

## Written evidence submitted by Group 1 (ECS0038)

### Transcript of roundtable event with cancer services clinicians and practitioners held on Tuesday 1<sup>st</sup> February 2022 for the Health and Social Care Committee Cancer Services Expert Panel.

#### Group 1

**Jane Dacre:** Thank you everyone for coming today. During this session we'll try and get through everybody, to make sure that everybody has a voice. The first couple of questions are focused on workforce. In the work that we've been doing with the select committee, workforce is a hot potato- there are problems with workforce everywhere. So my kick-off question is what your experience is of levels of staff in cancer care? Participant A, would you like to go first?

**Participant A:** This morning, my endoscopy list of two-week wait suspected cancer patients was cancelled, and that was cancelled because of a lack of nursing staff. We're currently taking it in turns as endoscopists on rotation to have our lists cancelled. I work in a major teaching hospital, in a town of people that just need to come and see a doctor because they need help. I work in a new endoscopy unit, it's the third time it been rebuilt at our hospital, and it was closed just before the start of COVID-19 in order to be modernised. But due to "commissioning processes" (I will put that in speech marks), the rooms size was increased to four endoscopy rooms to five endoscopy rooms in order to provide more capacity, but due to the length of time it takes to build such a unit, the availability and the performance of the rooms is not COVID-19 safe, as they were based on building plans pre COVID-19. So instead of having perhaps 10 people on my list that I can do an endoscopy camera test to diagnose their gastric, oesophageal or bowel cancer because of the fallow time, the air circulation not being up to scratch, it's below pre-COVID performance. Unfortunately the fourth and the fifth room are too small to allow a patient, a trolley and the staff member in, let alone and arrest trolley. This unit costs several million pounds, and I'm sure we've all got stories to tell where the cost of changing a sink in our hospital costs £150,000, whereas the local plumber will do it for £100 cash. So I'm sorry that I'm being quite working class about it, but that is the brutal reality of the situation. Our radiology colleagues I would describe as world class and I'd have any of my families scans- if they required a scan- reported by them, but due to the pressure, the volume and the complexities the average reporting time for an urgent requested scan is 20 days. Each month we're given an update of how long it takes to report scans and we know only a minority of our patients go through dedicated two-week pathways, with the majority of patients coming through routine pathways. So the length of time it takes for abnormalities to be reported, fed back, referred to the appropriate speciality is more than ticked on.

**Jane Dacre:** Thank you. We'll focus on the workforce issues and then we'll come back to some of the other issues that you raised later. So thank you for a great start.

**Participant B:** The pathology workforce is an area that has been under-resourced for a very long period of time. I know that all areas of healthcare are, but pathology has been forgotten about repeatedly, again and again. There are innumerable examples of very high level documents talking about pathways for various tumours or investigations, all of which talk about everything in fantastic detail and are superb, but their comments about pathology are things like 'take the biopsy and get the result.' There may be an entire page on- and no disrespect here- the nurse practitioner who did it or the support services or occupational therapy, but there is no mention of pathology. I use that as

an example because that means that they are missed out on every opportunity for funding and resources, in terms of workload. We have a situation now where we have about 25% too few people capable of reporting slides of cancers than we would ideally have. Each of these people will take 15 years to train, so what that means in terms of the backlog is that you do not have the resources and the personnel to be able to do that reporting. And however much money you put into the system; you're not going to be able to address that. It is a huge bottleneck, and it will be the thing that is basically unsolvable when trying to deal with the cancer backlog because it is historic and there is very little that you can do. Even if you do something now, that will have minimal effect for 10-15 years.

**Jane Dacre:** When you say resources, can I just clarify that you're talking about staff resources mainly?

**Participant B:** I can talk about resources until the cows come home, but at the moment I'm just talking about workforce.

**Jane Dacre:** Thank you.

**Participant C:** So obviously, as a nurse I'm really talking about the nursing community. I work in metastatic breast cancer, and certainly as a community of nurses we are a very small community. I think the power of history and routine has meant that specialist nurses, for example in oncology, have been predominately within the surgical directorate and never walk along the corridor to the oncology centre. I am one of a very small but growing community, and a report published 18 months ago suggested that there 444 breast care nurses in early breast cancer, and there were only 44 in metastatic disease. Considering our systemic treatments are evolving, and there's a large patient population that need more specialist support- that's not only in breast cancer, but other advanced cancers- as a workforce, yes, there is a huge nursing vacancy, but I think moving forward the boundaries of our roles are certainly shifting. I think for professional development, which can underpin our roles without more work burden, I think there are great opportunities for nurses and allied healthcare professionals to develop their roles. However, there is no incentivisation for that as a bigger picture. And similarly to what Participant B was saying there about pathology, you can't just put a senior nurse into specialist roles. There's not enough done in terms of frameworks for professional development and moving forward, so you're very much engaged with local internal models to develop staff, and most of the time you develop them locally and then they'll move on to more senior jobs. I will be retiring within the next five years, and although I have been able to do a succession plan, I know that my colleagues around the country haven't been able to do that, so I think that's a big concern for workforce as well. There is going to be a significant loss of specialist nursing workforce, I'm sure, across all specialities and amongst allied health professionals for that successional planning. So although I firmly believe that, as a nurse, that I've had many opportunities for professional development in advancing my practice, it's not incentivised anywhere else in terms of national program, whether that be banding or job description. But again, similarly, I am very concerned that within my specialty of metastatic breast cancer (and for many patients with advanced disease) where there are no targets to understand the scale of the problem, that there will be many patients in advances who do not have specialists in nursing or allied health care professional support.

