships.

ICBs were expected to work with system providers to grow local workforce supply pipelines, expand placement capacity and use apprenticeships to develop current staff or locally employed entrants into registered roles. The aim over the period of the plan was to reduce reliance on international recruitment.

The plan emphasised retention and productivity as strongly as new supply; it described better use of technology and wider skills mix as two ways to free up clinical time.

NHS England has just published its Medium-Term planning requirements and templates. These extend the operational planning horizon from the traditional 1-2 years to 3-5 years. There are planning obligations which will impact on the North East London cancer workforce including:

- A specific requirement to triangulate activity, finance and workforce plans – this effectively means aligning workforce plans to performance trajectories such as the Faster Diagnosis Standard, the 62-day standard, and any backlog reduction.
- System-level people planning - ICBs must coordinate system-wide workforce plans, moving away from siloed provider-by-provider planning. Cancer Alliances are expected to support this by providing pathway-level workforce insight and modelling for cancer services.
- Reducing temporary staffing and agency use – there is now an explicit expectation to reduce bank and agency expenditure, eliminate off-framework agency use and convert critical posts to substantive roles where possible. For cancer, this means demonstrating a trajectory away from agency radiologists/oncologists and short-term CNS cover, towards sustainable substantive posts backed by domestic supply.

There are also requirements on productivity, rostering and new ways of working, and on staff wellbeing, equality and retention across the Trusts. One clear intention of this revised operational planning framework is to enable both systems and providers to improve strategic workforce planning.

Summary

The shifting national strategic framework is likely to have profound political, social and economic impacts on the North East London cancer workforce. To understand the combined impacts of these national strategic workforce requirements, a PESTLE analysis has been undertaken. This is included at Appendix 1. The main themes of this analysis are explored in more detail where relevant in each of the sections which looks at predicting future trends.

Aligning with the North East London ICB's Workforce Strategy

The North East London Integrated Care Board (ICB) produced a system-wide 2024-2028 People and Culture Strategy[2], which aims to create a skilled, supported, and diverse "one workforce" to meet the needs of its diverse population. The strategy has a strong focus on retention, workforce development, health equity through training, and increasingly seamless collaboration across health and social care partners.

Key priorities include implementing inclusive retention and health and well-being strategies, increasing local resident recruitment into health and social care careers, especially through apprenticeships, and creating a workforce representative of North East London's diverse population. This latter ambition includes a specific focus on increasing the ethnic diversity of senior leadership.

The recommended actions include creating innovative and flexible career paths, promoting skills transfer and recognition across sectors, and offering consistent development and mobility opportunities for all staff.

Two themes that are particularly relevant to cancer are the development of specialist roles to meet local needs (including social prescribers), and enhanced personalised care offers, like personal health budgets.

The strategy seeks to address high vacancy and attrition rates in secondary care and primary care, and a growing vacancy problem in social care. It recognises a particular problem in an aging primary care workforce, and it seeks to equip staff with the skills to address the specific health needs of underserved groups.

North East London Cancer Alliance's Cancer Workforce Strategy seeks to align with these priorities and actions for both staff and the patients they serve. The themes of the ICB strategy underpin much of the narrative describing the current cancer workforce in the section below.

[2] https://northeastlondon.icb.nhs.uk/wp-content/uploads/2025/01/NEL-People-and-Culture-Strategy-2024-to-2028.pdf

Current Workforce

Workforce data from the three acute NHS Trusts within the Cancer Alliance footprint were reviewed to provide a comparative, system-level view of workforce composition, age profile, vacancies and turnover:

- Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- Barts Health NHS Trust
- Homerton Healthcare NHS Foundation Trust

Data comparability and service configuration caveat

While the available workforce data allows high-level comparison across Trusts, it is important to note that the figures do not represent a like-for-like comparison of identical services staffed in identical ways. Cancer pathways are supported by a wider multidisciplinary workforce that may be organisationally located in different ways across Trusts.

For example, services such as Physiotherapy, Occupational Therapy, Dietetics and other Allied Health Professional roles may sit within cancer-specific teams in some organisations, but be managed and recorded within corporate, community or generic service lines in others.

As a result, workforce numbers, age profiles, vacancy rates and turnover may reflect differences in organisational structure and workforce accounting rather than true variation in service delivery or staffing intensity. Comparisons should therefore be interpreted as indicative of overall workforce patterns rather than definitive measures of equivalent service models or staffing levels.

Workforce Age Profile

All three Trusts provided key age-profile data, revealing important differences in workforce maturity:

- Barts Health NHS Trust has the youngest workforce profile, with approximately 54% of staff under the age of 40. This indicates strong early-career recruitment and a large developing workforce, but also implies higher training demand and the need for structured progression pathways.
- BHRUT and Homerton Healthcare NHS Foundation Trust show a more balanced age distribution, with a larger proportion of staff aged 50 and above.
- Both BHRUT and Homerton therefore face greater medium-term retirement risk, particularly in experienced clinical and leadership roles.

Alliance implication: succession planning, leadership development and retention of mid-career staff are critical to maintaining workforce stability as senior cohorts approach retirement.

WTE by Band / Workforce Structure

Across all three Trusts, the workforce structure is broadly consistent:

- The majority of staff are employed within core clinical grades (Bands 5 - 7).
- Support roles (Bands 2 - 4) form a significant base, particularly at Barts Health and Homerton, reflecting the scale and service mix of these organisations.
- Senior roles (Bands 8+) represent the smallest proportion of the workforce across all Trusts, though they are most concentrated at BHRUT.

Alliance implication: Trusts with leaner senior structures may be more vulnerable to the loss of key individuals. Cross-Alliance leadership development, mentoring and rotational opportunities could help strengthen resilience.

Turnover

Turnover data show common themes where available:

- Barking, Havering and Redbridge University Hospitals NHS Trust and Barts Health NHS Trust both demonstrate higher turnover in Allied Health Professionals, administrative and support roles and lower turnover in medical staff.
- This pattern reflects broader NHS labour market conditions, where support and AHP roles experience greater competition and mobility.

Alliance implication: agreement on a standardised turnover metric across Trusts would enable more effective system-wide workforce planning and targeted retention interventions.

Vacancy Position

Vacancy pressures differ across Trusts:

- Barking, Havering and Redbridge University Hospitals NHS Trust shows an overall vacancy rate of approximately 7.7%, with vacancies concentrated in administrative and clerical roles.
- Barts Health NHS Trust shows low net vacancy overall, with some clinical areas slightly over-established, suggesting active workforce management to mitigate service risk.
- Homerton Healthcare NHS Foundation Trust has the highest vacancy level (approximately 12.5%), particularly within administrative roles and selected senior clinical posts.

Alliance implication: workforce pressures are not uniform. There is potential benefit in shared recruitment initiatives, collaborative workforce planning and targeted system-wide interventions.

Overall Summary

The three Trusts share a broadly similar workforce architecture, dominated by core clinical roles, but differ significantly in age profile and vacancy risk.
Barts Health NHS Trust has a younger workforce with lower retirement risk, while Barking, Havering and Redbridge University Hospitals NHS Trust and Homerton Healthcare NHS Foundation Trust face greater medium-term succession challenges. Addressing data gaps and adopting coordinated, Alliance-level workforce metrics will be essential to sustaining cancer services across the system.

Comparison with Other Cancer Alliances

North East London Cancer Alliance sits in a national landscape where every Cancer Alliance is grappling with the same structural pressures - rising cancer incidence and prevalence, a growing cohort of people living with and beyond cancer and continued strain across diagnostic and treatment pathways - yet the way those pressures play out varies sharply by geography, deprivation and the maturity of local workforce infrastructure.

Nationally, a defining feature of the current cancer workforce is fragility in specialist roles, particularly in nursing and diagnostics, combined with an ageing workforce profile and persistent vacancy and retention challenges. The ACCEND national workforce survey reinforces this picture, describing a workforce concentrated in senior bands and with a notable proportion approaching retirement, while wider NHS staff experience continues to show high levels of work-related stress and burnout risk.

Against that national backdrop, North East London Cancer Alliance shares many of the same pressures as the rest of England, but experiences them in a distinctive combination. Like much of the country, North East London Cancer Alliance faces significant challenges in filling and sustaining specialist posts; an example is that the national skin cancer CNS census illustrates this most clearly, showing that North East London has a comparatively high establishment of skin cancer CNS capacity per trust, but a weaker fill rate than most other Alliances. This pattern is important because it suggests that North East London Cancer Alliance's risk is not only about the size of the workforce it needs, but also about stability - vacancy, turnover and continuity in specialist roles that carry a high proportion of pathway coordination, patient support and service development.

Across the rest of the country, there are three broad contrasts that help position NELCA. First, many Alliances outside London - particularly in parts of the North and Midlands - operate under a heavier demand burden driven by older populations, higher incidence and in many places, worse outcomes, reflecting the strong national relationship between deprivation and cancer mortality. These areas often face the compounding effect of higher case-loads per head of population and more late-stage presentations, which translates into a workforce requirement that is not just larger but also more specialised and resilient. Some of these Alliances nevertheless show strong post stability in specialist nursing roles, demonstrating that robust workforce leadership, structured development pathways and deliberate retention approaches can deliver resilience even in high-burden settings. For North East London Cancer Alliance, this provides a clear signal that vacancy reduction and retention can be treated as strategic levers, not simply consequences of national shortages.

Second, many Alliances in the East of England, South East and parts of the South West present a different risk profile. They often appear relatively stable in filling specialist posts, but operate with leaner specialist establishments and in geographies that include rural and coastal communities where access, travel and workforce distribution challenges are persistent. In these systems, the strategic risk tends to be responding to unforeseen resource shortages - small teams with limited cover can be vulnerable to absence, retirement or changes in demand. North East London Cancer Alliance's position differs in that it benefits from the advantages of a dense urban service environment and proximity to major teaching providers, yet still

demonstrates a vacancy pattern in specialist posts that many of these more dispersed Alliances have managed to avoid.

Third, within London itself, North East London Cancer Alliance is operating alongside peer Alliances that show either greater workforce stability or, in some instances, substantially higher specialist nursing capacity. This matters for two reasons. It suggests that the London labour market, while competitive and shaped by high living costs, does not inevitably lead to the vacancy levels seen in North East London Cancer Alliance; and it indicates that there are nearby examples of practice - particularly around structured CNS development and cross-system workforce approaches - that North East London Cancer Alliance can draw on to strengthen its own resilience.

Overall, the national comparison reinforces that North East London Cancer Alliance's strategic workforce challenge is best understood as the intersection of high population health demand with workforce stability risk. Deprivation and inequality drive high pathway complexity and demand for navigation, personalised care and sustained engagement; workforce shortages or instability in specialist nursing and diagnostics therefore carry disproportionate operational and quality risk in North East London. At the same time, the wider system shows that where Alliances (for example Greater Manchester) have invested in clear career pathways, structured development programmes, education capacity and visible workforce governance, they have been better able to sustain specialist roles and manage pressure. For North East London Cancer Alliance, this national context supports a strategy that treats recruitment, retention and development - particularly for specialist nursing and diagnostic roles - as the central enablers of sustainable pathway performance, rather than as supporting activities.

National & Local Workforce Supply Challenges

Cancer services across the UK are constrained by long-standing and, in several areas, chronic workforce shortages along the whole pathway from diagnosis to survivorship. Framing these shortages by pathway stage should help North East London Cancer Alliance to understand the link between these shortages and cancer performance.

Early diagnosis and diagnostic pathway

Imaging: clinical radiologists and diagnostic radiographers

Consultant clinical radiologists and diagnostic radiographers sit at the heart of early diagnosis and staging (CT, MRI, ultrasound, mammography, CT colonography, etc.).

The Royal College of Radiologists (RCR) 2024 clinical radiology workforce census describes "dangerous shortages" of clinical radiologists, with workforce growth (about 4–5% a year) consistently outstripped by demand for imaging (around 8%

year-on-year)[3]. In England, the shortfall in clinical radiologists is estimated at roughly a third of what is needed and is forecast to worsen over the rest of the decade[4].

In parallel, the Society of Radiographers (SoR) reports a "chronic shortage" of radiographers, with an average vacancy rate of around 15% and many departments relying on regular overtime to staff rotas[5]. These gaps affect diagnostic radiographers in CT, MRI and general imaging, as well as mammographers and sonographers supporting cancer pathways. Taken together, radiologists and radiographers are a clear chronic shortage area nationally, with direct implications for delivery of Faster Diagnosis Standards and screening uptake.

Pathology: histopathologists and supporting laboratory staff

Histopathology is the backbone of cancer diagnosis and molecular stratification. The Royal College of Pathologists warns of "chronic workforce shortages across all areas" of pathology, driven by rising workload and persistent vacancies[6]. An earlier histopathology census found that only 3% of NHS histopathology departments had enough staff to meet clinical demand, underscoring the depth of the gap in services vital to cancer diagnosis. These shortages affect consultant histopathologists, but also biomedical scientists and advanced practitioners who support high-volume biopsy and resection reporting and the growing genomic testing workload.

Endoscopy workforce for suspected cancer and bowel screening

Early diagnosis of colorectal and upper GI cancers is highly dependent on endoscopy. A UK bowel cancer screening workforce survey identified a serious potential shortfall in screening colonoscopists over the next 5–10 years, driven by an ageing workforce and job-plan pressures[7]. This affects consultant gastroenterologists and colorectal surgeons, but also nurse and non-medical endoscopists, GI anaesthetists and endoscopy nursing staff. As bowel screening expands (e.g. FIT from age 50), this will become a systemic pressure point.

Nuclear medicine and PET-CT

Nuclear medicine physicians, radiologists with PET-CT expertise and nuclear medicine technologists/radiographers are routinely highlighted by cancer alliances as constrained groups, given the central role of PET-CT in staging and response assessment for many cancers. These roles sit within the broader diagnostic imaging workforce, where the RCR and others are already documenting structural undersupply.

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[3] Royal College of Radiologists (2025). *Clinical Radiology – Workforce Census 2024* and summary pages.
[4] https://www.rcr.ac.uk/news-policy/policy-reports-initiatives/clinical-radiology-census-reports
[5] Royal College of Pathologists (2025). *The pathology workforce* and workforce census spotlights. https://www.rcpath.org/discover-pathology/public-affairs/the-pathology-workforce.html
[6] Royal College of Pathologists (2025). *The pathology workforce* and workforce census spotlights. https://www.rcpath.org/discover-pathology/public-affairs/the-pathology-workforce.html
[7] Ravindran S. et al. (2021). *Bowel cancer screening workforce survey*.

Systemic anti-cancer therapy (SACT) and medical oncology

Consultant clinical and medical oncologists

Clinical oncologists (radiotherapy + SACT) and medical oncologists (SACT only) are core to treatment decision-making and delivery. The RCR 2024 clinical oncology workforce census reports a 15% shortfall in clinical oncology consultants, with projected shortfalls approaching one-fifth of required numbers by 2029 if current trends continue.

Medical oncology numbers have grown, but national briefings from Cancer Research UK and parliamentary debate papers highlight ongoing difficulties recruiting enough oncologists to meet rising SACT demand, especially when combined with retirements and new indications for immunotherapy and targeted agents[8].

Oncology pharmacists

The Oncology Pharmacy Workforce Review from Wessex Cancer Alliance emphasises that oncology pharmacists are integral to modern SACT services, personalisation of medicine and the shift of treatment closer to home but face persistent recruitment challenges and workload pressures[9].

Chemotherapy / SACT nurses and cancer clinical nurse specialists (CNS)

Macmillan Cancer Support's reports "Cancer Nursing on the Line" and "Addressing the Gap" describe the specialist cancer nursing workforce as "facing a crisis", concluding that "we have too few cancer nurses" and that those in post are struggling with excessive workload and limited development opportunities[10]. Their censuses of cancer, palliative and chemotherapy specialist nurses show substantial gaps across tumour sites and regions, with many services reporting insufficient CNS capacity to provide the holistic support and coordination envisioned in national cancer strategies.

For SACT, chemotherapy/SACT nurses are central to safe delivery and toxicity management. Rising treatment volumes, longer treatment durations and seven-day/extended-hours services have not been matched by workforce growth. Cancer

[8] NHS Workforce Levels: Impact on Cancer Patients - Hansard

[9] Wessex Cancer Alliance (2023). *Oncology Pharmacy Workforce Review*. https://wessexcanceralliance.nhs.uk/wp-content/uploads/2023/09/2309-WCA-Oncology-Pharmacy-Workforce-Review.pdf

[10] https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/4323-10061/cancer-nursing-on-the-line-why-we-need-urgent-investment-in-the-uk
https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/9598-10061/addressing-the-gap-report

CNS roles (by tumour site) and SACT nurses should therefore be treated explicitly as shortage and high-risk roles in any cancer workforce strategy.

Radiotherapy pathway

Radiotherapy is a core curative and palliative treatment, but national data show it is constrained by workforce and infrastructure. A recent analysis by Radiotherapy UK[11] suggests that more than 60,000 cancer patients a year in England do not receive radiotherapy they are expected to need, and many who do receive it face lengthy waits. Radiotherapy leaders explicitly link this to staff shortages as well as equipment and funding issues.

The key professions here are:

- Consultant clinical oncologists – covered above
- Therapeutic radiographers – identified by the SoR and AHP workforce guidance as essential members of the radiotherapy team, working closely with clinical oncologists, physicists and oncology nurses. There is evidence of a sustained shortage of therapeutic radiographers, contributing to limited capacity to extend hours or adopt advanced techniques.
- Clinical scientists in radiotherapy physics and dosimetrists – these roles are difficult to recruit and retain[12], and are essential for safe planning and delivery of IMRT, SABR and other modern treatments.

Radiotherapy is thus another area where chronic workforce gaps in multiple professions are directly associated with under-utilisation and delays in treatment.

Surgical and procedural cancer care

Surgery remains the main treatment for many solid tumours. While national workforce data are often organised by specialty rather than “cancer” per se, several surgical specialties with high cancer caseloads face sustained pressure:

- Colorectal surgery
- Upper GI and Hepatopancreatobiliary (HPB) surgery
- Urological surgery
- Thoracic/lung surgery
- Gynaecological oncology

Parliamentary research on the impact of NHS workforce shortfalls on cancer patients highlights that shortages of surgeons, anaesthetists, theatre nurses and critical care staff contribute to repeated breaches of 62-day treatment standards and to cancelled or delayed cancer operations. These surgical shortages interact with the endoscopy workforce constraints described earlier, since colorectal and upper GI surgeons are often key colonoscopists for symptomatic and screening services.

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[11] https://radiotherapy.org.uk/wp-content/uploads/2024/10/Radiotherapy-Survey23-100924-FINAL.pdf
[12] https://www.ipem.ac.uk/news/medical-physics-and-clinical-engineering-workforce-shortage-needs-urgent-action/#:~:text=Ageing%20population%20fuels%20increasing%20demand,'

Living with and beyond cancer, rehabilitation and palliative care

Specialist cancer nurses and palliative care nurses

Beyond the acute treatment phase, Macmillan Cancer Support, Sue Ryder and Marie Curie all emphasise that cancer clinical nurse specialists (CNSs) are central to survivorship, coordination and personalised care, yet their numbers remain inadequate relative to the growing population living with and beyond cancer[13].

District nurses also play a vital part in palliative care and Advanced Care Planning. Their workforce is also aging, and numbers are declining[14].

Allied Health Professionals (AHPs) in cancer rehabilitation

Macmillan Cancer Support and NHS England highlight AHPs as critical to quality of life, function and independence throughout the cancer journey, including prehabilitation and rehabilitation. Key AHPs include:

- Physiotherapists and occupational therapists
- Dietitians
- Speech and language therapists (SLTs), especially for head and neck, upper GI and lung cancers
- Lymphoedema practitioners
- Specialist rehab exercise professionals

The recently published evaluation of North East London Cancer Alliances prehabilitation services made six recommendations:

1. Patient Engagement: Continue to prioritise patient feedback, engagement and empowerment as central to the prehabilitation process, fostering an active role in health management
2. Standardise Metrics: Develop and implement standardised metrics for outcome measurement across all services to facilitate comparative analysis and continuous improvement
3. Financial coding option appraisal: The objective is to establish a more accurate and reflective tariff system for these prehabilitation services.
4. Enhance Integration: Services should be further integrated into existing care pathways, ensuring seamless transitions and continuity of care.
5. Expand Access: Explore sustainable funding models to maintain and expand access to prehabilitation services.
6. Foster Collaborations: Encourage collaborations between the NHS and third-sector organisations to leverage community resources and enhance service delivery.

[13] https://www.mariecurie.org.uk/document/experiences-of-palliative-and-end-of-life-care-in-the-east-of-england-summary
[14] Palmer W (2025) "The lamentable decline of district nurses in the NHS in England". Nuffield Trust.

This evaluation showed that sustainable funding is being offered by providers for the core elements of this workforce, and enabled the Alliance to pull back to monitoring and measuring the success of the scheme.

Macmillan cancer prehabilitiation[15] and rehabilitation[16] pathways and guidance identify these AHP roles as core to cancer rehab services, while alliance-level mapping in London demonstrates variable provision and capacity across trusts[17].

Wider workforce evidence (for example, the British Dietetic Association's safe staffing guidance) notes that there is a shortage of AHP workers in the UK, with the NHS seeking to expand training numbers to ease the situation[18]. This is not cancer-specific, but given the growing cancer prevalence it implies constrained capacity for oncology AHP services unless specific investment is made.

Psychological and psychosocial support

Psychologists, counsellors and other mental health professionals with oncology expertise are frequently reported by services and patient organisations as limited in number relative to need. Macmillan's AHP and rehab/prehab resources explicitly note the importance of psychological and wellbeing support as an integral part of cancer rehab/prehab pathways, but capacity is patchy.

The London Integrated Model for Cancer Psychosocial Care[19] produced by the Transforming Cancer Services Team and Macmillan Cancer Support makes recommendations for integrating psychosocial care within cancer pathways to deliver optimal clinical outcomes, prevent and address distress and improve patient experience and quality of life for people affected by cancer. The accompanying mapping of Psycho-oncology services report[20] identifies gaps across London and North East London. More recent work by the North East London Cancer Alliance Psycho-social ERG identifies significant capacity issues and risks within the North East London system.

Research, data and coordination roles

Finally, there is a group of cross-cutting roles that are essential to modern cancer care but often under-counted in traditional workforce statistics:

- Research nurses and clinical trials practitioners
- Clinical trials and data coordinators

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[15] https://www.macmillan.org.uk/healthcare-professionals/cancer-pathways/prehabilitation
[16] https://www.macmillan.org.uk/assets/macmillan-cancer-rehabilitation-pathways.pdf
[17] https://www.macmillan.org.uk/assets/macmillan-cancer-rehabilitation-pathways.pdf?utm_source=chatgpt.com https://www.macmillan.org.uk/healthcare-professionals/cancer-careers/allied-health-professionals
[18] British Dietetic Association (2024). *Safe Staffing and Safe Workload Guidance*. https://www.bda.uk.com/resource/safe-staffing-and-safe-workload-guidance-may-2024.html
[19] https://www.transformationpartners.nhs.uk/wp-content/uploads/2020/02/Refreshed-February-2020-Guidance-doc-Psychological-support-for-people-affected-by-cancer-.pdf
[20] https://www.transformationpartners.nhs.uk/wp-content/uploads/2020/02/Mapping-Report_Psychological-Services-Final.pdf

- Cancer data managers and analysts (including registry staff)
- Multidisciplinary team (MDT) coordinators, cancer support workers and patient navigators/trackers

Cancer Research UK and Health Education England evidence briefs stress that workforce shortages affect not only frontline clinicians but also the support staff required to run MDTs, deliver trials and monitor outcomes. Currently there is also the highest proportion of vacant clinical academic posts since 2007 and there has been a 6% decline in medically trained research staff between 2012 and 2022[21]. Without sufficient numbers in these roles, alliances struggle to open new studies, deliver personalised care/stratified medicine ambitions, or track performance against waiting-time and quality standards.

Addressing Known Local Deficits in Workforce Provision

As the previous North East London Cancer Alliance Workforce Scoping and Mapping Report outlined in detail, benchmarking of workforce provision against other cancer alliances shows a 'structural deficit' in key professions.

Clinical Oncologists

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[22]. 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 North East London Cancer Alliance would need 21 (an additional 11) and to reach mid table North East London Cancer Alliance would need 19 (an additional 9).

[21] 10 Year Workforce Plan Call for Evidence, CRUK Response, November 2025.
[22] 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).

Therapeutic Radiographers

As the table below shows, Barts Therapeutic Radiographers workforce ranks 13/16 among its comparator centres, and Queen's Hospital (BHRUT) ranks 16/16:

	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

Matching the strongest performing centres would require a significant uplift. The top 5 cancer centres operate with staffing levels equivalent to 55–57 radiographers per million population. For Barts, this equates to approximately 66–68 WTE based on the current population served — requiring approximately an additional 13–15 WTE above the current funded 2022 establishment.

Similarly, reaching the top 10 cancer centres (c.50 radiographers per million population) would require approximately 60 WTE — meaning an uplift of around 7–8 radiographers above the 2022 staffing level.

A move to the national mid-table level (aligned to 8th position, between 49–50 radiographers per million population) would require approximately 59–60 WTE, which represents a smaller but still material increase of 6–7 additional radiographers.

Radiotherapy Physics

The Radiotherapy Physics Census of November 2023 shows Barts ranks 11/13 and Queen's Hospital 13/13 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

*Includes proton service

To remain competitive and sustainably support projected treatment demand, strengthening staffing levels is required. Benchmarking against higher-performing centres illustrates the scale of change needed:

- The top 5 cancer centres operate at c.31.2 Medical Physicists per million population.
  For Barts, this would require approximately 37.4 WTE, representing an uplift of around 10 additional posts above the current funded establishment.
- Achieving a position in the top 10 centres (22.8 per million population) would require approximately 27–28 WTE for a similar population size. Barts is already very close to this threshold, requiring only a minimal adjustment (+1 WTE) to move into the top-10 category.
- Moving to a national mid-table position – the safest option (rank 7), equivalent to c.26.2 per million population — would require a total of approximately 31–32 WTE, or an additional 4–5 WTE staff members.

Radiologists

In 2026, North East London faces complex radiologist workforce dynamics characterised by a national-level shortage despite having some of the highest consultant-to-population ratios in the UK. While specific raw numbers for "North East London" alone are often grouped within wider London data, recent census findings highlight the following for the region:

- As of late 2025/early 2026, the clinical radiology shortfall in London is approximately 27% to 29%. This is notably lower than the 40%+ shortfalls seen in North East England and the East Midlands, but it still represents a significant gap between demand and staff in the wider labour market.
- Across London, roughly 3.4% of complex scans (CT and MRI) take longer than one month to be reported, which is above the national average for England.

To mitigate this issue relating to waiting times, North East London Cancer Alliance has adopted AI tools to manage severe backlogs for chest X-rays, aimed at reducing waiting times that were previously critical due to staff gaps.

The projected deficit of clinical radiologists across the UK is forecast to reach 39% to 40% by 2026–2027 if current recruitment trends continue. Imaging demand (CT/MRI) is growing at approximately 8% annually, while the consultant workforce has only grown by about 4.7% per year, leading to a compounding "radiology emergency". Nationally roughly 10% of consultant posts remain vacant, with over 60% of these remaining unfilled for more than six months due to a lack of qualified candidates.

Sonographers

In 2026, the shortage of sonographers in North East London creates a significant delivery pressure point, mirroring a critical national deficit. The latest available data from late 2024 and 2025 indicates a national average vacancy rate for sonographers of approximately 14.9%.

There are estimated to be only about 1,945 full-time equivalent (FTE) sonographers in post across the entire UK, a number deemed unsustainable given the demand for over 10 million ultrasound tests annually.

Roughly 29% of the current sonography workforce is at or near retirement age, threatening to deepen existing gaps as experienced staff leave the service. Non-obstetric ultrasound has been identified as the worst-performing diagnostic test in England, with the highest number of patients waiting more than two weeks due to a lack of scanning staff.

As of late 2025, London maintains the highest NHS vacancy rate in England at 7.7**%** overall. However, specialist diagnostic roles like sonography often experience much higher local vacancy rates, exceeding 12% across London’s imaging departments.

Summary

Given the current financial constraints, the three acute Trusts within North East London will only be able to address these local deficits progressively over the next five years. To ensure that any available investment is spent in the most critical areas, an analysis has been undertaken of all the shortage professions to understand how North East London is resourced compared with both the other London ICBs and the rest of England. A 'heat map' of these shortages professions has also been produced, identifying which of the higher local deficits has the most impact. The details of North East London's structural deficit and this heat map are explained in more detail below under the final section on Future Workforce Modelling.

Learning from Deep Dives, Focus Groups and Stakeholder Interviews

AHP and Nursing Deep Dives

The two deep-dive reports provide a detailed picture of the current state of cancer nursing and allied health professional (AHP) roles across North East London, and together they highlight a consistent story: specialist cancer workforce capacity is fragile, uneven, and constrained by systemic and structural barriers rather than lack of capability or motivation.

Across both reports there is a shared recognition that cancer expertise takes time to develop and depends on stable teams, protected learning, and clear career pathways. Yet the experience in practice is highly variable, and in some places largely dependent on individual managers or short-term funding sources rather than an established and sustainable system.

A recurring theme across both professions is the disproportionate impact of workforce gaps in cancer services due to the small size of teams. In AHP and CNS workforces, teams are often made up of lone practitioners or single posts per tumour site. As a result, sickness, turnover or retirement has a direct effect on service stability and patient experience. This vulnerability is expressed repeatedly across both reports: shortages affect continuity of patient relationships, the ability to participate fully in MDTs, and capacity to train or support junior staff. In both cases, workforce supply is described as uncertain, with recruitment pipelines either fragile or non-existent. For example, in cancer nursing there is "no vibrant pipeline" and students are not consistently exposed to cancer early enough to choose it as a preferred career route, while in AHP services national shortages are compounded by limited opportunities for specialist exposure during training.

Training and upskilling feature heavily in both reports. Both workforces report that existing training routes are inconsistent and often dependent on local funding rather than system strategy. Training for advanced practice – including prescribing or autonomous roles – is viewed as essential for future service models. However, there are cases where staff have completed training without a corresponding role being

available, creating frustration and risk of attrition. In cancer nursing, for example, advanced practice qualifications are valued yet progression structures are unclear, leading some nurses to describe the CNS role as a “career cul-de-sac”.

Similarly, AHPs report that the lack of nationally recognised oncology modules creates barriers to competency development, and lone practitioners struggle to access supervision. In some disciplines, such as speech and language therapy, there is a steep learning curve and no structured national framework. This is described as a challenge that could be better addressed through regional or national collaboration, rather than each Trust building bespoke solutions.

Retention challenges also appear consistently. Burnout, emotional load, high caseloads and lack of protected development time are shared concerns, and while staff express strong commitment to patient care, the sustainability of this commitment is questioned. New models such as virtual clinics, personalised stratified/patient-initiated follow-up and pathway redesign are emerging, but these changes are often driven by operational pressure rather than workforce planning. Both reports suggest that digital solutions, rotational roles, career pathways, and support for supervision could make a meaningful difference if systematised. However, at present these approaches are inconsistent, and in some cases pilots that demonstrated value were not sustained due to lack of recurrent funding.

Structural barriers such as insufficient clinic space, lack of administrative support and organisational awareness are highlighted across both professions. In cancer nursing, administrative burden is significant, with some CNSs estimating that a substantial proportion of their role involves tasks that could be undertaken by dedicated support staff. In AHP services, administrative and estates issues are described as limiting clinical productivity and training opportunities, reinforcing the perception that cancer AHPs are “invisible” in system planning.

Despite the challenges, both reports identify opportunities. There is enthusiasm for system-wide rotational roles, shared training programmes, cancer-specific apprenticeship pathways and a stronger leadership framework. There is also recognition that the NHS England ACCEND programme, and wider workforce reform under the NHS Long Term Plan, may provide a foundation for structured development if regional implementation is prioritised. Several interviewees stressed that workforce planning must be aligned with pathway redesign, and that a balanced model of nursing, medical and AHP input is required if personalised cancer care ambitions and other operational performance and timeline targets are to be realised.

Overall, the picture presented is one of committed and highly skilled staff working within systems that are not yet configured to support long-term sustainability. Without intervention, shortages will continue to compound, particularly given reliance on small teams and the age profile of the workforce. However, with coordinated planning, improved visibility of career structures, protected development time and system-level investment in training infrastructure, the reports suggest that the cancer AHP and CNS workforce could be strengthened and stabilised.

Faster Diagnosis Standard Nursing

Interviews were undertaken to understand how the new Faster Diagnosis Standard Nurse role has landed. The main feedback was that people do not wish to stay within these roles – the average is between a 1 and 2 year tenure. Job satisfaction is low because there is no autonomous practice. Routes onward from FDS nursing vary, either to different departments in the same Trust or outside the employing Trust. In terms of resourcing, the FDS nurses are pushed to their limits – the role was mostly perceived as unattractive because of the time pressure as well as the lack of patient contact.

When FDS nurses were asked if the role could be made more attractive, their main feedback was that they would like to be involved in Face to Face clinics. If the cohort were enabled to take Non-Medical Prescribing courses and/or Advanced Assessment courses then this would be possible, and might create a viable bridge across to CNSs roles in due course. Ideally, each FDS nurse would have their own cohort of patients, following them through the resolution of symptoms, discharging (or indeed rejecting the referral). There is also some opportunity for improving the training for primary care – at the moment, it is only possible to reject a referral in specific specialties e.g. Lower GI but even their unoutcomed referrals could also be reduced.

Cancer CNS Development

Alongside the other London Cancer Alliances North East London Cancer Alliance are delivering a Cancer CNS Workforce Development project with Macmillan funding for a Cancer CNS Development Lead (CDL) in each London ICB area. This role provides mentoring, coaching, observation and 1:1 support for new CNSs to expediate their development and competencies, as well as championing and promoting the CNS role. The aim is to attract more nurses into cancer CNS roles and to accelerate CNS development to help address the supply, recruitment, retention, and aging workforce issues faced in cancer nursing.

An interview with the North East London Cancer Alliance Cancer CNS Development Lead (CDL) produced interesting reflections on CNS development. Development is probably different for different target roles. Chemo Nurses could definitely be developed in the oncology wards; they could then spend time with CNSs. Homerton can provide only limited opportunities for development as the Trust does not offer chemo, oncology wards or radiotherapy. Their ward nurses would only be involved in cancer through palliative care needs – so this creates a difficulty. Rotations across the other two Trusts would therefore help.

The answer might be to create more training posts at Band 6 to attract qualified nurses. These training commitments are not always delivered on – so training contracts need to be firmed up.

Barts has a skilled mix which focusses on the lower bands as it has less difficulty attracting staff. There are more Band 8as at BHRUT, but not many Band 8bs there. So, Barts loses Band 7s and BHRUTs loses Band 8as either to the other Trust or

outside North East London. Homerton has at least some Band 6s doing Band 7 roles, largely from lack of funding. Homerton is fairly stable in workforce terms; these Band 6s are essential to the development of 'progressive grading'.

Very new CNSs take a while to develop – if they come in from a different background it's probably 6-12 months before they can undertake any truly autonomous practice. The CNS Workforce Development project is using a competency framework, aligned to the ACCEND framework, and adopted across all three Trusts to support progress and individual action plans. The support and coaching requirements for effective CNS development and retention can therefore be very high, and isn't always met by line managers. The North East London CDL is currently trying to meet that need but there is no succession plan beyond the fixed term post. Group discussions can help but they are not individual goal based. The Trusts provide leadership development but not specific clinical leadership development.

Developing cancer support workers into cancer nursing: Clinical Support Workers are not able to access apprenticeships. Trusts are pulling back on the number of apprentices they fund; there is limited appetite in cancer services to support apprenticeships as the teams are small and the specialty is highly complex. This tends to mean that the Clinical Support Workers who are funded for Trainee Nurse Associate and nursing apprenticeships go elsewhere.

Approach to pan-London Cancer Nurse Specialist data

The data below was collated across all of London showing the relevant Tumour Group for the workforce, which includes ANPs, Nurse Consultants and Cancer Support Workers. The variation in workforce profiles is likely due to different demand profiles and service models across the tumour groups.

This data is more detailed than the other workforce information gathered under the Freedom of Information conditions, and therefore is not comparable data.

Following discussion with the Lead Cancer Nurses of all three acute Trusts, a first stage of validation of the data has revealed some anomalies which will need to be corrected. Further analysis of this workforce is then needed to understand whether the resourcing across tumour groups is equitable and inline with demand profiles. Initial recommendations suggest undertaking headline time and motion studies in breast, where some of the greatest discrepancies in resource allocation may occur.

Band Mix of CNS Workforce by Tumour Group

Tumour Group	Total CNS WTE	Band 8a+ WTE	Band 7 WTE	Band 6 WTE	CSW WTE
Breast	**113.89**	22.9	77.29	2	11.7
Colorectal	**91.72**	23.4	55.35	5	7.97
Haematology	**91.5**	17	62.3	3	9.2
Lung	**68.47**	5.5	49.27	1.6	12.1
AOS	**65.91**	20.9	33.4	8.61	3
Urology General	**60.53**	14.63	33.8	4	8.1
Oesophago-gastric	**53.56**	10	34.16	2	7.4
Head & Neck	**46.65**	6.1	28.1	6.35	6.1
Gynaecology	**43.6**	6	33.1	1	3.5
Prostate	**39.05**	10.55	23.8		4.7
Dermatology	**27.12**	6.92	18.2	1	1
HPB	**26.3**	4	21.8		0.5
Neuro	**24.5**	8	14.6	0.4	1.5
Enhanced Supportive Care	**12.2**	2.2	2		8
Myeloma	**11.6**	0	9.6		2
Bladder	**10.65**	1	7.4	1.25	1
Renal	**10.06**	1.5	6.8	0.76	1
Urology Metastatic	**10**	2	6	1	1
NET	**7**	2	5		
Renal, Testes, Bladder	**6.8**	1.8	3	1	1
Sarcoma	**6.4**	2.4	3		1
All Tumours	**827.51**	**168.8**	**527.97**	**38.97**	**91.77**

The data below was collated across all of London showing the relevant amount of Fixed Term Funding for workforce by Tumour Group.

A key concern based on this data is that a considerable element of the wider Urology provision is weighted towards fixed term funding more than other tumour groups.

This may pose a considerable risk to provision of these services in the long term and should be an area considered for review. It is acknowledged that this service area is a nationally challenged labour market.

CNS WTE on Fixed Term Contracts/Funding

Tumour Group	Total CNS WTE	WTE on FT funding	% on FT Funding
Urology Metastatic	10	2.7	27%
Enhanced Supportive Care	12.2	2	16%
Renal, Testes, Bladder	6.8	1	15%
Urology General	60.53	6.5	11%
Prostate	39.05	3	8%
AOS	65.91	3	5%
Head & Neck	46.65	2	4%
Breast	113.89	4.54	4%
Colorectal	91.72	3.5	4%
Dermatology	27.12	1	4%
Lung	68.47	1.5	2%
Haematology	91.5	2	2%
Neuro	24.5	0.5	2%
Oesophago-gastric	53.56	1	2%

The data below was collated across all of London showing the relevant amount of vacancies for workforce by Tumour Group.

Vacancies are critical for a consistent development of careers and workforce, however timely filling of these vacancies is also important to ensure existing workforce is not unduly required to deliver services without sufficient resources.

Vacancies above 10% begin to create considerable pressures for service delivery – meaning Head & Neck, Dermatology, Bladder, Urology Metastatic and Enhanced Supportive Care are all vulnerable across London.

CNS Vacancies across specialties

Tumour Group	Total CNS WTE	Vacancies (WTE)	% Shortfall	Net Filled
Enhanced Supportive Care	12.2	3	25%	9.2
Urology Metastatic	10	2	20%	8
Bladder	10.65	2	19%	8.65
Dermatology	27.12	4.5	17%	22.62
Head & Neck	46.65	6.4	14%	40.25
Renal	10.06	1	10%	9.06
Haematology	91.5	8.2	9%	83.3
Breast	113.89	8.24	7%	105.65
Urology General	60.53	4	7%	56.53
Colorectal	91.72	6	7%	85.72
Oesophago-gastric	53.56	3	6%	50.56
Gynaecology	43.6	2	5%	41.6
AOS	65.91	3	5%	62.91
HPB	26.3	1	4%	25.3
Myeloma	11.6	0.3	3%	11.3
Prostate	39.05	1	3%	38.05
Lung	68.47	1.2	2%	67.27
Neuro	24.5	0.4	2%	24.1
NET	7	0	0%	7
Renal, Testes, Bladder	6.8	0	0%	6.8
Sarcoma	6.4	0	0%	6.4

Support Worker Focus Groups

Clinical support workers across the three Trusts described their roles as meaningful and rewarding, largely due to direct patient contact and the opportunity to support people through emotionally difficult points in their cancer journey. Strong relationships with wider multidisciplinary teams were motivating, and many valued the variety and autonomy within their roles.

However, the feedback also highlighted recurring challenges. The role is not consistently defined, leading to variation in expectations and, in some cases, underutilisation of existing skills. Training was described as limited, uneven and often focused on induction rather than development, leaving some staff feeling unprepared for the emotional and practical complexity of cancer care. Recruitment delays, gaps in cover and unclear escalation pathways further affected workload and patient experience.

Career progression emerged as a key concern. Many participants felt they had reached a ceiling, with limited opportunities to advance without moving into purely administrative or non-patient-facing roles. The absence of a structured career pathway between Band 4 and Band 7 was repeatedly highlighted.

Overall, the insight suggests that clinical support workers are a committed and valued part of the cancer workforce, but their role remains underdeveloped. With clearer role definition, equitable access to training and recognised progression routes—including alignment with navigator or care coordinator models—this group could form a stronger and more sustainable part of the future cancer workforce.

Psycho-oncology workforce

The current funding to uplift the psycho-oncology level 3 / 4 workforce across North East London runs out at the end of 2026. The team are therefore working together to try to produce an economic analysis which demonstrates the benefit of providing cancer patients with improved psychological support.