**Jane Dacre:** Thank you, that's very helpful and reflects some of the things that Participant A was saying.

**Participant D:** Our challenge is therapeutic radiographers workforce, the people who treat with radiotherapy. At the moment we have a critical shortage to the point that for patients with breast cancer it takes 12 weeks from surgery to begin radiotherapy, when they should start within 8 weeks. We have had to stop advanced radiotherapy techniques to be able to give more time to the radiographers to plan because we don't have enough of them. My next point is similar to the one that Participant C presented, in that we only have one metastatic breast cancer CNS amongst five consultants, and when we do clinics together she goes from one clinic to another so it's impossible to keep up with the volume of patients that need support. The third point is on the radiologist shortage, and the concern is that if the radiology workforce is currently struggling to report then what is going to happen when we have the CDCs, the community diagnostics centres- who is going to man those centres as well as the secondary care reporting? Finally, on the point of pathologists I agree with Participant B completely.

**Participant E:** I'd firstly like to concur with what has already been said. My experience is that we've got a backlog in pathology that is affecting MDT. We've got a shortage of radiologist that is affecting things, and certainly I think Participant C's point about the provision of specialist provision in oncology versus surgery is certainly an issue. In my experience, as Participant D mentioned, there is a national shortage of therapeutic radiographers, and it's retaining as well as recruiting them. We've had a lot of staff that have been poached come into mammography because it's much easier to go up the pay scale that way. We've had a lot of staff, more staff than you'd think, going in that direction. My other point would be that we don't have a structured framework for progressing, and it's happening ad-hoc. For example my role is a temporary role, I've been taken from my previous research-lead role into becoming a consultant radiographer, and that money was taken from an oncologist that was on maternity leave- we're not putting together a business case forward to make me permanent. My point is that I think that this is happening in many, many places and I think it's very hard work to break the glass ceiling, particularly as an AHP, or non-medic nurse. There are problems with succession planning, and we're not oncologists, we are our own entity doing something completely different, and I think there is a grave concern at the lack of therapeutic radiographers.

**Participant F:** I'm just going to step back a little bit. If we were in the Department of Defence, we'd be having regular defence reviews which would consist of 'who is the enemy, how do we deal with them, what should be that nature of the staff and what tools should we bring to deal with the problems in front of us?' But we don't do that in oncology. The current direction of travel, just to summarise, our patient numbers are going up because we have more treatments that we can use sequentially across tumour types, so the numbers of patients are going up because survivals are increasing, which means that as the patients survive longer they have increasing complications which need many different specialities involved- scans, palliative care, interventional radiology. We have many more treatments in oncology- I'm talking mainly from an oncology perspective- so for my patients with breast cancer, some patients now have 5-6 lines of therapy we can use sequentially. We don't really understand the number of patients we have. If you look at our data collection, we are very poor at collecting data on just basic...we spoke about metastatic breast cancer, but how many women do we have with metastatic breast cancer in the UK? We don't even know that. We guesstimate 35,000, but I've just been working on the HES database which suggests that it's more than that, so we don't even know how many patients are dealing with. From a workforce perspective we have patients living longer, more treatments, but we don't know how many patients are living longer. So when we think about workforce, we've got to really think about what tools we're using and how many more patients we've got to look at. As to specifics around staff, Participant B has spoken about pathology and I echo that, pathology is under resourced and it's