They are finding that there is a fundamental problem with the availability of data that can demonstrate economic value: Retrospective analysis is considered extremely problematic due to lack of data. Prospective analysis may yield better results. However, the nature of psycho-oncology services is that the team provides a wide range of interventions for patients at different stages in their cancer journey and for different presenting problems. So pre and post therapy metrics will not capture this complexity fully.

Suggestions to improve the economic and business case include looking at more valid measures of added value such as QUALYS rather than more problematic indicators such as bed day, A&E stays, time in oncology clinics etc. There may also be power in consideration of the ‘counter-factual’ i.e. what would have happened during the fixed term funding period to each patient if they did not have appropriate psychological support. This would need to be based at least partly on patient-recorded outcomes.

Primary Care Workforce

Primary care plays a critical role in cancer prevention, early detection, and support for people living with and beyond cancer. Improving screening uptake is identified as a key workforce priority, with opportunities for the wider primary care team - including Additional Roles Reimbursement Scheme (ARRS)- to proactively identify non-attendance and support patients to navigate screening pathways. This requires improved system alerts, clearer ownership, and targeted workforce development.

Trauma-informed practice is highlighted as essential to improving engagement with screening and early diagnosis, particularly for underserved groups. While GPs generally receive training in this area, other parts of the primary care workforce, including pharmacy and newer ARRS roles, require more comprehensive and practical development to enable effective patient conversations.

Primary care networks are increasingly using multidisciplinary team working, social prescribing, care coordination, and group consultations to support people following a cancer diagnosis. However, capability and maturity vary significantly between neighbourhoods. Training hubs are identified as a key enabler for upskilling the wider workforce, particularly in cancer pathways, psychosocial support, and navigation of complex services. Strengthening these capabilities would enhance primary care’s contribution across the full cancer pathway.

Public Health Workforce

Public Health plays a central role in addressing cancer risk, prevention, and inequalities across North East London. Workforce efforts are focused on tackling upstream risk factors and improving access to screening for diverse and deprived populations, where literacy, language, and cultural barriers significantly affect uptake and outcomes.

Improving screening participation requires a broad workforce approach, extending beyond health services to faith, voluntary, and community organisations. Culturally competent staff and community advocates are often the most effective means of overcoming barriers to engagement. Public Health teams also work closely with partners to improve screening access for people with learning disabilities.

The workforce challenge extends into diagnosis and early intervention, where social prescribers and wider community-facing roles could play a more dynamic role through “making every contact count.” There is a clear need for additional training across the wider primary care workforce to embed cancer awareness, risk factor understanding, and screening knowledge. Embedding equity as a core principle across the workforce strategy is essential to improving access, experience, and outcomes.

Patient Engagement

Patient feedback highlights workforce-related challenges at key transition points in the cancer pathway. The period between GP referral and specialist assessment is consistently associated with high anxiety, with limited evidence of structured support from the wider primary care team during this time. This suggests an opportunity to strengthen workforce roles focused on communication, reassurance, and navigation.

While diagnosis is often welcomed as an end to uncertainty, the manner in which news is communicated is variable. Time pressures and remote communication can result in poorly timed or inadequately supported conversations. Patients also report inconsistencies in understanding treatment options, the role of their key worker or CNS, and access to holistic needs assessments.

Post-treatment, many patients describe feeling isolated and unclear about ongoing support. Workforce capacity constraints limit proactive follow-up, and peer support options are not consistently available. These insights reinforce the importance of a workforce strategy that prioritises communication skills, continuity, clear role definition, and integration between acute and primary care teams to improve patient experience and outcomes.

National Cancer Patient Experience Survey

North East London Cancer Alliance’s results within the National Cancer Patient Experience Survey are consistently below the England average, across all metrics captured. See table below. The 2025 national survey has been launched and will close February 2026 to enable improved analysis of workforce related solutions.

	Case mix adjusted scores			England score
	2024 score	Lower expected range	Upper expected range	
Q05. Patient received all the information needed about the diagnostic test in advance	**90%**	91%	95%	**93%**
Q06. Diagnostic test staff appeared to completely have all the information they needed about the patient	**80%**	81%	86%	**83%**
Q08. Diagnostic test results were explained in a way the patient could completely understand	**75%**	76%	82%	**79%**
Q09. Enough privacy was always given to the patient when receiving diagnostic test results	**93%**	93%	96%	**95%**
Q16. Patient was told they could go back later for more information about their diagnosis	**81%**	81%	89%	**85%**
Q18. Patient found it very or quite easy to contact their main contact person	**80%**	81%	88%	**85%**
Q19. Patient found advice from main contact person was very or quite helpful	**93%**	94%	97%	**96%**
Q23. Patient could get further advice from a different healthcare professional before making decisions about their treatment options	**52%**	53%	62%	**58%**
Q24. Patient was definitely able to have a discussion about their needs or concerns prior to treatment	**68%**	69%	77%	**73%**
Q26. Care team reviewed the patient's care plan with them to ensure it was up to date	**98%**	98%	100%	**99%**
Q35. Patient was always able to discuss worries and fears with hospital staff	**61%**	61%	70%	**66%**
Q39. Patient was always able to discuss worries and fears with hospital staff while being treated as an outpatient or day case	**76%**	76%	84%	**80%**
Q42_1. Patient completely had enough understandable information about their response to surgery	**82%**	84%	89%	**87%**
Q43. Patient felt the length of waiting time at clinic and day unit for cancer treatment was about right	**70%**	74%	85%	**79%**
Q46. Patient was given information that they could access about support in dealing with immediate side effects from treatment	**84%**	85%	91%	**88%**
Q48. Patient was definitely able to discuss options for managing the impact of any long-term side effects	**50%**	51%	61%	**56%**
Q51. Patient definitely received the right amount of support from their GP practice during treatment	**42%**	43%	53%	**48%**
Q54. The right amount of information and support was offered to the patient between final treatment and the follow up appointment	**76%**	76%	85%	**81%**
Q59. Patient's average rating of care scored from very poor to very good	**8.8**	8.8	9.1	**8.9**

North East London Cancer Alliance carried out a Patient Engagement workforce survey during December 2025 to provide additional patient input to the development of the workforce strategy.

In addition to this an interview was carried out with a patient who provided further detailed information on their lived experience. Across this feedback and the survey, the findings were that key strengths included compassionate staff, professionalism and personalised care.

Key areas for improvement centred on emotional support at diagnosis, clearer communication during waiting periods and continuity of care. The findings suggest that relatively small changes in communication and support roles could have a significant positive impact on patient experience. The full survey results can be found in Appendix 2.

(Patient focus groups were also offered but not taken up. This will be explored further to ensure meaningful patient engagement and collaboration with the development and implementation of the strategy going forward).

Recommended action points from the NELCA Workforce Patient Experience Survey

1. Strengthen support at diagnosis and early pathway stages
2. Improve communication during waiting periods
3. Clarify points of contact across the care pathway
4. Enhance emotional and psychological support provision
5. Protect and promote continuity of care
6. Use digital tools in a patient-centred, flexible way
7. Reinforce respectful, individualised care

Known Service Model Changes

Cancer care in the UK is being reshaped by a combination of rising demand, persistent outcome gaps compared with peer countries, and a deliberate policy push towards earlier diagnosis, personalised care and care closer to home. The NHS Long Term Plan set ambitions that by 2028 an extra 55,000 people each year will survive cancer for five years or more, and 75% of people will be diagnosed at stage 1 or 2.

Service model change is therefore not hypothetical or optional. It is already being implemented at scale through national programmes, and further shifts are clearly signalled in policy documents.

The workforce will need to adapt to models that are more distributed, more digital, more genomically informed and more prevention-focused than the hospital-centred paradigms that have shaped previous planning rounds.

Service model changes already in train

The first major area of change is the diagnostic front end of the pathway. The Faster Diagnosis Standard now commits the NHS to diagnosing or ruling out cancer within 28 days of an urgent suspected cancer referral. This has driven the roll-out of Best Practice Timed Diagnostic Pathways, Rapid Diagnostic Services and greater use of straight-to-test models, supported by the GIRFT diagnostics programme[23].

Community Diagnostic Centres (CDCs) are a central plank of this shift: more than 160 are now open, backed by £2.3 billion capital to 2025 and specific ambitions in operational planning guidance and in the 10-Year Health Plan.

Many CDCs are now moving to extended hours and seven-day operation, delivering large volumes of additional MRI, CT and endoscopy activity and explicitly aiming to make tests more accessible for working-age people.

[23] See GIRFT national reports on Radiology and Pathology.

Screening and early detection are also being remodelled. The Targeted Lung Health Check programme has evolved into a national Lung Cancer Screening Programme, now inviting close to a million people annually and delivering significant improvements in early-stage diagnosis.

Risk-stratified approaches are emerging in cervical and breast screening, with pilots and impact assessments exploring how to tailor screening frequency and modality to individual risk in order to improve benefit-harm balance and make better use of capacity.[24]

A second, connected area of change is the shift of care out of hospital and into home and community, supported by virtual and remote-monitoring models. Virtual wards are being scaled nationally as "hospital at home" services, and cancer is beginning to feature explicitly within this agenda through oncology virtual wards that monitor patients receiving systemic anti-cancer therapy and allow earlier discharge or avoidance of admission[25].

Alongside this, chemotherapy and immunotherapy at home are moving from niche innovation to a more mainstream expectation, with centres such as The Christie delivering thousands of home treatments annually and new SACT homecare trials starting in other trusts. The dramatic expansion of remote consultations during the pandemic are also likely to remain a feature of cancer pathways wherever clinically appropriate.

Third, the follow-up and survivorship phases of care are being redesigned around personalisation and supported self-management. Personalised Stratified Follow-Up (PSFU) is now an established national model: patients are stratified after treatment into traditional, shared-care and supported self-management pathways, with digital remote monitoring systems and Patient Initiated Follow-Up as core components.

Personalised cancer care more broadly, including holistic needs assessment, personalised care and support planning, and access to emotional wellbeing, prehabilitation and rehabilitation interventions, is being embedded as a standard expectation rather than an optional add-on. This is already changing the balance of activity and skill mix between specialist nurses, allied health professionals, primary care and the voluntary sector.

Fourth, there is a structural and commissioning shift towards system-level planning and networked delivery. Cancer Alliances bring together providers, commissioners and partners to plan and improve whole pathways, and their role is being deepened through closer alignment with Integrated Care Systems (ICSs). From 2024/25, ICS Integrated Care Boards are assuming responsibility for commissioning more specialised cancer treatments that were previously held nationally, with the aim of aligning these services with local pathways and population needs.

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[24] https://www.england.nhs.uk/2025/06/nhs-rolls-out-more-personalised-cervical-screening-for-millions/#:~:text=More%20accurate%20human%20papillomavirus%20(HPV,app%20notification%20isn't%20opened.

[25] See for example https://www.royalfree.nhs.uk/patients-and-visitors/patient-information-leaflets/virtual-oncology-ward

This redistribution of authority is already affecting how services are configured across provider collaboratives, including consolidation of complex surgery, shared oncology rotas and networked diagnostics.

Finally, diagnostics and treatment planning are undergoing a digital and genomic transformation. The national diagnostics strategy and operational guidance commit to maturing all pathology networks digitally by 2024/25, with digitisation of histopathology a particular focus.

Imaging is being reconfigured through regional networks and underpinned by the National Imaging Registry, which allows real-time sharing of images and reports across organisational boundaries. On the treatment side, the NHS Genomic Medicine Service is now delivering hundreds of thousands of genomic tests a year[26], explicitly including cancer, with whole-genome sequencing and tumour panels expanding access to personalised oncology.

Recent announcements of nationwide liquid biopsy services for lung and advanced breast cancer, using blood tests to profile tumour DNA, illustrate that this is not an aspirational future but a service model now being rolled out.

Forthcoming and near-term changes on the horizon

Looking ahead over the next five to ten years, several developments are either in active design or early implementation that will further reshape cancer service models and, in turn, workforce needs.

The first is the National Cancer Plan, currently being developed following a government call for evidence. Early signals suggest it will emphasise leadership in clinical trials and access to innovative therapies, more targeted and risk-stratified screening, stronger prevention measures and a more systematic approach to addressing variation and inequalities.

In parallel, the 10-Year Health Plan and Major Conditions Strategy frame cancer within a multi-morbidity context, pushing systems to plan services and workforce that can manage cancer alongside cardiovascular, respiratory and mental health needs rather than in isolation[27].

There is a clear trajectory towards more targeted and stratified detection models. Work on risk-based breast and cervical screening is progressing, with emerging evidence that such models are feasible, acceptable and potentially cost-effective.

Combined with lung cancer screening and pilots in community pharmacy and primary care settings for other cancers, this points to a future diagnostics landscape in which cancer risk assessment, testing and surveillance are distributed across high-street, primary care and community venues, supported by digital decision-support rather than concentrated in hospital clinics.

[26] https://www.england.nhs.uk/long-read/the-nhs-genomic-medicine-service-achievements-in-2024/
[27] https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

AI and advanced digital tools are poised to change workflow in radiology, pathology and screening. The planned “world’s largest trial” of AI for breast cancer diagnosis in the NHS is a flagship example[28]. The NHS is running the EDITH trial (Early Detection using Information Technology in Health), which involves nearly 700,000 women and tests multiple AI systems across 30 sites in England.

The trial began in April 2025 and aims to improve diagnostic speed and efficiency. If results are positive, the model of double reading by two radiologists may shift towards AI-supported single reading, potentially altering workforce roles and productivity assumptions.

More broadly, digital pathology networks and national image registries are laying the infrastructure for large-scale deployment of AI tools across tumour sites, even if the precise timelines and regulatory pathways remain unknown.

Treatment delivery itself is becoming more flexible. The introduction of subcutaneous “super-jab” formulations of immunotherapy, such as the new injectable nivolumab, reduces chair time from around an hour to a few minutes and enables treatment to be delivered in a wider range of settings including home.

There is a broader system reform agenda that will indirectly reshape cancer service models. Proposals for a “radical NHS reset” include new financial incentives for hospitals to shift activity into community-based care and diagnostic centres, enhanced use of the NHS App as a digital front door, and new targets to ensure 85% of patients start cancer treatment within two months of referral by the late 2020s.

Seven-day “health hubs” and expanded CDC opening hours are intended to absorb more diagnostic and minor procedure activity outside traditional hospital outpatient settings. For cancer, this is likely to mean more evening and weekend diagnostic lists, more pathway coordination outside acute hospitals and greater use of remote monitoring and virtual wards to sustain flow.

Genomics, vaccines and novel therapeutics are also likely to become more mainstream. The Genomic Medicine Service is expanding its test directory and volumes year on year and there is an explicit ambition in national plans to use genomics and data to enable predictive and personalised medicine by the mid-2030s.

This will influence demand for specialist research nurses, data managers, genomic counsellors and pharmacists, and for stronger links between routine services and research networks.

Implications and drivers for North East London Cancer Alliance’s cancer workforce strategy

Taken together, these current and emerging service model changes create a set of powerful drivers for change in the cancer workforce.

[28] https://preventbreastcancer.org.uk/ai-breast-screening-trial/#:~:text=The%20Biggest%20Breast%20Cancer%20AI,the%20images%20from%20each%20screening.

The ambition for earlier and faster diagnosis, delivered through CDCs, rapid diagnostic pathways and expanded screening, significantly increases demand for radiographers, reporting radiographers, radiologists, endoscopists, pathologists and cancer-literate primary care professionals.

The shift of diagnostics into community and extended-hours settings adds a geographical and temporal dimension: more staff will be needed outside traditional hospital cores, working evenings and weekends, often in smaller multi-professional teams. This pushes towards new advanced practice roles, cross-skilling and stronger career pathways in diagnostics.

The move to virtual wards, home-based SACT and remote monitoring changes the profile of nursing and AHP work. More specialist nurses will spend more of their time coordinating and supervising care delivered at home or through digital platforms rather than providing all care themselves in hospital clinics.

Skills in risk stratification, remote assessment, escalation and digital communication will become core, as will the partnership skills needed for working with community teams, primary care and independent sector homecare providers. Workforce models will need to allow for both the hands-on technical competencies required to deliver treatment safely at home and the oversight and governance capabilities to manage distributed care.

Personalised stratified follow-up and personalised care require a broader team beyond medical oncologists and surgeons. Holistic needs assessment, supported self-management, prehabilitation and rehabilitation draw on psychology, physiotherapy, occupational therapy, dietetics, social work, nursing, primary care and the expertise of the voluntary and community sector.

This implies growth in non-medical roles, new “care coordinator” and “cancer navigator” functions, and closer integration with non-NHS partners. It also means the workforce strategy must consider not just numbers but the balance of roles and the training needed to support truly personalised, inequality-sensitive care.

The digital and genomic transformations create an urgent need for upskilling and new specialist roles. Radiology, pathology and screening staff will need to work effectively with AI tools, understand their limitations and participate in continuous quality assurance.

Clinicians across disciplines will need basic genomic literacy to order and interpret tests, discuss results with patients and incorporate them into shared decision-making, supported by specialist genomic nurses, counsellors and scientists. Data management, informatics and clinical trials delivery capacity will all need to grow if the National Cancer Plan is to realise its ambition of world-leading access to innovative treatments.

The system-level reconfiguration through ICSs and Cancer Alliances means that leadership, workforce planning and deployment will increasingly operate at system rather than individual-trust scale. This cancer-specific workforce strategy therefore needs to align with ICS-wide approaches to recruitment, training and retention, making use of provider collaboratives, shared rotas and networked services. It also

needs to address regional variation head-on, given current evidence of major inequalities in access to treatments such as radiotherapy.

The persistent and well-documented workforce gaps in key cancer specialties, highlighted above mean that any workforce strategy must treat service model changes not just as additional pressure but as potential levers for sustainability.

AI support, new assistant and advanced roles, redistribution of tasks across professions, and smarter use of remote and community-based care can all help close the gap between demand and capacity – but only if they are planned for explicitly, supported with appropriate education and supervision, and embedded within clear governance frameworks.

Summary

Cancer service models in the UK are already shifting towards earlier, more targeted diagnosis; digitally enabled, community-based treatment and follow-up; and genomically informed, personalised care, all within a more networked and system-led structure. Over the next decade these trends will accelerate as the National Cancer Plan, the 10-Year Health Plan and technology advances bed in.

This cancer workforce strategy needs to use these drivers for change to shape the size, skills, distribution and leadership of the future workforce rather than trying to retrofit yesterday's staffing models onto tomorrow's services. Please see section below on Future Workforce Models.

Digital Transformation

Digital transformation as a structural driver, not a side project

In UK cancer care, digital transformation is progressively being hard-wired into national policy, funding streams and regulatory expectations. The NHS England Cancer Programme and its Faster Diagnosis Framework explicitly assume digital, data and AI-enabled pathways as the main route to hitting the 28-day Faster Diagnosis Standard and 62-day treatment targets.

This means that, over the next few years, cancer teams will be expected to work in an environment where digital tools are optimised and provide the default mechanism for meeting performance standards and demonstrating quality. Most roles will therefore be reshaped by this shift, not simply supported by it.

Data platforms and real-time oversight of cancer pathways

There is a clear move to shared, national-scale data platforms. The NHS Federated Data Platform (FDP) is being rolled out with explicit cancer use cases, including tools such as "Cancer 360", which pull together investigations, appointments and treatments into a live dashboard for pathway oversight. Early sites report faster diagnosis times and earlier treatment starts when multidisciplinary teams can see bottlenecks and risks in real time rather than retrospectively.

For the workforce, this changes the nature of pathway coordination and management. Cancer managers, coordinators and clinicians are moving from manual tracking and chasing to interpreting dashboards, acting on predictive risk signals and participating in data-driven improvement cycles.

Analytical and informatics capability is increasingly needed inside cancer teams, not just in corporate BI functions. This workforce strategy therefore has to assume growing demand for roles such as data-savvy pathway coordinators, operational analysts embedded in Cancer Alliances, and clinical leaders who are comfortable using live data to achieve performance or redesign services.

AI-enabled diagnostics and digital pathology

AI in cancer diagnostics is actively entering routine practice. Funded AI tools include AI chest X-ray analysis for suspected lung cancer[29] and autonomous skin cancer triage solutions[30].

Trials of AI-supported MRI reporting for prostate cancer are underway across multiple NHS hospitals, aiming to provide same-day results and prioritisation of scans for radiologist review. In parallel, many pathology networks are moving to digital pathology, creating image archives that are a prerequisite for AI-assisted reporting.

These technologies do not remove work; they reconfigure it. Radiologists, reporting radiographers, pathologists and cancer clinicians will need skills in interpreting AI outputs, understanding limitations and bias, and communicating AI-supported decisions to patients.

New governance expectations are emerging around validation, safety monitoring and incident response for AI tools, which in turn implies roles such as clinical AI safety leads, digital pathologists with algorithm expertise, and informatics-literate radiology leaders.

North East London Cancer Alliance's workforce strategy will need to address training pathways, protected time and career structures that allow clinicians to take on these hybrid digital–clinical responsibilities without simply adding them on top of existing workloads.

Genomics and precision oncology at scale

Through the NHS Genomic Medicine Service, whole genome sequencing and broader genomic tests are being embedded into routine care, including for children and adults with cancer.

This is moving precision oncology from niche to mainstream. Molecular tumour boards, genomics-guided trial matching, and increasingly complex disclosure conversations are becoming part of the standard offer.

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[29] https://www.nice.org.uk/consultations/2134/1/the-diagnostic-tests

[30] https://www.nice.org.uk/news/articles/ai-skin-cancer-detection-system-gets-green-light-for-conditional-nhs-use

Workforce implications include the need for more genetic counsellors, clinical scientists, bioinformaticians and oncologists who are comfortable integrating genomic reports into treatment decisions.

There is also a growing need for data engineers and analysts who can manage and link genomic data with imaging, pathology and outcomes data to support research and service improvement.

For frontline cancer nurses and allied health professionals, this shift requires at least a working understanding of genomic concepts so they can support patient understanding and shared decision-making.

Remote monitoring, virtual wards and care at home

National policy and recent investment rounds are pushing towards more care at home for people with long-term conditions, including cancer. Government announcements in 2025 describe dozens of new pilots using remote monitoring and self-reporting through the NHS App and other platforms to allow patients to share health updates directly with specialists.

Oncology-specific solutions such as MySunrise[31] are already enabling virtual ward models for patients on systemic anti-cancer therapy, using electronic patient-reported outcomes (ePROs) and symptom reporting to support early intervention and reduce avoidable admissions.

This transforms the profile of cancer nursing and allied health roles. Instead of episodic, in-clinic monitoring, more work will be conducted through remote dashboards, telephone and video contact, and digital triage of symptoms reported. Skills in remote assessment, risk stratification, use of digital triage algorithms, and escalation via virtual ward models will become essential.

Teams will need capacity to staff extended-hours remote monitoring services, with different rostering and supervision models to traditional outpatient clinics. The workforce strategy should therefore anticipate shifts in skill mix, new roles such as virtual ward cancer nurses and digital navigators, and the need for robust training in remote clinical risk management.

Patient portals and digitally-enabled communication

The NHS Transformation Directorate provides a collection of digital playbooks designed to support clinical teams in redesigning care pathways using tried-and-tested digital technologies[32].

From appointment management and results viewing to treatment information, messaging and shared care planning, the direction of travel is towards patients having a persistent digital front door to their cancer care. The NHS App is explicitly positioned as the core platform for this across conditions.

[31] https://www.mysunrise.co.uk/

[32] https://transform.england.nhs.uk/key-tools-and-info/

For staff, this means communication patterns will change significantly. Clinical nurse specialists and support workers, already recognised as central to patient experience, are likely to become the primary human interface with digital channels, managing secure messaging, video check-ins and digital education resources as part of their core role.

Administrative staff may shift from traditional call handling to managing digital queues and online queries. Digital literacy, skills in writing clear, compassionate messages, and confidence in using portal data during consultations will all be essential capabilities.

Workforce planning will need to factor in the time and headcount required to safely staff these new channels, rather than assuming they are time-neutral replacements for telephone work.

Infrastructure, interoperability and automation

Underpinning all of this is a broad upgrade in connectivity, cloud infrastructure and interoperability, supported by national programmes on wireless technologies, shared care records and core digital capabilities.

Real-time data transmission from devices and remote monitoring technologies is being actively promoted, with clear expectations that this data will flow into patient records and be usable by clinical teams.

As trusts adopt more automated booking, triage and workflow tools, routine administrative work in cancer pathways – from tracking two-week-wait referrals to managing MDT lists – is likely to become increasingly automated or semi-automated.

The implication for the workforce is not simply fewer administrative roles, but different ones: people who can supervise automated workflows, manage exceptions, and help optimise digital tools in partnership with clinical and IT teams.

Clinical staff will also encounter more decision-support prompts and automated alerts in their daily work, changing the balance between individual judgement and system-supported decisions. Training and culture interventions will be required to ensure staff understand when to trust, when to question and when to override system recommendations.

Implications for a cancer workforce strategy

The North East London Cancer Alliance has recently produced an AI strategy which will be launched at the same time as this workforce strategy. Taken together, these digital changes mean that almost every professional group in cancer care will require new skills, different patterns of work and, in some cases, new roles entirely. The workforce strategy will need to assume that:

- Digital tools and data platforms are integral to achieving cancer waiting-time and outcome ambitions, not optional add-ons.
- Roles that historically focused on manual tracking and episodic contact will become more data-driven and continuous, with staff expected to navigate

dashboards, AI outputs, genomics reports and remote-monitoring feeds as part of routine practice.
- New specialist functions will emerge around AI governance, pathway analytics, genomics, virtual wards and digital navigation, and these functions will need clear career pathways and professional support.

Finally, digital transformation will only deliver its promised benefits if staff have the time, training and change-management support to adapt their practice; workforce planning will therefore need to build in capacity for learning and improvement, not just for delivering today's activity.

Framing digital transformation explicitly as a core driver of role redesign, skill-mix change and new professional identities in cancer care will help ensure that NECLA's cancer workforce strategy is aligned with the realities of what is already being implemented across the NHS, and what is firmly on the near horizon.

Recruitment & Retention

Recruitment

The London labour market is already tight; even with national uplift, recruitment to radiology, oncology, cancer nursing and CNS roles will remain a zero-sum game unless North East London Cancer Alliance explicitly positions itself as a "destination employer" (e.g. rotations across Barts/BHRUT, academic links, flexible working, innovative research and training).

Traditionally, North-East London has been reliant on international recruitment for key parts of its registered workforce particularly nursing. Post-Brexit, the main labour market drivers are wider immigration policy, the Health and Care Worker visa route, and global competition for specialised staff rather than EU freedom of movement per se.

The UK overall still remains heavily reliant on internationally educated nurses and doctors. Workforce plans should therefore include ethical recruitment pipelines, enhanced pastoral support and structured development for overseas staff to improve retention and progression into specialist cancer roles.

Policy and visa uncertainty introduces risk; North East London Cancer Alliance's strategy should explicitly scenario-plan for a tightening of migration rules (e.g. by expanding local training pathways and apprenticeships into cancer support worker, assistant practitioner and advanced practitioner roles).

North East London includes some of the most deprived areas in England alongside rapidly 'gentrifying' neighbourhoods. High housing and childcare costs make recruitment and retention challenging, particularly for mid-band staff (Band 5–7 nurses, AHPs, admin).

To remain competitive locally, North East London Cancer Alliance partners may need to offer: flexible and hybrid working where clinically appropriate (e.g. remote MDT attendance, remote follow-up clinics). It will also need to focus on recruiting internally

or externally to “grow your own” models – apprenticeships, links to FE colleges and universities in London, targeted programmes for under-represented communities across Barking & Dagenham, Newham, Tower Hamlets etc.

Retention

Retention interventions (career frameworks, protected development time, housing advice schemes, childcare support, and wellbeing offers) will be at least as important as recruitment, given the cost of replacing specialist cancer staff and the national shortage in key specialties.

Nursing and AHP Education and Training

Conversations were held with the Training and Education Leads and Clinical Practice Educators at all three Trusts about Nursing and AHP Education and Training. Each Trust had evolved a slightly different approach to workforce development, so a summary of each conversation is provided by Trust below.

Also provided is a summary of the national ACCEND programme and framework; and the pan-London Cancer CNS Development Lead Project

The Aspirant Cancer Career and Education Development (ACCEND) Programme and Framework

The ACCEND programme[33] is a national cancer career and education development programme aimed at cancer support workers, nurses and AHPs who work or aspire to work with people with cancer.

It will increase and improve the supply of the cancer healthcare professional workforce in the future, as well as providing the existing cancer workforce with access to the education and training needed to match the competencies required for their role.

The ACCEND Framework is a nationally agreed multi-level education framework underpinned by learning related to the four pillars of practice – clinical practice; leadership and management; research/evidence based practice and quality improvement; and specialist cancer focused education.

There are various national workstreams developing tools and resources to support the implementation of the framework, alongside local implementation plans and NHSE requirements of Cancer Alliances.

Workstreams include the supportive and assistive workforce; the registered enhanced to advanced workforce; and the leadership, advanced and consultant practice workforce.

[33] https://www.hee.nhs.uk/our-work/cancer-diagnostics/aspirant-cancer-career-education-development-programme

Pan-London Cancer CNS Development Lead Project

Macmillan and NHSE are currently funding a 3-year London Cancer CNS Development Project. The aim of the project is to improve the recruitment, retention and career development of cancer CNSs, increase awareness and understanding of the CNS role, and support ACCEND implementation.

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.

The North East London CDL is currently providing enhanced support to 31 new CNSs across the three acute Trusts in North East London. The enhanced offer includes coaching, mentoring, observation, education and support working through the relevant ACCEND competencies.

The post holder has developed a universal education series aimed at nurses, AHPs and other healthcare professionals with an interest in cancer which runs bi-monthly online, alongside more targeted training on the wards and day units at each of the Trusts.

In addition, a series of podcasts and videos promoting the CNS role is being developed to be shared on the North East London Cancer Alliance social media platforms and website.

Barts Health NHS Trust

SACT Nurse Development
On the job training is an important part of Barts' approach to workforce development. The Day Unit did an analysis of training needs recently. There had been a drive to ensure that the unit was fully staffed – this meant some inexperienced staff – so there was a need to develop them within their roles.

A Continuous Professional Development culture has proved critical to this endeavour; new recruits are supported by more experienced staff until they have gained sufficient experience.

Barts has developed accelerated training pathways for Chemo – with regular slots of in-house training mixed with on the job-training. They also run a 'post-chemo' course, to help the staff brief the CNSs responsible for the HNAs on the patients' ongoing needs.

CNS Development
A 6 week rotation has been developed across Haematology, Oncology and a week with an experienced CNS plus time on the Cancer Assessment Unit. This should help enable those wanting to become CNSs to find a specialty they like, and feel more comfortable about the CNS pathway in due course.

University places for CNS courses are limited – could the North East London system reserve places? Study days are more available than places for Modules Levels 6 and 7 (needed for those transitioning across to CNSs from previous cancer experience e.g, Chemo). Nurses without oncology experience require Foundation Courses in Cancer. Macmillan courses help to provide introductory programmes. 'Oncology Emergencies' is a vital part of initial training – as is Communication training.

Ward Nurses need core competencies relating to specialties and tumour sites to progress their careers beyond the ward role. This takes 15-18 months to work through – some struggle because they are swamped with operational priorities. Once the core competencies have been worked through, there are opportunities for further training e.g. Car-T, DNA/RNA using lipid nanoparticles (LNPs) other cutting edge cancer therapies.

The CNSs work separately from the ward nurses – to transition into a CNS role, a ward nurse would need to buddy with a mentor or preceptor amongst the CNSs. If a more formal scheme could be established this could be a possible 'bridge' across the experience and training gap.

The Cancer CNS Development Lead (CDL) provides information and education to support awareness and transition for ward nurses interested in CNS roles, as well as providing enhanced 1:1 support for new CNSs. The CDL also uses the ACCEND framework to support awareness and understanding of a cancer career pathway. However, this is a pilot fixed term project and a business case would need to be developed to support the role beyond the initial two year term.

The role of the Barts Academy

Four courses provided by the Academy support Cancer Nurse training:

- Effective Communication Skills for Cancer
- Advanced Communication Skills for Cancer
- Introduction to Cancer Care
- MDT working for CNSs

Barking, Havering & Redbridge University Hospitals Trust

SACT Nurse Development
SACT training days (which are a pre-requisite for all those involved in SACT delivery) and wider clinical skills training is provided as standard. This includes training in blood transfusion, haematology etc. CNSs provide some of the clinical skills training for nurses new to cancer, but much of this kind of training is not cancer-specific.

CNS Development
Each CNS would have a tailored individual training plan. Royal Marsden provides study days, Principles of Psychology Levels 6 & 7, Haematology training etc are all available. The CNSs are encouraged to apply for modules; Advanced Nurse Practitioner training is also available for Band 7s.

Medicines management training is also provided for all CNSs. Non-Medical Prescribing courses would be funded for both AHPs and Nurses who need it – mostly the Band 7s but occasionally the Band 6s. Practice is then overseen by the Chief Pharmacist.

Role of the BHRUT Academy
BHRUT's academy runs simulation days; it has recently provided one on cancer toxicities. There are not many cancer ward nurses – BHRUT has one cancer inpatient ward (19 beds), the Sunshine Suite and outpatients. Cancer-related courses are run for the ward nurses – and non-cancer nurses sometimes attend to extend their knowledge base about cancer.

The Trust keeps a careful watch on risk factors to ensure that they provide additional training programmes as needed.

Commissioning of training programmes
BHRUT do commission from the HEIs but they are more likely to provide internally or use the Royal Marsden and Hospices. The nurses seeking training tend to make the decision based on their personal preferences. The commissioning cycle is annual – starting in March, training requirements are collated into a plan; this is signed off by the Senior Matron and the Lead Cancer Nurse in July alongside the decisions on funding.

Gaps in current training offer?
*C*ancer Education would help. For example, a training day on Blood Cancers. The trials team run these courses updating on new drug therapies – but as yet, other medics aren't providing much development input. There is a seminar room available to provide ad hoc courses – so BHRUT would welcome initiatives involving medics in broadening the educational offer. Ideally this would be done at North East London level. It is difficult to release staff for training if it is off-site, but remote links could definitely be set up with the other two Trusts.

Living with and beyond cancer is not yet well covered in the training offer. BHRUT would like to involve community nurses alongside their acute nurses to help build appropriate support for patients. PIC line training is an obvious example – District Nurses don't necessarily know how to do this. BHRUT runs a 24 hour triage line for SACT support for up to 6 months post treatment. Maintenance regimes mean that acute chemo nurses do need to support both primary care and care homes. 'Red Flags' training might help the wider workforce; so might training on appropriateness of medication.

Homerton University Hospital NHS Foundation Trust

In common with the other two Trusts, Homerton undertakes a Training Needs Analysis annually and then tries to meet ad hoc requests. The Trust can provide simulation training, and provides cancer staff with training in both clinical and human factors. Advanced Practice qualifications are available, so are modules within that training.

The Trust is starting new meetings between People Partners and the Education team, to try to have a joined up impact on professional development. The barriers include funding – this is never agreed until July or August – and the decrease in University-based training. The focus is on affordability, which in reality means more short courses and less longer-term qualification related courses. The funding provided by NHSE cannot be used across years, which again makes provision tricky.

Backfill is a real problem, particularly now the Trust is focused on Agency and Bank reduction. There is also a shortage of mentors and supervisors. Some training is therefore commissioned externally; the quality of internal training is also carefully controlled.

Help from the other two acute Trusts
Homerton doesn't have a cancer in-patient unit – they have a colorectal consultant nurse; an acute oncology CNS, a Haemotology ACP (AHP). They mainly deal with cancer of unknown prognosis and palliative. To meet the requirements of the cancer workforce, Homerton develops Band 5 & Band 6 nurses with transferable skills or they recruit externally.

Homerton would appreciate any initiative to widen the on the job and work shadowing experience of their nurses from preceptorship onwards. This would benefit from system help – the other two Trusts have wider service models in cancer. Homerton will need more students in a couple of years, so a pre-reg lead (matron) is currently working through how to provide additional placements. These could be in either acute or community – the community placements would not be available in BHRUT or Barts so that could be an element of the quid pro quo.

Medical Education and Training

The cancer medical workforce needs a managed transition to ensure that appropriate levels of skills and experience are maintained. The RCR work states that the average age of retirement for an oncologist is 55. Based on that, there are a substantial number of consultants who are likely to retire in the next 10 years, and the more junior consultants no longer have the breadth of experience that this older cohort represent. There is therefore a clear need to accelerate the development of the younger consultants.

Population increases and increases in prevalence of cancer both create increased demand. The impact of more screening programmes is not yet known. They might mean earlier diagnosis but it might just create more demand for treatments. Treatments are also more complex with more medical and clinical interventions. Cancer is still often diagnosed at the later stages. Longer appointments are needed for these iller patients. Over the next 5 years, North East London will need more Stratified Follow Up, more nurse- and more pharmacy-led clinics, if for cost and supply reasons oncologists are only used at decision points.

Barts Health NHS Trust Feedback to Challenges
Even assuming that consultant/wider medical input is only needed at decision points, there are internal bottlenecks in the training pipeline for consultants. There are insufficient internal medicine courses for SHO level doctors – this is required for all

Physician training alongside rotations across wards, A & E and medical specialties. Working with the Deanery Barts Health are trying to expand the number of places but the full training for Physician Consultants takes 9 years, so the actual numbers won't increase fast.

The picture could change if the North East London system could influence decisions about early retirement. Consultants at the end of their career have nowhere to go. If a concentrated initiative held a dialogue with consultants and asked what would enable them to stay, it might be possible to provide more opportunities for development and fulfilment in the latter third of people's careers.

The other key issue which needs to be addressed is the increasing numbers of trainees that will be needed given that the younger generation is less likely to work full-time. This is not fully understood – work on 'participation rates' amongst the under 35s or 40s should be undertaken to work this through. The ROI on any training is obviously less – but this is the shape of the future medical workforce. Meanwhile, older consultants are having to cover for their younger colleagues' lifestyle and career choices.

Given shortages of workforce and development challenges, there will be little choice but to progressively change the skills mix. Nurse-led clinics, and Nurse +Physician Associate cover on wards with consultants only providing oversight are likely to become the norm. To enable these changes appropriate protocols will need to be co-created across the professions.

BHRUT Feedback to Challenges

BHRUT faces significant and sustained challenges in its oncology workforce, particularly in Medical Oncology. Benchmarking data shows that, when considering both Clinical and Medical Oncologists per head of population, BHRUT is the most under-resourced provider nationally. While Clinical Oncology staffing is slightly stronger than at neighbouring centres, Medical Oncology capacity is substantially weaker, resulting in Clinical Oncologists routinely covering Medical Oncology activity. This has proven difficult to sustain and has contributed to workforce burnout.

Despite agreement to recruit five consultants over the past three years, only three posts have been filled, and repeated recruitment attempts for Medical Oncology roles have been unsuccessful. Structural constraints in training pathways - with Medical Oncology training largely limited to a single provider - further exacerbate recruitment difficulties. As a result, some patients are required to travel outside their local area for treatment, impacting access and experience.

Progress has been made in developing the wider multidisciplinary workforce, including enhanced pharmacy roles, non-medical prescribing Clinical Nurse Specialists, and the introduction of Advanced Clinical Practitioners. However, the transition from a consultant-delivered to a consultant-led model remains at an early stage and is constrained by limited professional development capacity and leadership resource. There is a clear opportunity for system-wide approaches to training, mentoring, and accelerated development of a relatively young consultant cohort to support sustainability and resilience of the oncology workforce.

Recommendations for Medical Education and Training

Medical education and training capacity is a critical constraint on the sustainability of the oncology workforce. Exposure to oncology during early postgraduate training remains limited, reducing the likelihood that resident doctors choose oncology as a career. Although national training numbers have increased, they remain insufficient to offset retirements and turnover, particularly following the redistribution of training posts away from London.

Given current workforce deficits - especially at BHRUT - there is a strong case for a system-wide approach to increasing Clinical Oncology training numbers and extending Medical Oncology training beyond a single provider. Any expansion would require coordinated planning with higher education institutions and sufficient investment in supervision, mentoring, and educational infrastructure.

In parallel, there is a growing need for accelerated development and support for relatively newly appointed consultants, particularly at tertiary centres.

A system-wide professional development and mentoring model, drawing on expertise across providers, would support workforce resilience, improve retention, and enhance clinical leadership capacity. Improved trainee experience, reflected in recent GMC survey results, provides a stronger foundation for these future workforce development proposals.

Apprenticeships

Barts Health NHS Trust

Overall, Barts has around 750 staff on an apprenticeship programme, 150 of whom are Nursing, Midwifery and Allied Health Professionals (NMAHP)
From the Nursing, Midwifery and Allied Health Professional staff undertaking apprenticeships there are:

- 20 PGCert (Academic professional)
- No Advanced Clinical Practitioners
- 34 Data / Digital skills
- 13 Leadership
- 13 Health & Care Support Workers

A year to date review of all apprenticeships shows:

- 473 starts, 105 of whom are nurses, midwives or AHPs (22% of all starts).
- 35 are undertaking a clinical apprenticeship (NA/physio/HCSW)
- 438 are undertaking a non-clinical apprenticeship (Data/digital skills / PGCE / Senior leadership are the main ones)

Barts apprenticeship programme is therefore heavily weighted towards admin and clerical, with particularly limited uptake in AHP and support workforce apprenticeships as the table below shows.

YTD Apprenticeship Starts by Staff Group	
Staff Group	**Grand Total**
Add Prof Scientific and Technic	41
Additional Clinical Services	36
Administrative and Clerical	175
Allied Health Professionals	31
Estates and Ancillary	5
Healthcare Scientists	22
Medical and Dental	89
Nursing and Midwifery Registered	74
Grand Total	**473**

Barking, Havering and Redbridge University Trust

At BHRUT, there is currently one Trainee Nurse Associate apprentice within cancer, and another who is just starting on a Nursing Apprenticeship for whom a Band 5 role has been identified. A third individual is about to qualify as a Nurse having spent 4 years on the two apprenticeship courses. BHRUT do have an ACP who was originally a Macmillan Support Worker and built her career through apprenticeships.