going to become much more important because of genomics. Increasingly we're asking for repeat biopsies to be done for reassessment of the genomic landscape of the metastatic lesions, given we know that it changes. With the advent of liquid biopsies, we're going to need clinical scientists to do reports of the genomic analysis of those. It's clear that the direction of travel is going to be increasingly genomic driven, and that's going to need pathologists and non-medical clinical scientists to do those reports and set up the genomic MDTs to do that. In regards to research, we are haemorrhaging research nurses and research practitioners who are also key to providing care for patients, and ensuring that we have more treatments, but also so that we de-escalation of treatments- a lot of the studies that we're doing with cancer now are about deescalating treatments ie given less rather than more. We also, sometimes forget about our pharmacy colleagues who during the pandemic have been the unsung heroes. They really turned new protocols around and enabled things to happen very quickly, so we should also consider our pharmacy colleagues and their needs, and the fact that they are also under pressure. So, overall, we've got pressures across the board in all of our specialities. The question is how we posture staff? So its not only who do we need, but for instance for medical oncologists with increasing treatments we can't see all of those patients, so how do we ensure that the doctors see the right patients? How do we bring in CNSs? CNSs for breast cancer are few and far between, we have 3 ½ at my Trust but that is not enough for the number of patients that we have. So it's not just looking at what staff we have, but also how we upskill those staff for doing other things that ordinarily other colleagues might do. For instance, once we start patients on an urgent treatment maybe the monitoring can be done by other staff, and not the consultants so that they can see other patients. So it's not only where the holes are, but which members of staff need to be upskilled to enable them to take on tasks, which will relieve the pressure off of other specialities or colleagues. Also, Participant E spoke about pay and conditions, we're losing staff from one trust to another, because people are moving from a band 7 to a band 8 and they're being poached. So we need to recognise the value of staff in both their pay and their conditions, to retain staff and to develop, and that will solve some of these problems. Hopefully that wasn't too long winded.

**Jane Dacre:** No, that's great. Really, really helpful.

**Participant G:** Hello. I'd just like to touch on that last point. Surgical oncology patients have had a really bad couple of years. In my trust, we stopped all surgery for nearly six months in two parts, and we have not resumed the cancer surgery in the same way as it was pre-pandemic. And the reason for this is nursing staff. Out ITU used to hold between 90-100 patients, and it can now only hold between 55 and 60. So today, I was lucky that our patient was given an intensive care bed, but only two out of six patients who were listed for ITU got a bed. So the situation is dire here and it will continue to be dire, because the nurses are either off sick or they've left the hospital because of the pressures of intensive care. I don't think we really know how many of those nurses are going to come back, but it is a daily struggle to get a patient there. My team here is quite small, but we do 2-3 big cases a week. Last week we had 8 patients that have now been cancelled for a third time, and two weeks prior to that the fourth time cancellation for intensive care. So when we talk about staffing shortages for us, it's very much intensive care that is a real problem. I just worry that those nurses who worked extremely hard through the pandemic have now decided that enough is enough. I think that that's unfortunately what has happened.

**Jane Dacre:** That's really interesting because those levels of shortages are echoed across all of the different reviews that we've done, which is quite horrifying actually. I've just got a couple of supplementary questions. One of the things that we believe is really important is the

multidisciplinary teams and interdisciplinary roles, so does anybody want to make a comment on what impact staffing shortages is having in relation to that, and how is that affecting patient care.

**Participant C:** Locally, we used to have a metastatic MDTM- which was separate to a general early breast MDT- and that involved a radiologist, a research nurse, a palliative care nurse, myself as a consultant CNS and all the five breast oncologists that allowed us to prepare for the week ahead and for the interplay of the clinic to make sure patients had timely reporting. Our research recruitment would go up as a result of that screening. Unfortunately, we have had three consultant breast radiologists leave and so we have now been informed that, as of three weeks ago, the MDTM has now been suspended. We still meet for peer discussion with our oncologists, and I think interestingly it is actually now more about support. Building on the comment that Participant G made about the challenges of patients, one thing that I've noticed from being on the front line of oncology is that I've never been spoken to in such an aggressive way, and I've been sworn at. It is all misdirected anger, frustration and anxiety from patients, and in my 33 years of oncology I have never really experienced that before. So for us, our experience is: loss of radiology, delay in pathology reporting and not having a metastatic MDTM now, which ultimately affects our whole service and quality of care for our patients, and our recruitment for clinical trials has dipped again.

**Participant A:** I think irrespective of staff shortages, I think despite the glorified pathways patients do get a raw deal and access to multidisciplinary team members, such as a nurse specialist, is very much dictated by what treatment they receive. So a patient will come to me as a diagnostician, and I will diagnose their cancer, but I won't have the nurse specialist with me in the clinic and I have to rely on independent organisations like Maggie's to help support this in-between stage of waiting for that cancer MDT to take place, after they've had a tissue diagnosis by means of a biopsy or endoscopy, which is several weeks. And then when they meet their oncologist, if they have a systemic oncological therapy, great, because then they'll get introduced to the nurse specialist linked to that chemotherapy, but we know that a significant proportion of our patients diagnosed with cancer don't have treatment because of either comorbidity or advanced stage disease and we do such a group of patients a disservice.

**Participant D:** the impact of the shortages on MDTs is multiple. The multi-disciplinary meetings themselves now lack effectiveness and efficiency in decision making. There is often a delay in discussing patients, and we rollover patients because pathology is not ready, because the images have not been reviewed due to workload, which means a delay in patients getting treatment. We also have poor patient experiences. In the big gap between diagnosis and starting treatment, the patient could have some prehabilitation where they could be optimised with some nutrition advice and physical activity, and that cannot happen because we don't have the allied health professionals to see and advise the patients. So that big gap not only de-conditions the patients, but they also have worse outcomes because they are getting into treatment in a weaker and more anxious state. It also impacts staff morale in the clinics and the hospitals, because they realise that they are not offering the world class service that they should be, as there are single-handed individuals for so many people. And of course the clinic times have got bigger for clinicians. Consultants take on the workload of CNSs sometimes because they share those CNSs, and therefore clinics become unmanageable and again that lead to delays.

**Jane Dacre:** Thank you. Obviously, there are workforce problems because there are just not enough people on the ground, and it sounds that you're suggesting that that does affect the patient experience. One of the other things that we're asking is, is this because there aren't enough people or because there isn't enough money. Is the budget there to deliver good cancer care?

**Participant E:** I would say both. I think one of the frustrations that we've had in our department with radiographers, is that we haven't had the four-tier structure with advanced clinical practitioners and consultant roles- we're only just getting the consultant roles in. We don't have site specific radiographers. We just don't have the money to implement all those things, and consequently we have to a drain of staff either to other departments or, as I mentioned previously, to other specialties. We've got a whole tranche of radiographers going to various other cancer service roles, and whilst it's great that they're staying in cancer services, they are not staying as therapeutic radiographers on the ground where we need them. So I think the lack of more senior roles, and a structure to get to a more senior role, means that you don't have the retention. So it's a bit of a chicken and egg; it's both. If you have the money there, you'd retain good staff.

**Jane Dacre:** Thank you. Can I just add to the question for other people that are coming in and ask whether you've noticed is there is a regional difference in all of this? Is there a North/South or East/West divide?

**Professor B:** Not in pathology. In terms of workforce, everything is bad in pathology everywhere, but there are some pockets where it is really, really bad as opposed to just really bad. The base question is interesting because 5-10 years ago, the reason would have been that there is not enough money, which means that there are not enough training posts. Now, it doesn't matter how much money you give us. There are a few things that you can tweak, like digital pathology and things like that, but there is nobody to employ, and there isn't anybody in labs to employ which is a significant problem in terms of BMS lab staff. There are no consultant histopathologists spare. None. So you could have infinite money, but you cannot overcome the bottleneck that you have. It's historic, because 15 years ago we said that you needed to train more, but not money was put into it. Obviously, money would help, it helps everything, but however much money you're got there are not enough people to employ to get rid of the backlog.

**Participant F:** I think we have less. I'm based in the North West, and I think we definitely have less training posts in terms of registrars. I think money vs staff is a bit of both. As Participant E said, I think it's enabling our nursing colleagues and radiographers to develop. I know that we've lost one radiographer to another region as they got a consultant post, and we lost a senior nurse to another trust because she went from a band 7 to a band 8. I said to retain her we need to make her a band 8, but that didn't happen. Particularly for the non-clinical roles, how do you develop staff and have a pathway like doctors have, to develop people and then enable people to develop into senior roles. Otherwise you will get this poaching of staff to other roles and other trusts. I think more structured development would solve some of the staffing issues in some areas. I think pay is important and we've clearly lost staff because of an inability to up-band them. I think pay will be an increasing issue, particularly with the current potential increase in inflation and cost of living. I think that we may come under even greater pressure as people's wages become worth less with inflation and they start looking to move to other roles. So it's how do we retain staff, because clearly people stay in the NHS if they move from a band 7 to a band 8, so we need to enable people to develop and this post and have that progression in the same trust. In the US you see lots of people moving halfway across the country, whereas here we're normally static in where we practise, we don't normally move around the country as staff members, so how do we enable that to allow areas that have staffing issues to attract people.

**Participant A:** I keep getting offered money from the region's Cancer Alliance but unfortunately, it's just on short term of fixed term things. For example, they'll offer £100,000 to get a new secretary or PA or a data analyst, but the money has to be spent by a certain time and due to the slowness of the NHS it takes forever for an advert of job description to be approved or advertised, by which time

you're like 'hey, do you want to slug your guts out for a fixed term post of three months, and they will be no money at the end of this?' So the Cancer Alliance keep offering millions of pounds and it goes back to Participant B's theme that there are no quick wins here. You need to invest in the most important resource, which is the personnel. Develop them and then you will get your slow but sustained gain for the service. It's not a year, it's a decade or 15 years.

**Jane Dacre:** Thank you, and that is something that Jeremy Hunt from the select committee is really, really pushing home. I want to move on now to what we call living well with cancer, so start getting ready for that, but first we'll go to Participant C.