The apprentice career pathways are not their main source of recruits – recruitment is rarely challenging. However, apprenticeships are available for staff if needed. Advanced Nurse Practitioner and Advanced Clinical Practitioner apprenticeships are available but given financial constraints the individuals requesting these would need their manager's support and an interview to work through the adjustments and implications.

BHRUT has made a policy decision to review all Band 2, 3 and 4 support roles for suitability for apprenticeships before proceeding to an external recruitment. This may increase uptake of Trainee Nurse Associate apprenticeships in cancer in due course.

Homerton University Hospital NHS Foundation Trust

Feedback from Homerton suggests that the Trust has less apprentices than it would like, mainly due to the financial issues over supernumerary time and backfill. As a result the Trust shares its levy across the system, helping other smaller organisations in City and Hackney.

East London NHS Foundation Trust (ELFT)

East London NHS Foundation Trust is running 20 apprenticeship programmes currently. These include several entry level/Level 3 schemes that could impact on cancer workforce supply in due course – for example, the 4 pharmacy technician apprentices, or those for Senior Health and Care Support Workers.

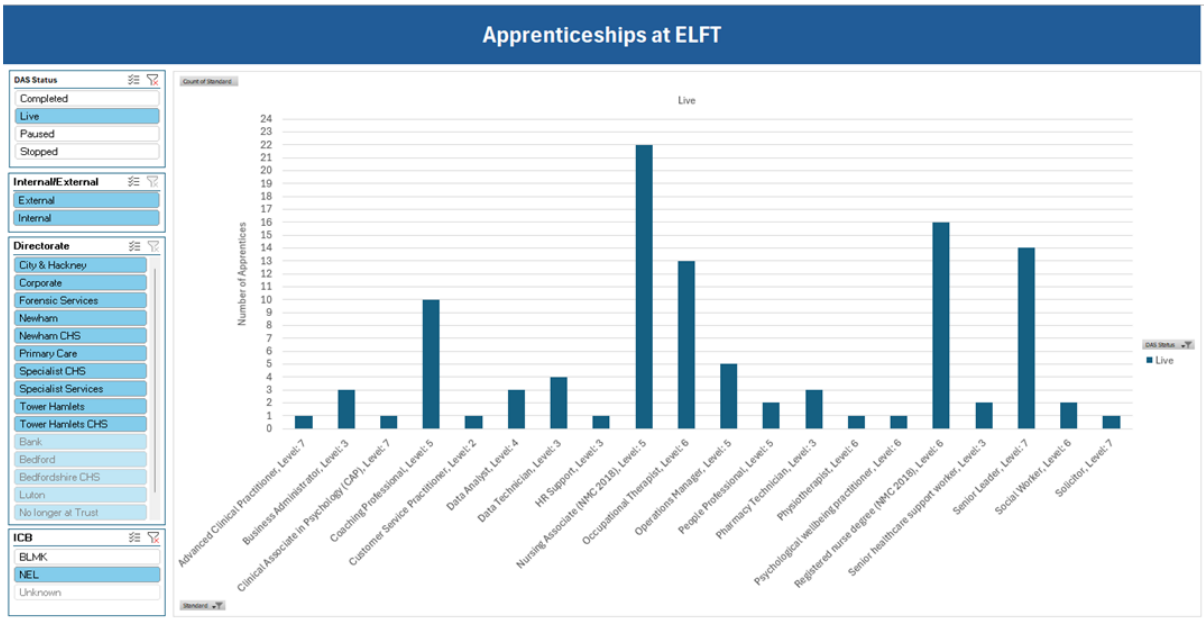
At registered professional level, they are running a series of AHP apprenticeships – the largest being in Occupational Therapy. Podiatry and Physiotherapy take up is

currently lower, and the first Speech and Language Therapist apprentice started this year.

The Trainee Nurse Associate apprenticeships that ELFT run focus on upskilling staff in their current roles, some then proceed to take the Nursing Degree apprenticeship. To complete the picture, ELFT also has good uptake of Advanced Clinical Practice qualifications – 20 have already completed, with more in the pipeline.

Sadly the national funding for this Level 7 qualification will be limited from the start of the next financial year, with only 1,000 slots to be funded nationally.

Despite a vibrant apprenticeship programme, ELFT does not spend all of its apprenticeship levy; transfers are mostly to support apprenticeships in primary care. As ELFT apprenticeship programmes include their workforce in Bedfordshire, they have provided a screenshot of their apprenticeship dashboard filtered to NEL ICB apprenticeships – see below.



North East London NHS Foundation Trust

Allied Health Professional registered professional degree apprenticeships are comparatively recent, but NELFT staff were involved nationally in the creation of the Physiotherapy apprenticeship in 2019. Perhaps as a result of this, NELFT has decided to have larger programmes of degree level apprenticeships than some other Trusts – they currently have 72 degree level AHP apprentices.

NELFT are currently working on a school leaver programme and on providing T-level placements, in order to focus more clearly on entry level roles – this will probably commence in the 2026-7 academic year. There is a healthy interest in both degree level apprenticeships and the Advanced Clinical Practice apprenticeship programme, as the table below providing NELFT apprenticeship numbers illustrates.

Programme Level	Programme/Course	Start Year	Graduating Year	Numbers
3	Senior Health Care Support Worker	2024	2026	2
		2025	2027	1
5	Assistant Practitioner FdSc (SLT)	2022	2024	3
		2023	2025	3
		2024	2026	2
	Assistant Practitioner FdSc (OT)	2023	2025	2
		2024	2026	1
		2025	2027	1
6	Occupational Therapy (BSc)	2020	2024	6
		2021	2025	4
		2022	2026	2
		2023	2027	2
		2024	2028	3
	Occupational Therapy (BSc) Top UP	2022	2024	2
		2025	2027	2
	Occupational Therapy (MSc)	2022	2025	1
		2023	2025	4
		2024	2026	1
		2025	2027	2
		2026	2028	2
	Physiotherapy (BSc)	2020	2024	1
		2021	2025	2
		2022	2026	6
		2023	2027	1
		2024	2028	2
	Speech and Language Therapy (BSc) Top Up	2023	2025	1
		2024	2026	3
		2025	2027	3
	Speech and Language Therapy (BSc)	2026	2030	2
	Podiatry (MSc)	2024	2026	1
	Dietetics (MSc)	2026	2028	1
7	Advanced Clinical Practice (MSc)	2020	2023	2
		2021	2024	2
		2022	2025	1
		2023	2026	1
		2024	2027	1
		2025	2028	1

	Advanced Clinical Practice (ePortfolio route)	2022	2024	1
		2024		1
		2025		2
Total				81

North East London Integrated Care Board (NEL ICB)

The NEL ICB is currently focussing its workforce initiatives on offering opportunities to work to those who are economically inactive. This includes an ‘Anchor Institution’ programme with Barts Healthcare, and a ‘WorkWell’ scheme funded until the end of the 2025-26 financial year. Government funding is focussed both now and in future financial years on reducing youth unemployment, and on enabling those who are currently not in employment, education or training to find work.

Local Authority support is being provided for ‘ Connect for Work’ through 4 partnerships and Job Centre Plus is providing a coaching service in order to help overcome barriers to employment. The Department for Work and Pensions is intending to use the ICBs to co-ordinate its Youth Employment Offer which will provide 6 month paid opportunities to get young people into working with appropriate employers.

The NEL ICB is currently pulling all agencies together to ensure co-ordination and eliminate duplication across the various schemes. Given the focus on entry level roles, and vibrant apprenticeship development offers at several of the North East London Trusts, the first part of an apprenticeship career pipeline is already being addressed.

The NELCA 1CB would value opportunities to work with NELCA to develop appropriate apprenticeships at higher levels for the cancer workforce (including applying for external government funding), given that thinking relating to the cancer pathway workforce development needs is more advanced than in most other specialties or pathways. Details of the current UK government funding for employment schemes has been provided to the NELCA Workforce Lead by the Lead at the ICB.

Summary:

Ideally a system-wide approach to cancer apprenticeships across all professions would help stabilise the future workforce. This would need to be brokered with each trust as costs of apprenticeships extend well beyond the levy. There is good practice across the five key trusts which could be used to help evolve this approach.

Population Health & Demand

The scoping and mapping report highlights that population need in North East London is a significant driver of current and future cancer workforce pressure. The report makes clear that demand is not only rising in volume, but is also shifting in complexity, influenced by demography, deprivation, ethnicity, and patterns of cancer incidence, survival and route to diagnosis.

North East London has some of the highest concentrations of deprivation nationally, with boroughs such as Newham and Barking and Dagenham among the most deprived in England. High levels of deprivation correlate with poorer health outcomes and barriers to accessing timely care, and the report notes that these boroughs also present with some of the highest levels of childhood obesity nationally.

This context is relevant because deprivation is associated with later stage diagnosis, higher levels of multimorbidity, and lower participation in screening. The report also indicates a gradient in staging, where more deprived groups are less likely to be diagnosed at stage 1 or 2.

North East London's population profile is younger than the national average but highly diverse, which adds complexity to demand for culturally responsive and personalised care. The report highlights that North East London is "one of the most diverse areas within the country."

While cancer incidence increases with age, cultural, linguistic and behavioural factors influence screening uptake, help-seeking and patient experience. The report notes that London's ethnic minority groups consistently report worse experiences in personalised care compared with white groups, and this is also reflected in lower response rates to national cancer experience and quality-of-life surveys.

Demand is expected to grow steeply. The report projects that the number of people living with and beyond cancer in London will increase from 43,204 in 2017 to around 65,900 by 2030 – a rise of nearly 53 per cent. This increase reflects both rising incidence and improving survival, meaning more people will require ongoing treatment, surveillance, personalised care planning and management of long-term consequences of treatment. The report notes that this growth will be most pronounced among older people with co-morbidities, but also comments on emerging increases in younger age groups, suggesting a broader shift in need.

Patterns of cancer type also contribute to pressure. Breast and prostate cancer are the most prevalent cancers among the North East London population, reflecting relatively high incidence and survival. However, lung and colorectal cancers remain major contributors to morbidity and mortality, and North East London has higher prostate cancer incidence than the national average.

Demand profiles are also shaped by cancers with low survival but high symptom and supportive care needs, including liver and pancreatic cancers. The report emphasises that the workforce requirements for poor-prognosis disease are distinct

from survivorship needs, requiring a balance between specialist treatment, psychosocial support, and palliative care.

A further element influencing demand is route to diagnosis. The report notes that late presentation, including emergency diagnosis, remains a feature of cancer pathways in North East London.

Emergency presentation requires intensive resource immediately post-diagnosis and is associated with poorer outcomes, higher patient distress and greater reliance on CNS, AHP and supportive care workforce.

Taken together, these factors create a picture of rising and increasingly complex demand for cancer services. The report describes this explicitly, noting 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."

The increases in survivorship, late-stage diagnosis, multi-morbid and socioeconomically disadvantaged populations all intensify requirements for workforce capacity, specialist skills, personalised care roles, and integrated models of community cancer support.

For the workforce strategy, this analysis highlights that demand pressure is not temporary or uniform. Instead, it is structural, patterned by local inequalities, and expected to continue rising. Any workforce planning response therefore needs to account for:

- sustained growth in prevalence and survivorship,
- the need for targeted workforce supply in deprived and high-need boroughs, and
- the skills required to deliver earlier diagnosis, culturally responsive care and long-term holistic support.

In doing so, the workforce narrative becomes not only one of recruitment and capacity, but of equity, capability and redesign that aligns the future workforce with the realities of population need in North East London.

Potential Changes in Skills Mix

The North East London labour market

For North East London, the future skills mix for cancer is shaped as much by the population as by national policy. The Cancer Alliance's delivery plans emphasise profound diversity (over 200 languages spoken, large Bangladeshi, Black African and Caribbean, Turkish, Eastern European and Charedi Jewish communities) and high levels of deprivation, with consistently lower uptake of screening in several boroughs. At the same time, North East London is building significant diagnostic and treatment capacity – Mile End Early Diagnosis Centre, Barking Community Diagnostic Centre, upgrading MRI capacity at Barts and the development of a new

breast cancer centre at St Bartholomew's. This combination of high need, rapid service expansion and strong equality, diversity and inclusion ambitions mean the cancer workforce of the next decade in North East London will have to be more community-facing, more multi-professional, more digitally enabled and more comfortable working across organisational boundaries than its current workforce.

Diagnostics and early detection: a shift to advanced practice and community-based teams

The Alliance's plans to expand early diagnosis, including major growth in endoscopy and imaging through the Mile End Early Diagnosis Centre, Barking CDC, and Targeted Lung Health Checks across multiple boroughs, signal a sustained increase in demand for diagnostic staff working in non-acute settings.

To support this with appropriate decision-making, skills mix will need to move further towards advanced and consultant-level non-medical practice. The explicit aim to roll out non-medical local anaesthetic transperineal (LATP) prostate biopsy in every provider, expand nurse-led hysteroscopy, and increase nurse roles and one-stop surgery on the skin pathway all point to more specialist nurses and AHPs taking on procedural and decision-making work traditionally done by consultants.

As Community Diagnostic Centres mature and run extended hours, North East London is likely to lean on extended-scope radiographers and sonographers, reporting radiographers, advanced nurse endoscopists and physician associates in diagnostic roles, supported by a smaller number of highly specialised medical staff working across multiple sites.

The Alliance's focus on improving histopathology turnaround and capacity, alongside the London-wide push for digital pathology networks and AI tools, implies growth in specialist biomedical scientists, advanced practitioner roles in pathology, and new technical posts that sit at the interface of lab science, IT and AI deployment.

In primary care, the development of a structured cancer education syllabus for clinical and non-clinical staff, and targeted work to improve referral practice in colorectal, lung and upper GI pathways, assume that the primary care workforce will have stronger cancer triage and screening navigation skills.

Reception and administrative teams, health care assistants and social prescribers are likely to be upskilled to support faecal immunochemical testing (FIT), HPV self-sampling, targeted lung health check invitations and follow-up of non-responders, particularly in practices serving communities with low uptake.

Tackling inequalities: new outreach, navigation and cultural-competence roles

North East London's delivery plans are unusually explicit about tackling inequalities through targeted, community-specific programmes: "It's Not a Game", "You Need to Know", school-based awareness, projects with Gypsy and Roma Traveller communities, unpaid carers, Charedi Jewish communities and Bangladeshi women, and small-grants "grass roots" projects delivered by community organisations.

This approach implies a future workforce that extends beyond traditional NHS roles. The North East London Cancer Alliance has recognised this need, and developed an Inequalities strategy and plan which will be launched alongside this workforce strategy.

Over the next few years, the cancer skills mix in North East London is likely to include more community health workers, peer advocates and “cancer champions” employed by both NHS and voluntary-sector partners; more link workers and navigators embedded in PCNs, women’s health hubs and CDCs; and stronger roles for interpreters, cultural mediators and outreach nurses who can work in specific linguistic and faith communities.

The plans to resource peer support and advocates within liver surveillance and other high-risk pathways are early examples of this direction.

This implies a structural change in the workforce which will move both recognition and funding towards non-registered and community-based roles as integral parts of cancer pathways. To do this, there will need to be clear supervision arrangements from clinical teams, as well as routes into formal qualifications for people recruited from local communities.

Treatment and follow-up: from hospital-centric provision to a distributed multidisciplinary workforce

On the treatment side, North East London’s plans to improve systemic anti-cancer therapy (SACT) capacity, reduce variation in treatment rates and make greater use of teledermatology, one-stop skin surgery and streamlined MDTs will reshape the composition and deployment of specialist teams. Over time, chemotherapy and immunotherapy at home or closer to home – already growing nationally – are likely to be delivered more systematically across the North East London footprint.

This will increase demand for specialist cancer nurses in community and virtual-ward roles, with skills in remote assessment, escalation and management of treatment toxicity. Pharmacy technicians and pharmacists will have to be able to support homecare models, improved patient education and complex medicine optimisation across multiple providers.

Personalised Stratified Follow-Up and the wider personalised cancer care agenda, which North East London is embedding through digital call/recall, surveillance pathways (for liver, ovarian, Lynch syndrome and pancreatic risk groups) and survivorship projects, may well pull more psychology, rehabilitation and vocational support into core cancer teams.

Skill mix is therefore likely to shift towards more cancer-specialist AHPs (physiotherapists, occupational therapists, dietitians, speech and language therapists), clinical psychologists and counsellors, plus care coordinators and “key worker” roles that provide a single point of contact and help patients navigate complex multi-morbidity and social issues.

For surgeons, oncologists and radiologists based at major centres such as Barts, an increasing proportion of work will be high-complexity cases, network leadership,

MDT participation and supervision of advanced practitioners working across the Alliance. Junior doctor rotas and training posts may need to be reconfigured to ensure exposure to community and virtual models of care as well as tertiary-centre activity.

Digital, AI and genomics: new technical, analytical and communication skills

The North East London Cancer Alliance is already piloting and rolling out AI solutions in MRI and CT, using AI for faster chest X-ray reporting, and planning further technology support for MDTs and Faster Diagnosis Standard pathways. Combined with London-wide digital pathology and national genomic medicine developments, this creates a clear demand for new technical and analytical skills.

In practice, this means growth in roles such as imaging and pathology informatics leads, AI “super-users” and clinical safety officers, data scientists working within cancer operations teams, and MDT coordinators who can manage complex digital platforms, data flows and performance analysis. Clinicians across disciplines will need enough digital and AI literacy to interpret algorithm outputs, recognise bias and error, and explain these tools to patients in language they can understand.

Genomics and precision prevention efforts in North East London – including mainstreaming Lynch syndrome testing, ovarian surveillance via the Precision Prevention Clinic at Barts, pancreatic and liver surveillance and targeted lung health checks – will require more genetic counsellors, genomics-trained nurses and physicians, and administrative and data staff able to manage consent, sample logistics and long-term registry follow-up. Cancer teams will need a baseline level of genomic literacy, with clear referral and escalation routes to specialist advice.

System-level workforce structure and leadership

Structurally, North East London’s cancer workforce will increasingly operate as “one workforce” across the ICS, coordinated through the Cancer Alliance. North East London-wide projects such as the urology Clinical Fellow post to tackle treatment variation, pan-Alliance MDT optimisation, and cross-sector community awareness campaigns already reflect a shift from trust-specific to system-level roles. Future workforce structures are likely to feature:

- consultant and advanced-practice posts with formal cross-site responsibilities
- shared diagnostic and on-call rotas across Barts Health, BHRUT and Homerton Healthcare
- centralised Alliance-level teams for data, improvement and education, and
- stronger formal partnerships with local authorities and VCSE organisations, including joint posts in outreach, prevention and survivorship.

For a workforce strategy, this means moving away from planning in organisational silos towards North East London-wide talent pipelines, rotational posts and training programmes, with explicit pathways from community and non-registered roles into registered professions. It also means investing in leadership and change-management capacity at every level: clinical leads for tumour sites, PCN-level cancer leads, Neighbourhood teams and operational managers who can work across providers, and service-user leaders who can help in pathway re-design.

Summary

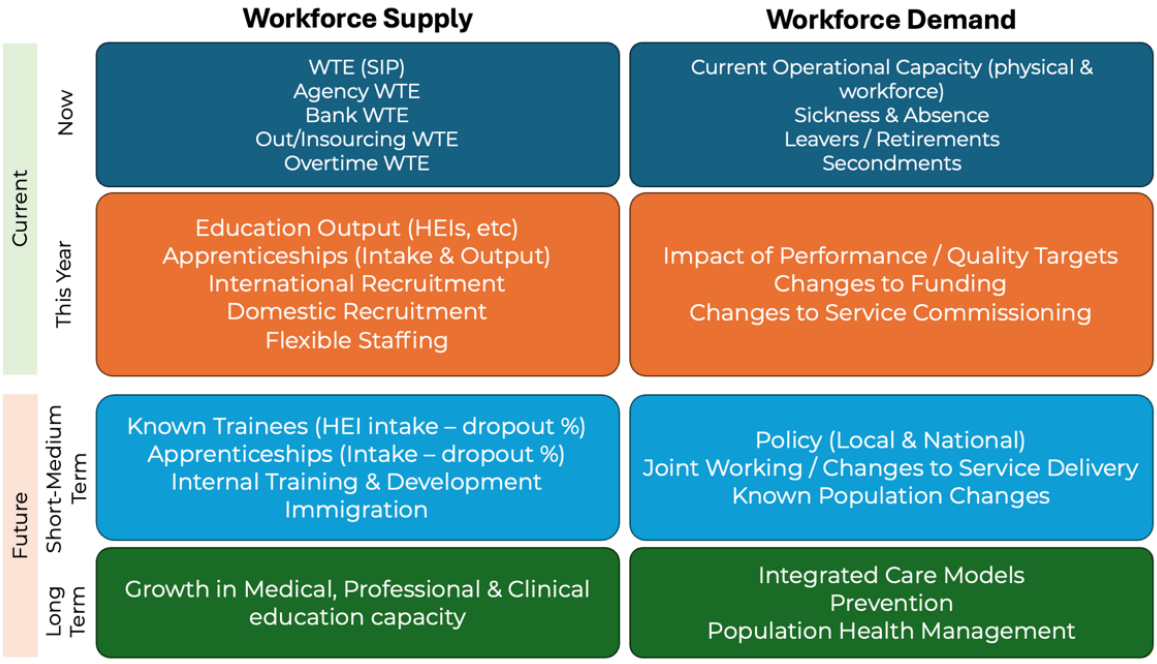
In summary, the future skills mix for cancer in North East London is likely to feature:

- more advanced and consultant-level non-medical practitioners in diagnostics and treatment
- a larger, more formalised community and outreach workforce drawn from local communities
- multidisciplinary teams that integrate rehabilitation, psychological and social support as standard
- technical and analytical roles to support AI, digital and genomics, and
- a more networked structure with staff and teams working across borough and provider boundaries.