**Participant C:** I just wanted to echo what Participant F was saying. I'm based in the South East and we don't have the rotations. We're so close to London so we don't get many of the rotations through. One of the reasons that my role came about, was looking at the boundaries of the role and what I could do to upskill myself. So working in metastatic breast cancer, those multiple returns to clinic with sequential treatments, I'm a medical prescriber as well, so the task of my role, and my level of practise would be maybe what a medic would have done previously. I don't think it's only upskilling; I think it's also about taking away things that aren't important. I see a lot of my oncology colleagues filling in applications and they're doing that, because there is no one else to. These are administrative tasks, that should be removed from consultants and appropriately put to administrators to free up more time. I have two support workers, which took away the administrative task of following my patients when they have fragmented care and are going off to tertiary centres. There are other ways to do things, and you just can't do more of the same. I also wanted to follow on what from Participant A said, my posts have come in on very short funding from quick fixes by the Cancer Alliance. There is no investment. I kind of feel like I should take the quick win, get the money in and prove that you can't do without that person so that the trust has to pick it up. But it's not a good way to work, and for that individual coming through I can't really invest in them with professional development. So, we don't feel very valued from the top down, we have to push ourselves from the bottom up. As a consultant nurse, I had to push every step of the way and I'm sure they gave me my banding and my funding in the end, because they just wanted to shut me up. I felt very disappointed that it was something that I had to push for, rather than someone acknowledging it from the top and I'm sure that is echoed widely across allied health care professional nurses.

**Participant F:** Sorry, can I make one final point? I think people like Participant C are critical for keeping oncology clinics going. We do need to develop people. As a medical oncologist, we need people like Participant C for treating patients and getting people safely through their treatments. We haven't got enough consultants and we need to upskill our nurses. People like Participant C shouldn't have to fight to have their work recognised, they shouldn't have to badger people, telling them what their value is, and asking 'why am I not banded for my skill set that I'm delivering and for bringing value to the trust and NHS?' We're having too many nurses who are like Participant C, who are worth their weight in gold, banging their heads against a brick wall to get recognised. I'm sorry to pick on you Participant C, but if we properly recognise and reward people who do your role across the specialities, we will have an NHS that is able to treat patients. We will retain our staff, and we have cohesive and happy teams who stay together and deliver excellent care and morale goes up. So I think we need to think about how we value members of staff and recognise their contribution so that we don't lose them. One final point is what should our staffing look like? I think that at the moment we are delivering care with staffing configuration that is 10 years old. We've got to think about how we do more remote care. How do we order the scans and then see the patient with the

result? Does the doctor have to see all the patients? I think we're practising in a configuration and manner that is not based on modern medicine, or modern oncology.

**Jane Dacre:** I think that's often the case safely in the health service. I'm going to move on now, but I think that these things will keep coming up. I want to talk about living well with cancer and living beyond cancer, because the huge numbers of patients that have had cancer and that are doing much better than they may have done before which creates, as many of you have said, a bigger burden on the system. A couple of the things here came up in our roundtable with patients, and following the diagnosis do you think that patients are getting a personalised care plan? There's a lot of chat about personalised care plans, and a lot of patients from the roundtable said it wasn't something they'd had. The other thing that was interesting, and again relates to workforce, is that patients had struggled to see people who weren't oncologists- so that's people like fertility experts, dieticians etc. Can I have some comments on that?

**Participant B:** So on personal care plans, just to touch on something that was said before, these are something that are going to be absolutely revolutionised by genomics and is already starting to be revolutionised by genomics. In all of our oncology specialities, there is a huge push to do more and more genomics, and this is going to be fantastic for patients, but it has huge workload implications for pathology and there is no fast fix for this, and it has been utterly unaddressed with funding. There is no real funding for it, it's like pennies and I mean pennies. And this is going to be like a parallel service to traditional histology in the next five years. So this is going to be massive in terms of personalised care, but massive implications. I know that this is not quite what you were talking about, but this is something in the background and if they don't address it now then we will be having the conversation that I have just had about diagnostic histopathology in five years' time, because they have missed the boat to invest in genomics.

**Jane Dacre:** Thank you. Can I part the genomics discussion, because I think we will need to bring that up again when we talk about innovations. So really crucial, and we need to remember to revisit that.

**Participant D:** So I think the answer to your question about whether there are any personalised care plans, would be that they are partly there. We are using personalised care plans, in a way, in mainstream oncology for example with genomics. We do use some element of genomics, for example, to guide us in the need for adjuvant chemotherapy in breast cancer. However, 40%-90% of patients with cancer, the seek practitioners outside of the NHS, separately to the oncology clinic. They seek complimentary therapies like relaxation and ways to combat side effects of chemotherapy and radiotherapy such as fatigue. We do not have a service in the NHS that wraps around the patients and offers personalised oncology. So, as a result, patients resort to charities in the UK who offer those things, or they go privately but the risk there is that the private practitioner and the oncologist will work in silos, and they don't communicate. So, that is the big problem at the moment. And as the evidence of integrative approaches- which is nutrition, exercise, relaxation, mind and body therapies- as prehabilitation and throughout the patients pathway to survivorship is increasing, patients know more than the clinicians themselves.

**Jane Dacre:** Thank you, a very fair point there.

**Participant E:** My answer is to do with the other professionals in the services. I think the problem is- and this is much the same problem in the advanced clinical and consultant roles- I think all of these other services are happening in different ways across the country, with individual trusts having to set things up individually. For example, the prehabilitation for radiotherapy is really important but there's not staffing availability at the moment. I'm in contact with the lead cancer nurse to see if we



can try and get things in, but there's not enough dieticians and physiotherapist, all that sort of stuff that we need, to get that service up and running. It's one of my pet projects, to get that service up and running. We're struggling to even run our pre-radiotherapy talks because we haven't got enough radiographers available for those. So there is a real lack of service. And at that the other end as well, one of my colleagues is fighting to get a late effects service up and running where we are, and it's a very specialist sort of subject, and again she's had to fight for the band 8 and she's had to do a business case. So I think there is a huge disparity, from what I can tell, with what patients are receiving in different areas of the country. Most of it is being paid for by charities. The late effects service is funded by our local cancer hospital charity and Macmillan are responsible for a huge amount of funding for aftercare. There is just no cohesive approach. And there's a huge lack of funding. I think it's a postcode lottery across the country, but also a lottery as to what cancer you've got as to what the services are and who is referring. I think it's a huge piece of work, and I would love to get to spent more time with our AHP colleagues, or our surgical colleagues who see patients post-treatment, but nobody has any capacity for this. We're all just trying to keep our heads above water.

**Participant A:** Just putting genomics aside, to talk about the setup of our cancer MDTs. In yesterday's esophagogastric MDT we had 25-30 patients to discuss in a one-hour meeting. How many minutes do we get per patient? So the patients personalised care plan is, 'Yes, we confirm that you have this cancer. Histologically, yes. Radiologically oncology systemic therapy next.' Why do we give so little time? Because of pressure of time and there are not enough of us. That is the brutal reality of the situation.

**Participant F:** I've agreed with all that was said. I think the issue is that sometimes we do these holistic need assessments, and we're very good at doing these holistic needs assessments, and Macmillan like us doing them, but as I say to colleagues, we're very good at documenting the issues but we can't then deal with the issues and then measure whether those interventions have resulted in benefits to the patient. So I'm afraid that I would say that these holistic needs assessments are stamp collecting, we are stamp collecting the problems of patients and often we don't have the mechanisms or the resources or the staff to deal with them. I can give an example, I have a patient on endocrine therapy, and has toxicities to do with sexual function and I don't have anybody to refer her to. I referred her to another trust and they wrote back to say that I would need to give them £200, or they wouldn't see her. So our patients face real issues with dealing with some of the problems that comes with treatment, because we don't have the services. It goes back to what Participant E eloquently said, it varies by cancer type and where you are in the country. Some centres in the country have very good services for particular cancers, and others don't so it is a real issue. And it's a growing problem, with more patients developing cancer and the ongoing toxicities related to cancer, and the disruption on life.

**Participant C:** I'm very much a nurse who is about empowering patients for their personal care, and this is aside from genomics and things. We cannot prove a matriarchal service, especially for metastatic patients may be living for many years, so I think the emphasis of my nursing has shifted to become very much about empowerment. We provide as much as we can in the community, so we are heavily reliant on our charities, like Breast Cancer Now, to run the secondary breast cancer service or a pre-hab exercise program, and our Macmillan Centre to run all those things to develop a more holistic personal care plan. And then we obviously rely on the oncology centre for treatment. Our role is about navigation towards those services, but I think it's very much about patient education to move away from that thinking that we as the healthcare team are providing a matriarchal service. There's that classic Kings Fund statement of 'no decision about me, without me'

which is very much about allowing patients to have some control as well. It's just not deliverable for us to provide everything.

**Jane Dacre:** That's a very good point actually about empowering patients, and I presume that's a big role for clinical nurse practitioners. I'm going to move on, if I may, as we've got two more topics to cover and they are diagnostics and then innovation. We've got a lot of people in this group who can probably give us a lot of support there. So in relation to diagnostics, the Government's commitment that we're assessing is that it aims to have a 28 day target from screening to diagnosis, and to diagnose a higher percentage of patients in stage one or two. Is this target being met? If it isn't being met, why, and is there a regional variation in relation to this?

**Participant B:** Firstly, on regional variation, that is a very difficult questions because in order to answer that you need to be dependent on pathology data, and there is no nationally kept data for pathology. It does not exist and nobody is able to get it. So as Mike Richards has been setting up community diagnostic hubs, he has been unable to get any national data and for pathology, and trusts are unhappy to share their data because they say it is commercially sensitive. So there are huge barriers to actually getting the information. People will tell you about P-CORD, but the bottom line is there is no proper data on it from pathology. So it's hard to say, but there probably is some regional variation. On the 28-day target, I think it is being missed in a lot of areas. One of the most significant reasons that it's being missed is a lack of diagnostic workforce, be that radiographers, radiologists and imaging or pathologists and lab staff to do the testing. They're doing the best they can, but it comes back to the argument that there is not enough staff, or in some cases machines, to do this. And there is no way of dealing with that because it's historic and that will take time.