Each of these shifts provide an opportunity to build a sustainable, local, culturally competent workforce that reflects North East London's population and can deliver on the Alliance's ambitions to prevent cancer, spot it sooner and ensure equitable access to high-quality treatment and personalised care. The last of the scenarios below will endeavour to forecast the combined impacts of these shifts.

Action Plan

For ease of comparison with other North East London Cancer Alliance action plans, this has been developed separately. The matrix below was used to decide which year particular actions could be taken. The most recent version of the Action Plan is copied below the thematic summary. As responsibilities are allocated, timeframes and actions recorded should not change much, but there may well be additional actions.



Emerging themes/workstreams to be captured in the action plan (outline actions year on year)

1. **Grow and diversify the cancer workforce pipeline**
    a. “Grow your own” and local recruitment schemes, apprenticeships and outreach to North East London communities.
    b. Ethical international recruitment with strong support and progression into cancer specialisms; ability over the five years to refocus recruitment on more local recruitment and less international.
    c. Expanded training capacity and educator roles aligned with the Long-Term Workforce Plan (LTWP) and ACCEND.
2. **Redesign roles and teams across the whole cancer pathway**
    a. Skill-mix and advanced practice in diagnostics, treatment and survivorship.
    b. New roles in navigation, community outreach, digital/remote monitoring and inequalities programmes.
    c. Team-based models that avoid single-handed posts and enable cross-organisational working.
3. **Retain, support and develop staff**
    a. Systematic retention programme: workload, flexible working, wellbeing, supervision, and inclusive leadership.
    b. Clear, visible career pathways (clinical, academic, leadership, digital) for all staff groups.
    c. Embedding digital, AI and sustainability competencies into ongoing professional development.
4. **Strengthen system-level workforce intelligence and governance**
    a. Dedicated North East London Cancer Alliance workforce planning and analytics function with robust data-sharing across the ICS.
    b. Governance frameworks for new roles, AI, cross-provider employment and information-sharing.
    c. Continuous evaluation of workforce changes against inequalities, quality, performance and staff experience metrics.

Reshape and Diversify the Cancer Workforce Pipeline

NELCA/System-wide action plan

- Map and gap the AHP Workforce by profession and intervention, and the CNS workforce, across the cancer pathway to identify opportunities for improved therapeutic interventions
- Cost a plan for addressing the 'structural deficit' in specific professional roles, build the case for addressing this gap over time once the opportunities of ARRS roles and Neighbourhood hubs is fully understood.
- Develop "Grow your own" and local recruitment schemes, apprenticeships and outreach to NEL communities to encourage entry level roles.
- Ethical international recruitment with structured support and progression into cancer specialisms.
- Expanded training capacity and educator roles aligned with the NHS Long Term Workforce Plan and ACCEND.
- Work with Barts to extend the medical oncology trainee scheme across the NEL system

Service or Trust level plans

- Develop targeted recruitment pipelines from under-represented and underserved communities.
- Create a costed plan to secure national workforce expansion funding aligned to LTWP priorities.
- Position NELCA as a "destination employer" (rotations, academic links, flexible roles).
- Expand apprenticeship pathways into cancer support worker, assistant practitioner and advanced practitioner roles.
- Build future workforce modelling for new diagnostics and genomic screening expansion.

health dynamics

Redesign Roles and Teams Across the Whole Cancer Pathway

NELCA/System-wide action plan

- Develop advanced practice role expansion across diagnostics, treatment and survivorship (Nursing and AHP).
- Once the neighbourhood hub model is clearer, introduce new roles in navigation, community outreach, digital/remote monitoring and inequalities programmes.
- Work with the ICB to understand the implications of primary care workforce shortages on support for the cancer pathway; address key gaps
- Shift over time to team-based models that avoid single-handed posts and enable cross-organisational working.

Service or Trust level plans

- Redesign roles to support home-based care, virtual wards and remote monitoring models.
- Develop supporting roles for personalised care and stratified follow-up models.
- Build educator/supervisor capacity to support rapid skills-mix change.
- Plan and implement skill-mix to support AI-enabled diagnostics, digital pathology and genomics workflows.
- Create sustainable advanced and consultant-level non-medical specialist roles.

health dynamics

Retain, Support and Develop Staff

NELCA/System-wide action plan

- Implement a systematic retention programme including identifying opportunities for retaining staff within NEL – including rotations, secondments, work shadowing, shared information on opportunities.
- Introduce visible and structured career pathways for all staff groups (using the ACCEND framework or other agreed national plans).
- Embed digital, AI, and sustainability competencies into professional development.

Service or Trust level plans

- Retention initiatives including workload, flexible working, wellbeing and inclusive leadership.
- Protect time and resourcing for digital, AI and genomic upskilling.
- Implement "just culture", anti-bullying and equality programmes to address disproportionate attrition.
- Create targeted leadership programmes to improve equity and representation in senior roles.
- Provide psychological and peer support structures to address burnout and workforce stress.
- Reduce reliance on agency staffing through conversion of temporary roles to substantive appointments.
- Develop mentorship and academic pathways (clinical research, consultant development routes).

health dynamics

Strengthen System-Level Workforce Intelligence and Governance

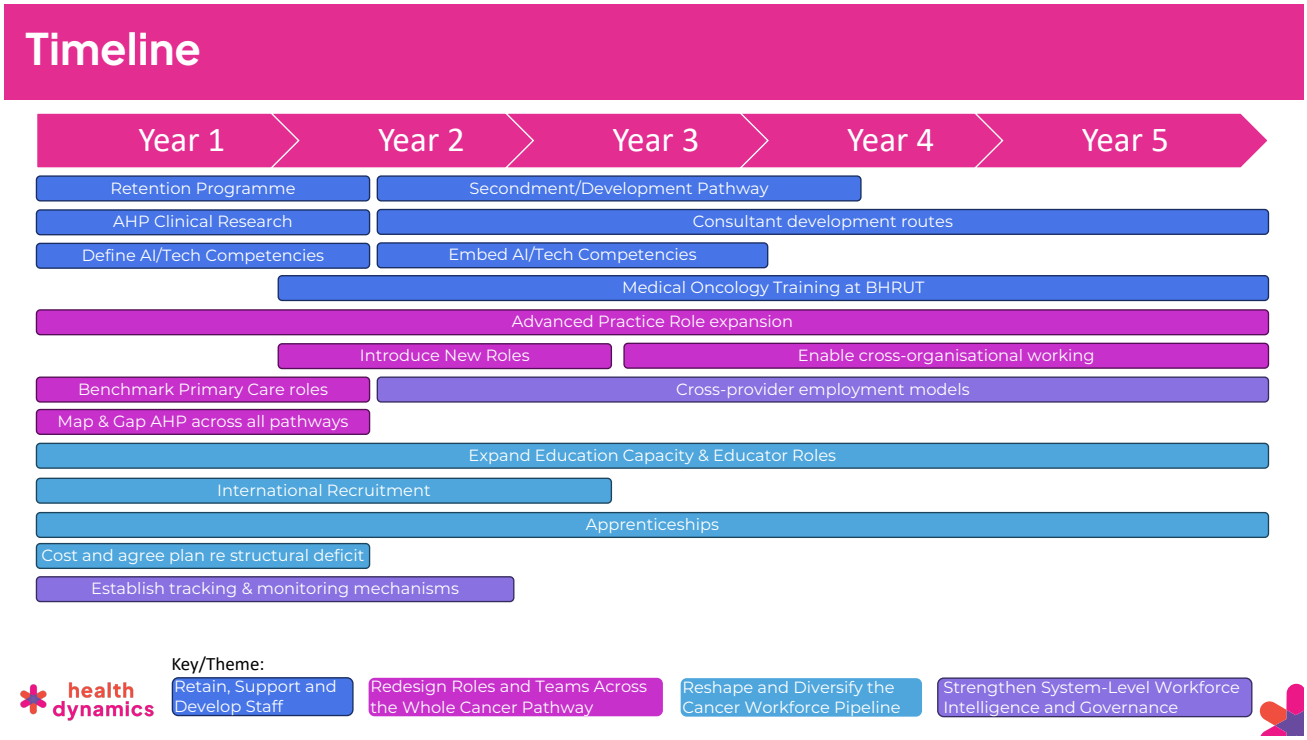
NELCA/System-wide action plan

- Introduce governance frameworks for new roles, AI, cross-provider employment, system wide training needs and information sharing.
- Develop formal cross-provider employment models (shared rotas, joint posts, ICS-wide career frameworks).
- Set up system-wide monitoring of progress against the strategic workforce plan and agree responsibilities for maintaining tracking, action log etc.
- Conduct continuous evaluation of workforce change against equity, quality, performance and staff experience metrics.

Service or Trust level plans

- Build workforce data dashboards aligned with real-time pathway monitoring and FDP/Cancer 360.
- Integrate legal and HR frameworks early for remote and cross-boundary clinical roles.
- Align operational workforce planning with medium-term financial planning and national standards.
- Create climate-resilient workforce contingency plans for heatwaves, travel disruption and infrastructure failure.

health dynamics



Future Workforce Modelling

The workforce data provided by the three acute Trusts substantially understates the full workforce involved in cancer diagnosis and treatment. The number of whole-time equivalents identified are only those whose pay is directly associated with cancer cost centres on the relevant Trust's financial ledger. This data set is the only data set for which the Trusts could also provide matching Bank & Agency, vacancy and turnover information.

Data excludes all Allied Health Professionals (their costs are allocated elsewhere). The nursing staff include the CNSs, but the proportion of ward nurses who nurse cancer patients, the Faster Diagnosis Standard Nurses and those who provide palliative care are all excluded. General surgeons who undertake cancer-related treatment are also excluded, as are many of elements of diagnostics. An assessment has been made of what proportion of the workforce this dataset represents. Based on areas of work and specialties on publicly available data, we believe that numbers of staff in post are approximately double that declared by the three acute Trusts.

Despite these reservations, there is merit in modelling a 5 year Workforce Transformation scenario based on the workforce data provided, as it helps identify the main priorities for workforce transformation interventions and gives a sense of the size of workforce change required, and the potential for change of each intervention. The 5 year scenario represented below shows the minimum aggregate movement required in the workforce by nature of intervention to meet the growing demand for cancer diagnosis, treatment and personalised care.

Heat Map of Workforce Risk

A detailed heat map of workforce risks (available on request) was developed using the following criteria:

- Future supply gap based on demand
- Drivers of the future gap
- Local market availability of that part of the workforce
- Domestic (UK) market availability of that part of the workforce
- International market availability of that part of the workforce
- Training & Development lead-time
- Impact
    - To service
    - On patient care
    - On quality and performance
    - On safety
- Opportunity for demand management through service model change
- Population health demand related to growth.

This identifies the following professional groups as having the highest (red) risk:

- Genomics/molecular pathology
- Medical oncologist
- Histopathologist
- Clinical psychologist
- Clinical oncologist
- Palliative care nurse
- District nurse
- Clinical Nurse Specialist
- Dietician

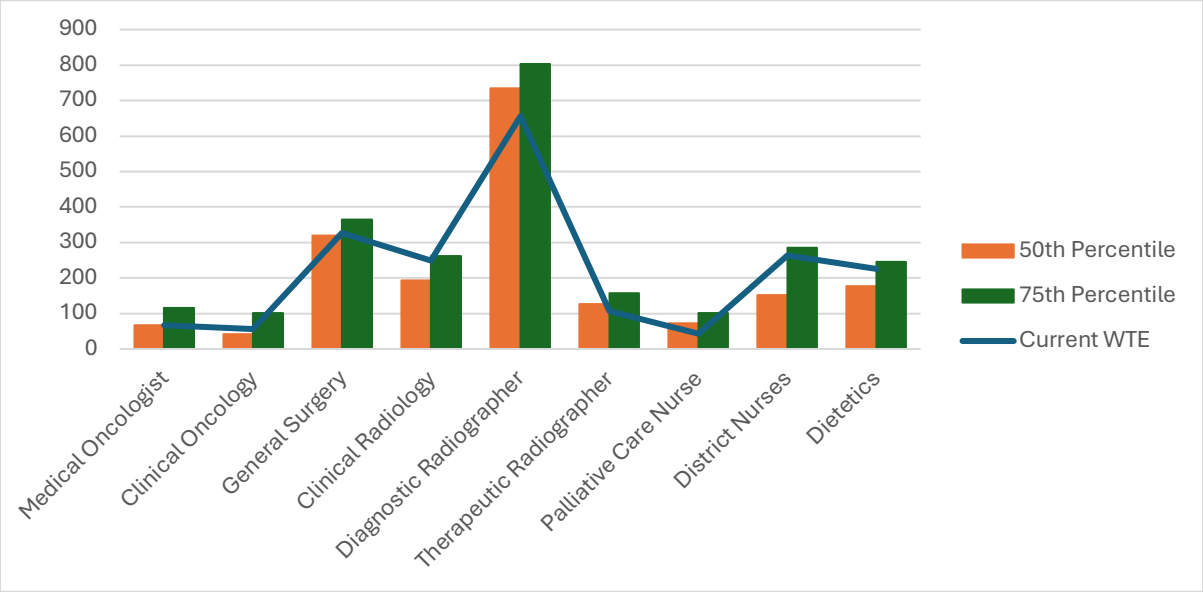
The second highest risks (amber) are:

- Radiologists
- General practitioners
- Sonographers
- Therapeutic Radiographers
- Diagnostic Radiographers
- General surgeons who treat cancer
- Practice nurses
- Speech and Language Therapists
- Pharmacists
- Biomedical Scientists

Sizing the local deficit in the highest risk professions

Wherever possible, an analysis has been undertaken to understand the size of the population served by Whole-Time-Equivalents (WTE) of each professional group compared with both London and other ICSs nationally. The numbers required to uplift to 50th and 75th percentile are indicated below. The numbers to uplift to the 50th percentile where this is not already attained have been included in the future workforce scenarios below.

National comparison of professional WTE serving numbers of population



The above chart shows where the Current WTE in North East London Cancer Alliance does not attain either the 50th or 75th Percentile.

The London comparison below highlights where this is shows that NELCA is below other London ICBs. The table. Immediately below provides the 'gap' in WTE terms to attain 50th or 75th percentile where this isn't already attained.

It is important to note that some of this data will be skewed by host organisations falling in the NEL ICB, for example ELFT hosts workforce which work outside the NEL ICB area in District Nursing.

	Current WTE	Uplift to 50th Percentile	Uplift to 75th Percentile
Medical Oncologist	67	0	49
Clinical Oncology	56	-15	46
General Surgery	327	-8	38
Clinical Radiology	249	-56	13
Diagnostic Radiographer	656	78	147
Therapeutic Radiographer	106	21	51
Palliative Care Nurse	43	30	59
District Nurses	264	-112	22
Dietetics	226	-49	20

London comparison based on national figures

Medical Oncologist	NWL in 50-75, SEL, NCL & SWL all 75th or above. NEL is at 50th percentile
Clinical Oncology	NWL worst (lowest 25th), SEL & SWL just below 75th, NCL above 75th, NEL between 25th and 50th but closer to 25th
General Surgery	NEL is between 25th and 50th; NWL is at 50th; SWL just below 75th; NCL and SEL are above 75th.
Clinical Radiology	NEL below 75th, all other London ICSs above 75th.
Diagnostic Radiography	NEL is lowest, NWL above NEL but also in 25-50th. SWL in 50-75th, SEL & NCL above 75th
Therapeutic Radiographer	NWL below 25th. NEL in 25-50th, SEL at 50th with SWL & NCL both above 75th
Palliative Care Nurse	NEL is the worst, NCL in 25-50th (but serving 12,000 pop less per WTE), SEL, SWL & NWL in 50-75th
District Nurses	NEL at 75th, only NCL above 75th percentile, rest of London has greater shortages with SW London below 25th percentile
Dietetics	NEL below 75th. SEL at 75th, NWL, NCL & SEL above 75th.

Summary

Other London ICSs are by and large in the upper quartile (above 75%) for the national comparison of WTE to numbers of patients served. An uplift to the London level will not deem to be affordable within current financial constraints. So where as a starting point, where an uplift is needed to reach the 50th percentile (Diagnostic Radiographers, Therapeutic Radiographers and Palliative Care Nurses), we have included these numbers in the 'demand-driven investment' uplift of the modelling below.

The reality is that any demand-driven investment would need to be spread a little more evenly across all the professions outlined above, but with priority being given to those below the 50th percentile.

Future Workforce Scenarios

Rationale for baseline, Bank & Agency, vacancy, turnover and efficiency assumptions over the five year period

The five year scenario is the aggregated position from 5 annual workforce scenarios where change assumptions have varied to reflect the main thrusts of the action plan above.

The baseline number of staff in post for Year 1 is that provided by the Trusts in the datasets. Subsequent years start from the end of the previous year's staff in post baseline.

Assumptions on Bank & Agency numbers show a very small decrease over the five year period. This is based on the need to recruit additional members of shortage professions to bring North East London in line with its comparators, and on the need to maintain at least some sickness cover and training backfill.

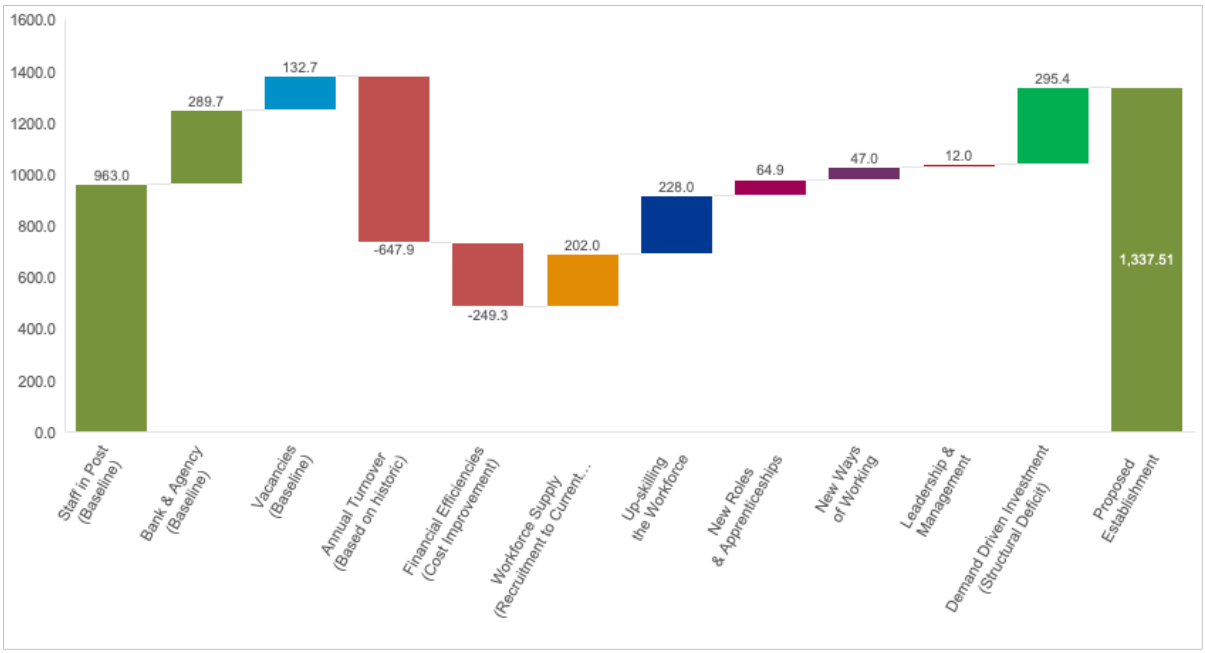
Vacancies increase over the five-year period, assuming that provider Trusts maintain sufficient vacancies in their budgeted establishment to fund and deliver the required organisational and role design changes over the coming year.

The turnover assumption is 12% across the five years. In general within the NHS, turnover is decreasing, but not in specialties and professions where the age profile shows a proportionately higher number of those at risk of retirement. There are sufficient staff in the higher age brackets within the cancer workforce to assume that turnover will remain at 12% throughout the period.

The percentage of financial efficiencies achievable has been decreased annually by 0.5% over the five years. For Year 1, 5% has been modelled; by year 5 this decreases to 3%. This follows the normal trajectory for efficiencies, which become progressively more difficult to achieve.

Workforce Transformation Bridge – Whole Time Equivalent

Total Movements over 5 Years



Workforce Change assumptions per year:

The movements per year for the five year period show the impact of different priorities, as outlined in the action plan. Increases in Workforce Supply reflect the need to progressively address the local deficit on key professions outlined above.

Numbers therefore increase as (hopefully) more funding becomes available or as funding is prioritised towards cancer treatment and away from less stretched areas of the workforce.

There is a very small increase of new roles in each annual scenario – stakeholder engagement has not outlined any specifics, but in reality most years do include a small amount of hybrid role and role expansion experimentation. These typically emerge in response to local service pressures, pathway redesign or emerging best practice.

This often involves the adaptation of existing roles rather than the creation of entirely new posts. This modelling therefore reflects a realistic assumption of ongoing, limited role experimentation and gradual skills-mix evolution, rather than transformational change in any single year.

One of the bigger variations between the five annual scenarios outlined below is that in new ways of working. Given the current system roll-out, particularly of Electronic Patient Records, it is reasonable to assume that there will be some gains from digital efficiencies in Year 2 so this year shows a decrease in staff in post.

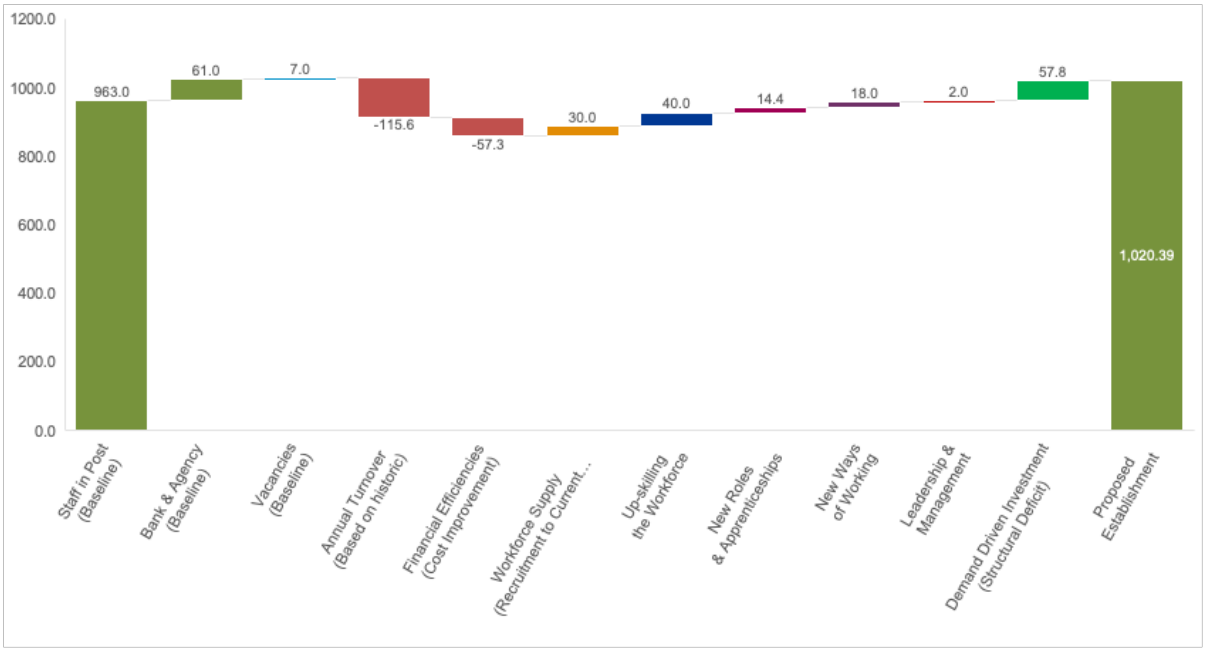
Equally, some of the other changes in ways of working outlined in the Alliance's digital strategy will take time to embed and will require additional staff – so an appropriate allowance for this has been made in the low level increases in Years 3, 4 &5.

Experience in the last 5-10 years has shown that cancer demand outstrips across the board population health demand trends. This is partly because of a higher incidence of cancer, and partly because of the need to monitor and support those living with and beyond cancer.

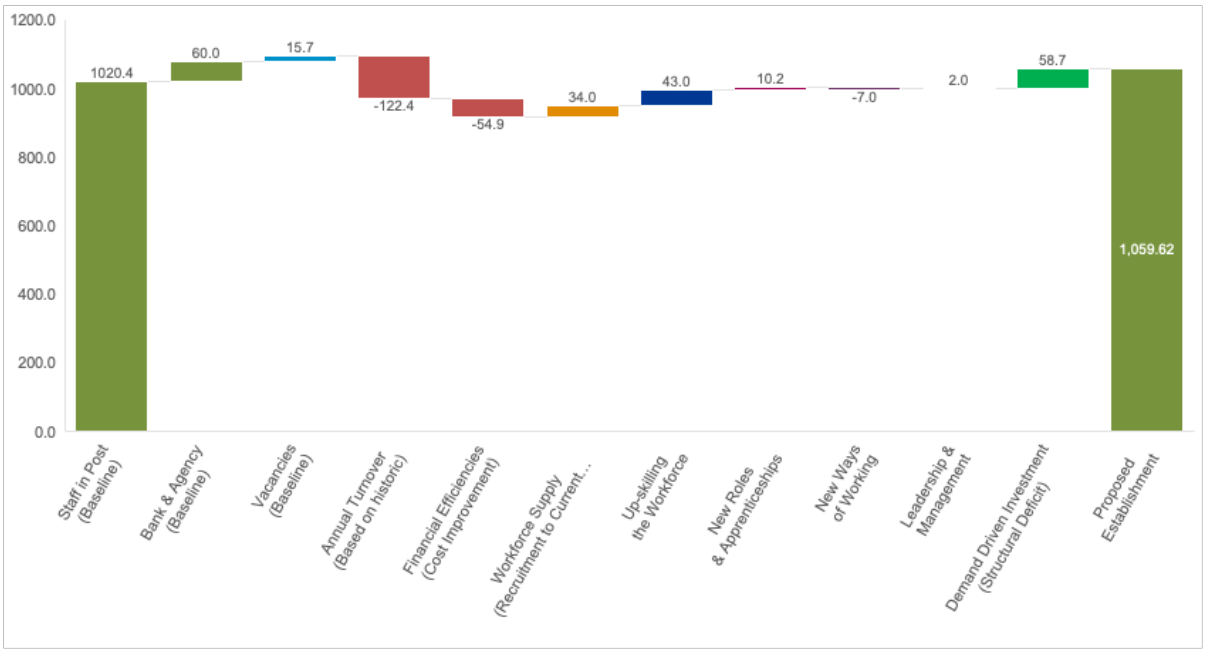
As the operational planning round overall allocates 3% demand, and as cancer-related demand outstrips this by 5-6%, a demand-driven investment percentage has been added annually to reflect this additional workforce.

This demand-driven investment decreases per year by 0.25% in the hope that earlier intervention manages down demand for cancer treatment faster than the demand for all cancer services grows.

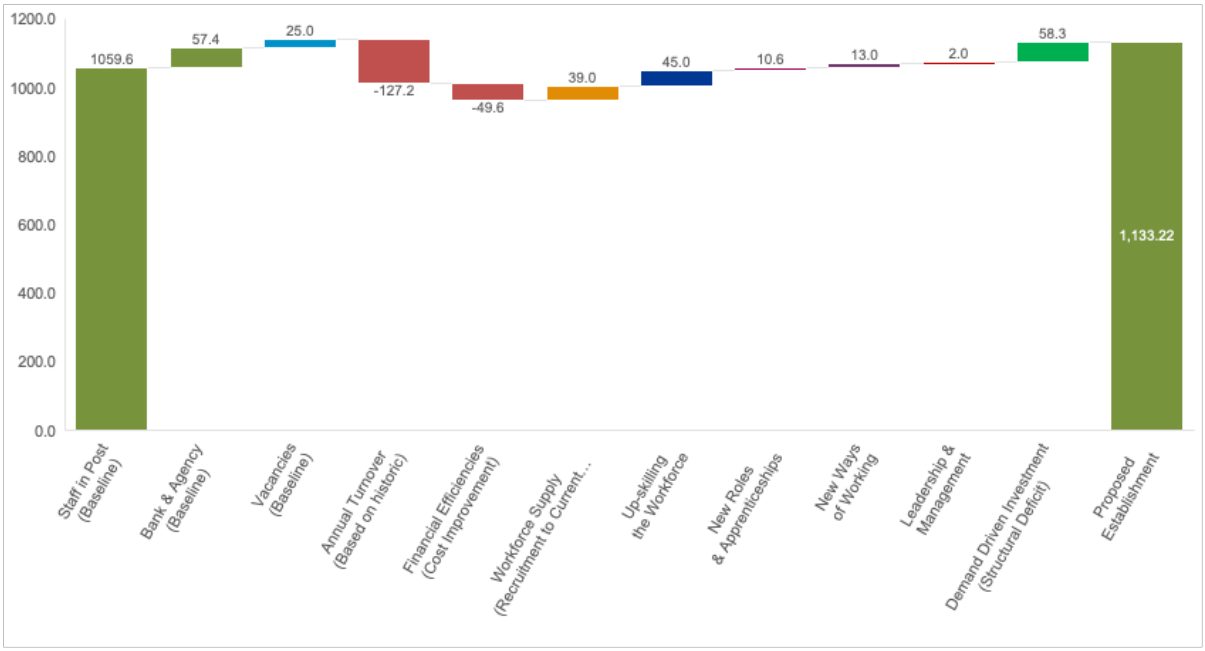
Total Movements - Year 1



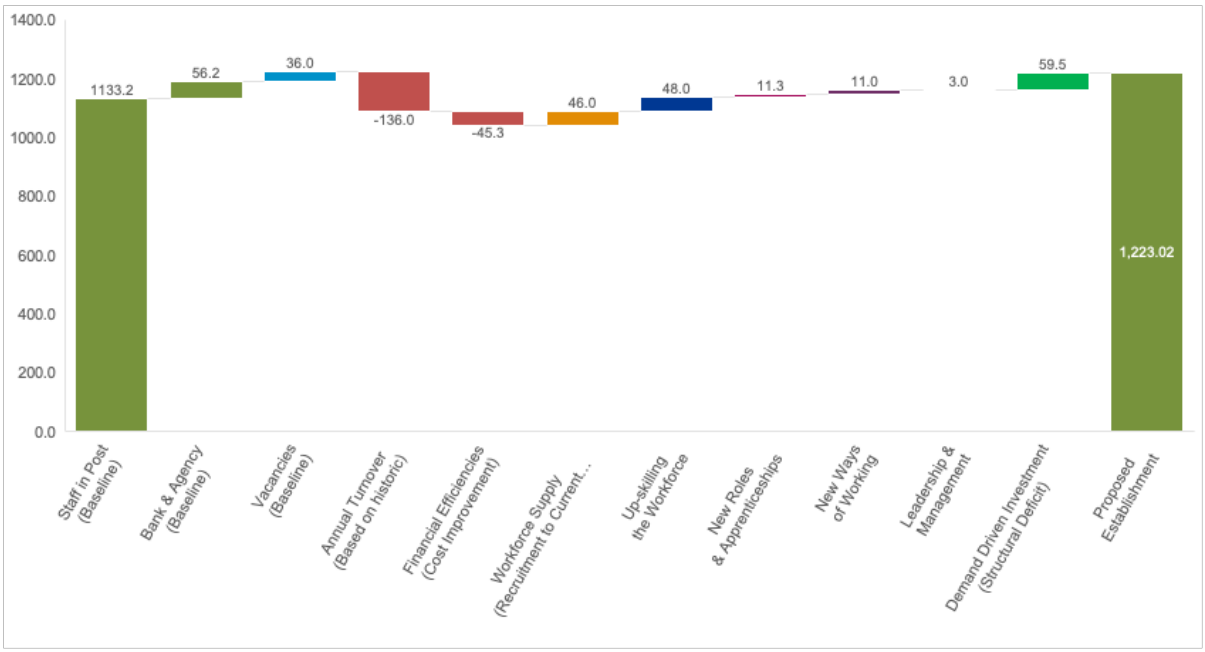
Total Movements - Year 2



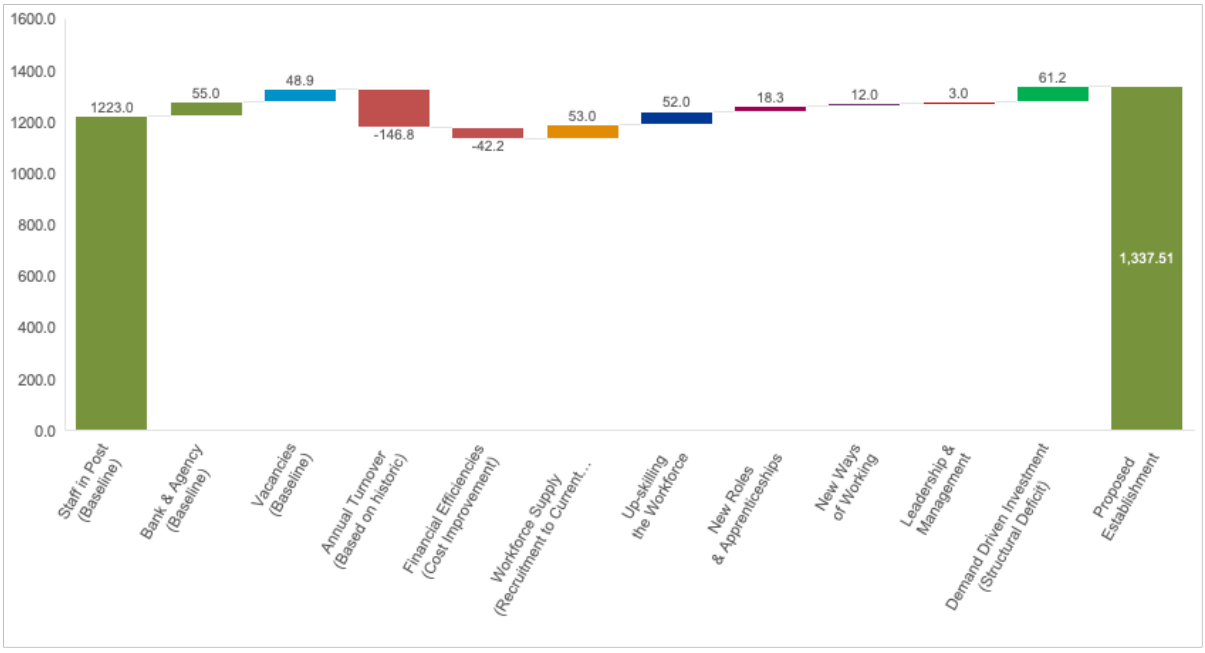
Total Movements - Year 3



Total Movements - Year 4



Total Movements - Year 5



Appendix 1 - Workforce Focussed PESTLE

P – Political

1. National workforce policy and funding direction

Although current financial constraints may mean reshaping, rather than growing, the overall NHS workforce, the NHS Long Term Workforce Plan (LTWP) commits to substantial growth in doctors, nurses and AHPs by 2036/37, backed by £2.4bn over five years. Nationally, the Department for Work and Pensions is focussing on employment for the economically inactive – see their recently published 'Keep Britain Working' report[34]. While this creates an opportunity to expand the cancer workforce, it also intensifies competition across specialties for training posts, educators and placement capacity. The next iteration of the national workforce plan, based on the objectives of the NHS 10 Year Plan, may signal a change in direction.

Workforce implications

- North East London Cancer Alliance will need a clear, costed workforce growth case aligned with LTWP priorities (e.g. imaging, oncology, general practice, advanced practice) to secure its share of national training expansions.
- The London labour market is already tight; even with national uplift, recruitment to radiology, oncology, cancer nursing and CNS roles will remain a zero-sum game unless North East London Cancer Alliance explicitly positions itself as a "destination employer" (e.g. rotations across Barts/BHRUT, academic links, flexible work).
- Workforce planning must be system-wide (ICS-level) rather than trust-by-trust in order to leverage LTWP funding effectively and prevent internal poaching between providers in north east London.

2. System reform and ICS governance

North East London Cancer Alliance sits within the North East London ICS and is expected to deliver NHS Long Term Plan cancer commitments (earlier diagnosis, faster diagnosis standards, personalised care). At the same time, national restructuring of NHS England (including workforce reductions in national teams) shifts more responsibility to ICSs for implementation and performance management.

Workforce implications

- North East London Cancer Alliance will increasingly need its own analytic and workforce planning capability rather than relying on national teams. This implies investment in workforce analysts, programme managers and business intelligence roles alongside clinical posts.
- As ICSs move towards greater provider collaboration, workforce strategy must support cross-organisational roles (e.g. pan-North East London consultant

[34] Keep Britain Working: Final report - GOV.UK

oncologist posts, shared CNS/ACP roles, system-wide rapid diagnostic centres) and tackle employment model and job-planning complexities.
- Performance pressures on cancer waiting times and early diagnosis targets will shape workforce priorities – with a premium on diagnostic capacity (radiologists, reporting radiographers, endoscopists, pathologists, RDC teams).

3. Migration and international recruitment

Post-Brexit, the main labour market drivers are wider immigration policy, the Health and Care Worker visa route, and global competition for specialised staff rather than EU freedom of movement per se. The UK remains heavily reliant on internationally educated nurses and doctors.

Workforce implications

- Cancer services in London are particularly dependent on international recruitment; workforce plans must include ethical recruitment pipelines, enhanced pastoral support and structured development for overseas staff to improve retention and progression into specialist cancer roles.
- Policy and visa uncertainty introduces risk; North East London Cancer Alliance's strategy should explicitly scenario-plan for a tightening of migration rules (e.g. by expanding local training pathways and apprenticeships into cancer support worker, assistant practitioner and advanced practitioner roles).

E – Economic

1. Macroeconomic conditions and NHS finances

The NHS faces continuing financial constraint, including efforts to curb overspends while cancer incidence and treatment costs rise. Local systems in London carry additional cost pressures linked to estates, pay weighting and agency spend.

Workforce implications

- Affordability will limit straightforward "more of the same" expansion of highly specialised consultant posts. Workforce strategy will need to emphasise skill-mix redesign (e.g. ACPs in oncology and radiology, non-medical endoscopists, cancer care coordinators) and productivity via digital tools rather than pure headcount growth.
- North East London Cancer Alliance will need strong value-for-money narratives to secure investment – for example, framing diagnostic workforce expansion as essential to unlocking earlier diagnosis, which is cost-saving at system level.
- Financial pressures on partner organisations (e.g. Macmillan's recent workforce and hardship grant cuts) reduce the "hidden workforce" available to support people living with cancer and may shift demand for psychosocial and navigation roles back onto NHS teams. Workforce plans must explicitly account for this substitution.

2. Local labour market and cost of living

North East London includes some of the most deprived areas in England alongside rapidly ‘gentrifying’ neighbourhoods. High housing and childcare costs make recruitment and retention challenging, particularly for mid-band staff (Band 5–7 nurses, AHPs, admin).

Workforce implications

- To remain competitive locally, North East London Cancer Alliance partners may need to offer:
    - Flexible and hybrid working where clinically appropriate (e.g. remote MDT attendance, remote follow-up clinics).
    - Local recruitment with “grow your own” models – apprenticeships, links to FE colleges and universities in London, targeted programmes for under-represented communities across Barking & Dagenham, Newham, Tower Hamlets etc.
- Retention interventions (career frameworks, protected development time, housing advice schemes, childcare support, and wellbeing offers) will be at least as important as recruitment, given the cost of replacing specialist cancer staff and the national shortage in key specialties.

S – Social

1. Demography, multimorbidity and rising demand

Cancer incidence is projected to increase markedly, with around 6.3 million new cases in England between 2025 and 2040 – a 14.2% rise on the previous 15 years – and London expected to see over 700,000 cases. North East London’s population is younger than England overall but growing fast and ageing, with high levels of deprivation-linked risk factors.

Workforce implications

- Demand growth will not be linear; it will be concentrated in screening, early diagnosis, treatment for common cancers (breast, prostate, lung, colorectal) and survivorship services for long-term consequences of treatment. Workforce planning must therefore span the whole pathway, not just acute oncology.
- Multimorbidity and frailty will increase complexity of workload. The workforce will need more generalist skills (e.g. geriatric oncology, palliative care, psychosocial support) embedded into cancer teams, and stronger links with primary care and community services.

2. Inequalities, cultural diversity and trust

North East London Cancer Alliance serves a highly diverse, multilingual population with significant health inequalities in cancer incidence, stage at diagnosis and outcomes. Tackling these inequalities is central to the Alliance’s mission.

Workforce implications

- Workforce strategy must prioritise cultural competence, language skills and representativeness. This suggests targeted recruitment from local communities, development of community health worker and cancer navigator roles, and systematic support for lived-experience roles and patient partners.
- Demand for outreach, prevention and screening promotion roles will grow (e.g. lung health checks, personalised screening invitations). These may sit partly outside traditional hospital teams and require flexible employment models (e.g. working with VCSE partners).
- Staff need training and support to work effectively with communities experiencing mistrust of institutions and to address structural racism and discrimination that influence both patient care and staff experience.