**Participant A:** From the diagnostic pathway, I deal with the suspected cancer of unknown primary. I see about 120 new patients a month, and I diagnose cancer in one in four of those, so a hit rate of 25% which is much higher than say a bowel cancer or lung cancer screening pathway. The majority of these patients, about 90%, will have stage four cancer at diagnosis. As a gastroenterologist, I'm not diagnosing GI cancers, my most common cancer is lung cancer. And that's because it's common, but also because on the current tick box 2-week referral that we have for lung and bowel cancer, there isn't a box for these people. It's great if you do have a haemoptysis as you can go straight into the lung cancer pathway, or a lump because then you can go straight to breath cancer pathway, but we know people are individuals and the majority of people do not present with localised symptoms. You need good people manning the pumps. A good physician or a good diagnostician who is seeing patients in the clinic face to face, which I know is a lot of resource, but it prevents the circular referral. So for example, a patient is referred to a kernel rectal pathway with weight loss where they do a colonoscopy and find that haven't got bowel cancer and are discharged, only to be sent to a get a gastroscopy to see if they've got gastric cancer. So these patients are just sent to several different pathways with no wider picture or history taken. And you require a patient that engages and understands and wants to access hospitals for tests. I think the question was about screening programs, and I know screening was put on the back burner during COVID-19, but we know that the health behaviours of the general population who turn up for their bowel cancer screen, that turn up for their mammograms are very different from the people that don't access healthcare until it's too late. So one size doesn't fit all, and I think we need to change the way we access people that really need our help.

**Jane Dacre:** So in relation to achieving the 28-day target and the stage, what I'm hearing from you is that by the time you see the patient they're already in the late stage.

**Participant A:** These are people that have gone to their GP surgery and told their doctors that they're unwell and that they've lost weight. They'll get into my clinic within an accepted two week wait pathway, but at that stage that I clap eyes on them they will have advanced cancer that I'm there to diagnose. So I think the million question is, how can you possibly diagnose stage one or stage 2 cancer? It's an asymptomatic state of disease, and even screen process like community-based chest x-rays to pick up early lung cancer, are not helpful and we just don't have the resources to invest in such early screening for the wider population.

**Participant C:** I don't really know enough about the 28-day screening, but again going back to metastatic breast cancer, we have not idea of the scale of the problem in metastatic disease because it's not even considered in the process of the screening or the diagnostic process of how many patients are diagnosed with metastatic disease. Similarly to what's been said earlier, most of our patients are either diagnosed in crisis coming in through an A&E- and that's gotten worse since COVID- or sometimes a GP has booked an MRI and the report has come back and the lower back pain is metastatic disease. The pathways are not specific enough, and they're too woolly sometimes to get patients back in within that period of time. The other things that I would like to comment on is the MDMT meetings, it never ceases to amaze me how oncologists and surgeons who are running an MDT list, are trying to keep to that 28-day data whilst sometimes discussing 120 patients in one go- just to meet targets and to that that tick box. I worry that there are just too many patients being discussed, and I'd to be patient number 128 on that list sometimes when they're discussing those things. So my concern is that there's not enough being done for the metastatic patients, as well as in terms of identifying who's being diagnosed.

**Participant E:** So I was going to say something positive. One good recent innovation, that I haven't been involved in myself, but locally they have set up a rapid assessment service for prostate patients. That's taken away one of the clinical visits with urologists, and especially for certain groups of patients the nurses can refer for them to go and have the MRI straight away. I'm not privy to the exact sort of criteria, and how it works, but certainly the patients that have come through that pathway- and it is a much more structured pathway- have positively reported back to me about their experience. The know what's going to happen each step of the way, it's very structured, whereas for the patients that come through different avenues there can be long waits between various procedures and appointments, and delays with MDTs and pathology. The other point that I was going to say, as a person who has got about five very close GP friends, I'm still getting patients now, and there is still a COVID hangover of people that don't want to go and see their GPs. We're certainly seeing many more late-stage cancers coming through, and I think that something needs to be done about it. We need to some kind of campaign to encourage people to see their GP, that it's ok to go and that the doors are open again. There's a huge amount of negative publicity about not being able to see a GP. In the clinic the other day, I had two consecutive patients that lied to their GP about their symptoms to try and get a PSA test for their diagnosis, because they thought that they weren't going to get that otherwise.