3. Workforce expectations and wellbeing

The UK cancer workforce is experiencing high stress and burnout; the Royal College of Radiologists reports a 30% shortfall in clinical radiologists and 15% shortfall in clinical oncologists, with many leaving earlier in their careers. Staff increasingly expect flexible working, meaningful development opportunities and psychological safety.

Workforce implications

- Retention strategies need to be core, not peripheral: structured supervision, peer support, psychological support for staff working with complex and end-of-life cases, flexibility, and reasonable workloads are prerequisites for sustaining specialist cancer teams.
- Workforce design should reduce single-handed or “heroic” roles – e.g. lone CNS posts covering very large caseloads – and shift towards team-based models with clear escalation, cross-cover and skill-mix.
- Career frameworks (e.g. ACCEND for cancer nursing and AHPs, defined pathways into consultant roles and academic careers) must be visible and resourced, or North East London Cancer Alliance will lose staff mid-career to less pressured specialties or sectors.

T – Technological

1. Diagnostic technologies and equipment

National reports highlight both shortages of diagnostic staff and insufficient MRI/CT capacity as key drivers of long waits for cancer diagnosis and treatment. North East London Cancer Alliance is already deploying innovations such as cytosponge and colon-flag.

Workforce implications

- Introducing novel diagnostics demands specific workforce planning:
    - Training radiographers, endoscopists and other staff in new modalities.

    - Creating advanced practice and reporting roles to maximise productivity of scarce consultant time.
    - Planning for shift-pattern flexibility to extend diagnostic operating hours without burning out staff.
- Technological upgrades without workforce redesign risk worsening pressure (e.g. more scans ordered without sufficient reporting capacity). Workforce strategy should therefore tightly couple equipment business cases with plans for skill-mix, recruitment and training.

2. Digital, AI and data analytics

AI tools in imaging, pathology, triage and risk-stratification are spreading, along with digital cancer care pathways, remote monitoring and virtual MDTs. North East London ICS is cited nationally for work on integrated data and VCSE partnerships.

Workforce implications

- North East London Cancer Alliance will need a digitally literate workforce:
    - Clinicians able to interrogate and trust AI outputs.
    - Data scientists, analysts and informaticians embedded in cancer programmes.
    - Clinical safety officers and governance roles for digital tools.
- AI will not eliminate roles in the medium term, but it will change tasks. The workforce plan should map which activities can be shifted (e.g. prioritisation of image review, automated follow-up reminders) and then redesign job plans to focus human effort on complex decision-making and relational care.
- Training time for digital competencies must be explicitly costed and protected; otherwise digital transformation risks widening skill gaps and inequalities between staff groups.

3. Remote and personalised care technologies

Increasing emphasis on personalised stratified follow-up, remote prehabilitation, and virtual support for living with and beyond cancer is evident in North East London Cancer Alliance's programmes.

Workforce implications

- New roles in care coordination, remote monitoring and digital navigation will be needed, some of which may be well suited to Band 4–6 staff with appropriate training, freeing specialist clinicians for complex interventions.
- Digital exclusion in parts of north east London means the workforce must be able to blend virtual and in-person offers and work with community partners to support digital literacy, rather than assuming technology will automatically reduce workforce demand.

L – Legal

1. Regulatory standards and professional scope

The Care Quality Commission (CQC), professional regulators (GMC, NMC, HCPC) and service specifications set expectations for safe staffing, supervision and competence. Expanded roles (e.g. non-medical endoscopists, advanced clinical practitioners) must comply with scope-of-practice and governance frameworks.

Workforce implications

- Rapid skill-mix change requires robust governance: clear competency frameworks, supervision arrangements, credentialing and revalidation support. Workforce strategy must build the educator/supervisory capacity required for this – including time in job plans and recognition for clinical educators.
- Any shift towards cross-organisational roles and virtual working must address medico-legal questions (e.g. which organisation holds clinical responsibility, information-sharing and indemnity). This necessitates legal and HR input early in workforce design.

2. Employment law, equality and inclusion

UK equality legislation, the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) create legal and regulatory imperatives to address discrimination and inequity in workforce experiences and progression.

Workforce implications

- Given the ethnic diversity of both staff and residents in north east London, North East London Cancer Alliance's workforce strategy must include concrete actions to improve equity in recruitment, promotion, disciplinary processes and access to development, supported by robust data.
- Failure to address bullying, harassment and discrimination contributes to turnover and sickness absence; investment in just culture initiatives, inclusive leadership development and staff networks is both a legal risk-mitigation and a workforce retention strategy.

3. Information governance and data

Data protection legislation and information governance requirements affect how North East London Cancer Alliance can use workforce and patient data for planning and AI tools, particularly when working with VCSE partners.

Workforce implications

- Workforce planning will require legal-compliant data-sharing arrangements between providers, tertiary centres and VCSE organisations. This means dedicated capacity in IG, data management and digital leadership.

- Staff need training in information governance for new models of working (remote access, shared care records, research and innovation), which should be built into induction and ongoing development plans.

E – Environmental

1. Net zero commitments and green theatres / diagnostics

The NHS has a statutory commitment to reach net zero, with decarbonisation plans spanning estates, travel, procurement and clinical practice. Cancer pathways (diagnostics, surgery, systemic anti-cancer therapy, radiotherapy) are energy- and resource-intensive.

Workforce implications

- Workforce strategy must integrate sustainability competencies: clinicians and managers who can lead green QI projects in theatres, imaging and chemotherapy services; estates and procurement staff skilled in low-carbon solutions.
- As services reconfigure to reduce patient travel (e.g. community-based diagnostics, virtual appointments), staff roles and work locations will change. Planning is needed for travel patterns, flexible working, equipment distribution and cross-site working contracts.
- There may be opportunities to make cancer roles more attractive by explicitly branding them as part of a “green cancer care” mission, appealing to staff motivated by climate issues.

2. Climate resilience and emergency preparedness

Heatwaves, air pollution events and extreme weather are increasingly affecting London, with implications for both patients (e.g. treatment tolerance) and staff (e.g. working conditions, travel disruption).

Workforce implications

- North East London Cancer Alliance will need workforce contingency plans for climate-related disruption: flexible rostering, remote working capabilities, cross-trained staff who can maintain critical cancer services when travel or estates are compromised.
- Staff health and wellbeing measures (cooling, rest areas, occupational health advice) will become more important in high-temperature environments such as radiotherapy departments and theatres, influencing estates and staffing model.

Appendix 2 - Patient Experience Survey Analysis Report

This report presents a question-by-question analysis of the Patient Experience Survey responses carried out by North East London Cancer Alliance during December 2025. The survey received 10 responses. Not all respondents answered every question.

Overall satisfaction with cancer care

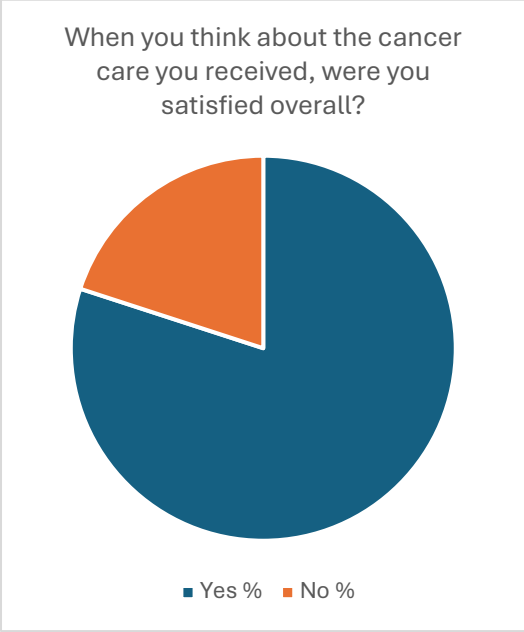
When you think about the cancer care you received, were you satisfied overall?

When you think about the cancer care you received, what stood out as positive?

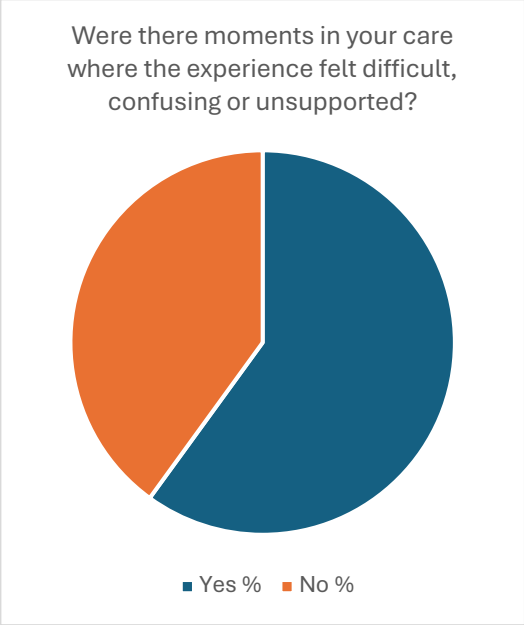
Statistical summary:

Yes: 8 respondents No: 2 respondents

Responses were strongly positive and highlighted professionalism, timeliness, and compassionate staff behaviour. Many patients emphasised rapid diagnosis and treatment, confidence inspired by consultants, and high-quality nursing and chemotherapy care. Personalised treatment planning and being treated as an individual rather than “just a patient” were recurring themes. One respondent noted “fast diagnosis and treatment, from a consultant who inspired confidence,” while another praised “the level of care and attention I received.” Overall, the sentiment reflects appreciation for both clinical competence and human-centred care.



Difficult or unsupported moments



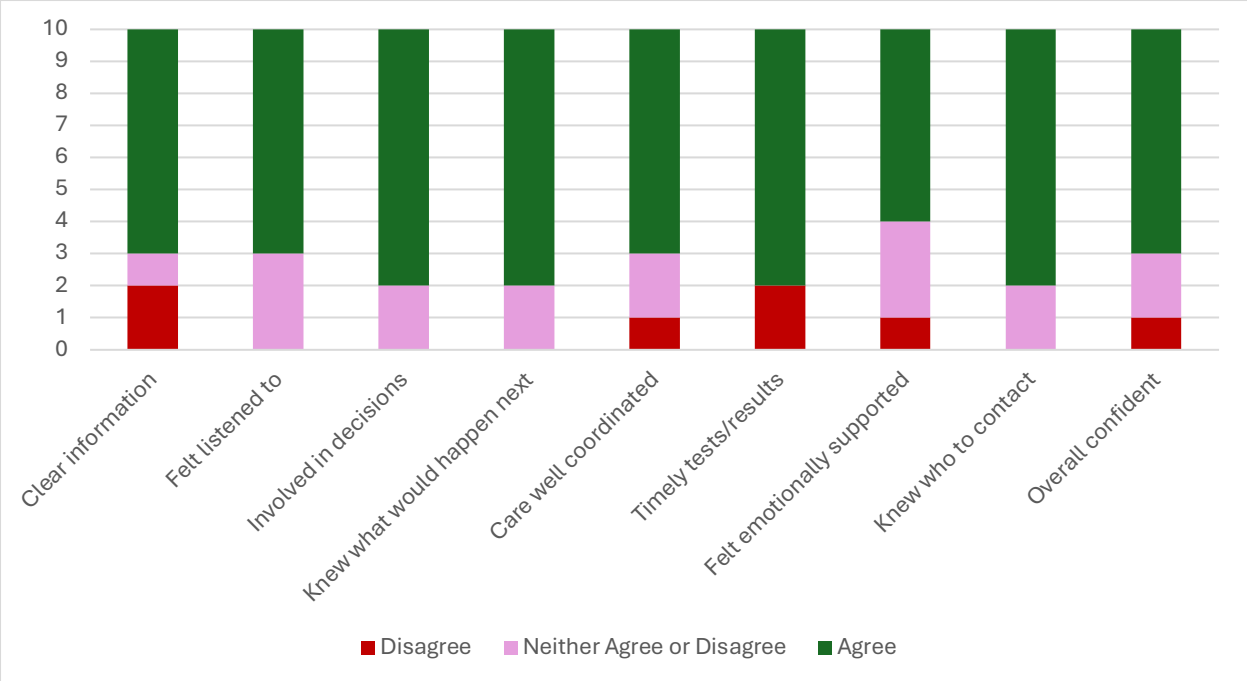
Were there moments in your care where the experience felt difficult, confusing or unsupported?

What were the moments where the experience felt difficult, confusing or unsupported?

Statistical summary: - Yes: 6 respondents - No: 4 respondents

Patients most frequently described challenges around diagnosis and the period immediately following it. Information overload, emotional shock, and uncertainty about next steps were common concerns. Several respondents described being given leaflets and phone numbers without adequate emotional support, which felt overwhelming. Delays, unclear communication, and lack of continuity also featured. One respondent described diagnosis support as “a bunch of leaflets and phone numbers… just an overwhelm.” The overall sentiment suggests that emotional and informational support at key transition points is an area needing strengthening.

Patient Experience Feedback



Clarity of information

I was given clear and understandable information about my condition and care.

Statistical summary:

Agree: 7 respondents

Neither agree nor disagree: 1 respondent

Disagree: 2 respondents

Most respondents felt information was clear, though a minority did not, reinforcing earlier qualitative feedback about information overload and communication gaps during stressful periods.

Feeling listened to

I felt listened to and taken seriously by healthcare professionals.

Statistical summary:

Agree: 7 respondents

Neither agree nor disagree: 3 respondents

No respondents actively disagreed, indicating generally strong performance in listening and respect, although some ambivalence remains.

Confidence and reassurance

Overall, I felt confident and reassured about the care I received.

Statistical summary: Responses were predominantly positive, with most respondents agreeing. A small number expressed neutral or negative views.

Confidence in care was high overall, closely linked to trust in staff expertise and communication.

Communication and support during waiting periods

What kind of communication or support from staff would have helped during times you were waiting for diagnosis, treatment or follow-up?

Respondents emphasised the need for proactive, regular communication and emotional reassurance during waiting periods. Many wanted clearer timelines, check-ins and a named point of contact. The sentiment suggests that silence or lack of updates increased anxiety, while even brief contact would have been reassuring.

Knowing who to contact

Did you always know who to contact with questions about your care?

If you did not know who to contact, where were the gaps?

Statistical summary: Responses were mixed, with several respondents indicating uncertainty at times.

While some patients felt well supported, others experienced confusion about points of contact, indicating a need for clearer signposting. Gaps were most evident during

transitions between services or after diagnosis. Patients described uncertainty about whether to contact consultants, CNS staff, or administrative teams, reinforcing the need for clearer care navigation support.

Staff interactions that made patients feel reassured

Which staff interactions made you feel seen, heard or reassured?

Compassionate listening, taking time to answer questions and continuity of care were key factors. Clinical Nurse Specialists and Consultants were frequently mentioned. Behaviours such as empathy, calm explanation and remembering personal details made patients feel valued as individuals.

Comfort with digital tools

How comfortable do you feel using digital tools or remote appointments for cancer care?

Responses suggested cautious acceptance. Many patients were comfortable with digital tools for routine follow-up but stressed that they should complement, not replace, face-to-face care.

When face-to-face contact is essential

When is face-to-face contact essential?

Respondents consistently identified diagnosis discussions, treatment planning and emotionally sensitive conversations as requiring in-person contact. Physical examinations and moments of high anxiety were also highlighted.

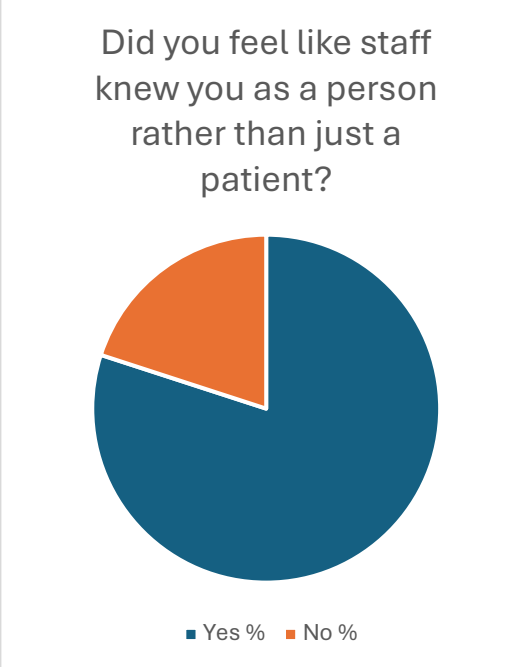
Being known as a person

Did you feel like staff knew you as a person rather than just a patient?

Statistical summary:

Yes: 8 respondents No: 2 respondents

Most patients felt personally recognised, though some experienced a more transactional approach.



Impact of staff changes

If staff changed often during your care, how did that affect your experience?

Frequent staff changes led to frustration, repetition and reduced emotional connection for some patients. Continuity was associated with trust and reassurance.

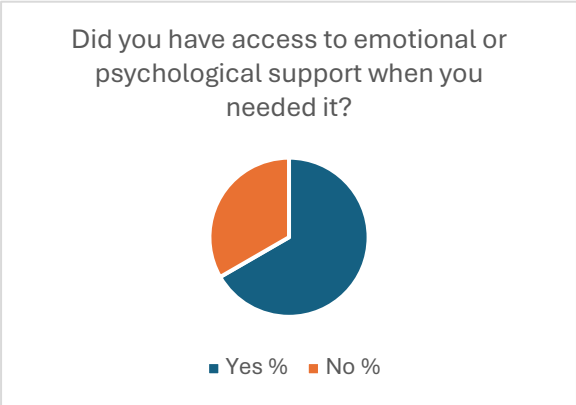
Access to & improving emotional or psychological support

Did you have access to emotional or psychological support when you needed it?

What kind of role or skill would have made emotional or psychological support better?

Statistical summary: - Yes: 6 respondents - No: 3 respondents

While most had access, a significant minority did not, highlighting an important gap in holistic care. Respondents suggested dedicated emotional support roles, counsellors, or patient navigators, particularly around diagnosis. Peer support or “buddy” systems were also mentioned.

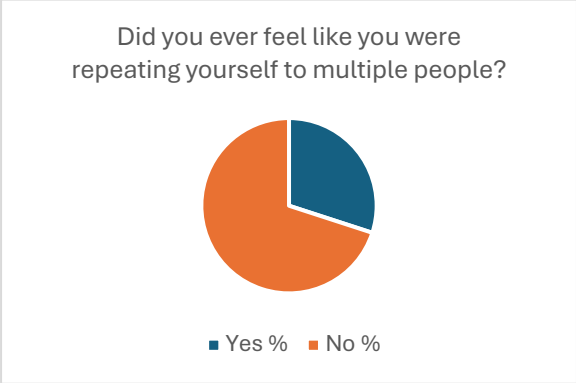


Repeating information

Did you ever feel like you were repeating yourself to multiple people?

Statistical summary: - Yes: 3 respondents - No: 7 respondents

Most patients did not experience this issue, but for those who did it was a source of frustration and stress.

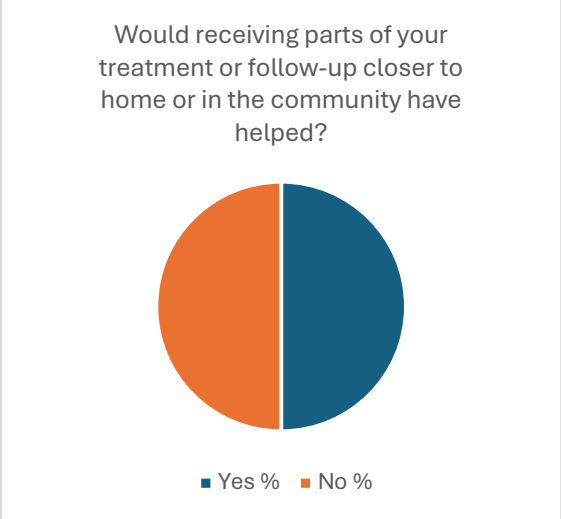


Care closer to home

Question: Would receiving parts of your treatment or follow-up closer to home or in the community have helped?

Statistical summary: - Yes: 4 respondents - No: 4 respondents

Views were evenly split, suggesting the need for flexible, patient-led choices.



New staff roles

Question: If we could design one new staff role to improve patient experience, what would it be?

Suggestions focused on care coordinators, patient advocates or navigators who could provide continuity, emotional support, and practical guidance throughout the pathway.

Culture, language, and respect

Question: What should staff understand about culture, language, faith, or identity to make cancer care feel respectful and personalised?

Respondents emphasised individuality, non-judgement, and avoiding stereotypes. Clear, accessible language and appropriate use of interpreters were highlighted. Several noted that respect and dignity were already strong, while others stressed holistic assessment and cultural awareness. One response summarised this well: “To not make stereotype assumptions… and to respect that we are all individuals.”

Overall themes

Across the survey, strengths included compassionate staff, professionalism, and personalised care. Key areas for improvement centred on emotional support at diagnosis, clearer communication during waiting periods, and continuity of care. The findings suggest that relatively small changes in communication and support roles could have a significant positive impact on patient experience.

Recommended action points

1. Strengthen support at diagnosis and early pathway stages
2. Improve communication during waiting periods
3. Clarify points of contact across the care pathway
4. Enhance emotional and psychological support provision
5. Protect and promote continuity of care
6. Use digital tools in a patient-centred, flexible way
7. Reinforce respectful, individualised c

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