**Participant F:** To the piece around stage one and two, I think we need to accept that there are many reasons why patients present later, why some cancers are picked up early versus late. In the UK we have a number of screening programs, for things like bowel and breast, so clearly, we're better at picking up stage one and two in these cancers. But it's also to do with education; the patient's red flag symptoms being picked up by the GP and then rapid referral onwards. The other thing that we've not really talked about is deprivation. We know that deprived communities do worse across the board, and COVID has really brought that out, so it's also reaching out to more deprived communities in regard to education around red flag symptoms and access to care. There is also the

language barrier in some parts of the country. I used to work in East London and the Bengali community presented very differently to the white population. So I think the Government's aspiration to have more people diagnosed with stage one and two, has to be a multi-pronged and much broader approach than just one area- it's about education for the public as well as having the people there to see them. The other thing that we need to bear in mind with regard to early diagnosis is we have got the Galleri test currently being tested in the NHS, so very soon we might have the facilities to do a blood test to pick up very early cancer, and then they'll be going to see Participant A, so she'll be getting more referrals based on the blood test rather than a GP referral. So we also need to think about how that might improve our diagnosis, but that it will also create pressures because clearly there's a false positive rate in that testing. So, how are we going to deal with a system that allows us to do a blood test in the over 50s and will pick up a portion that have cancer, but there will be patients that other things that cause the test to be positive, and then they've got to work through the system- that might come back under the innovation barrier. But for stage one and two, I think it's much more complicated about how we improve the rate. For instance with pancreatic cancer, they unfortunately all present very late unless something gets caught by chance on a CT scan. Ovarian cancer also presents late and there are no screens for that. So there are some cancers at the moment that are destined to present late. So it's a bit more complicated, that aspiration to diagnose patients with stage one and two much earlier. It's cancer dependent and there is much more feeding into that.

**Jane Dacre:** On the things that we can comment on is whether or not that target is appropriate and what I'm hearing is that it's not completely appropriate. Is that right?

**Participant F:** It should be much more tumour based.

**Jane Dacre:** It should be tumour based rather than a generic thing. Thank you.

**Participant A:** I just want to comment on a couple of points that were raised. So part of the referral criteria into my 'suspected cancer, but I don't know where' pathway, is a GP gut feeling, and that feeling that 'something bad is happening and I just need a hospital level clinician to have a second look at this patient in addition to what I've seen.' And the biggest risk factor I have in diagnosing people with cancer are those patients that have had a preceding two week wait in referral in the preceding year, and the GP is right, that patient has cancer. But in true orthopaedic style you've always got to x-ray the joint above and below the site of injury in order to find the cancer. So you cannot underestimate the quality and the intuition of our GP colleagues. We need to invest in our GP colleagues. I have, in my suspected cancer pathway, a GPSHO or BTS, that I'm training, as well as an oncologist, so that they can swing from 'I just treat cancer' to 'how difficult is it to actually diagnose cancer.' But I think going back to the point about regional variation, I think there is a regional variation in accessing the GP, and I think it'll be very interesting is there qualitative observational studies that have shown if, with the era of telephone consultations, there have been a significant volume to misdiagnosis that unfold down the line. Just as a personal plug, the 'Get it right' campaigns from Cancer Research, are always about rectal bleeding for bowel cancer, haematuria think of urological cancer, but a red flag that is very common, and in fact commons in most cancers is weight loss. I think that is an unsung red flag, and the general population need to know this in order to try and capture this discrete population.

**Jane Dacre:** Thank you. Does anyone else have anything to add in relation to the 28 day target and the distribution of stuff across the country?

**Participant D:** I just want to quickly say that I agree about the health inequalities, and I agree that we need to be more opportunistic, rather than reactive in how we approach people at risk. At the moment we've got so many opportunities, whether it's community pharmacy or social prescribers, for people who attend those sessions to be educated about screening. We underestimate how many people are not health literate, and they don't know what they need to do and hence they don't attend their screening. And also that preventative aspect, and this may come in the innovation bit and AI can help with that, but there are a collection of risk factors, and we can use personalised screening to prevent cancer.

**Jane Dacre:** Very good point on health inequality, and there is also an equality and diversity issue around people from different cultural groups presenting later, and that's come up in our other expert panel reviews. So thank you for pointing that out. Participant E is there anything to add about the distribution of radiotherapy equipment around the country.

**Participant E:** I think the interesting thing is the policy of not being able to have linear accelerators older than 10 years, has certainly meant that most of the equipment seems to have been, however I think there are often caveats that are involved with that. When one of our NHS England Linux was delivered it was on the basis that a perfectly good working one had to go out immediately, and we weren't allowed to keep it a service efficiency machine because that's not allowed anymore. So I think that the policy of new equipment is probably bringing up the bar. However, I'm in the South West and I think that naturally the big teaching hospitals, like the Christies and the Marsden, are always going to get the new whizzy kit, and it always feels like that have more stuff than us. But in particular, what I found very interesting with the formation of the South West Radiotherapy Network, was how incredibly difficult they were finding it to staff their departments, but also just getting basic equipment. Some of our colleagues in the peninsular trusts, can't actually get the equipment that they need to set the patients up on the bed. I know that much of our equipment has been procured through our hospital charity. It's not just the physical linear accelerators, but all the additional things that go with it. I think that there are regional disparities for sure.

**Jane Dacre:** So it's in the general stuff, not necessarily just the swanky kit.

**Participant E:** Yes, so you have the basic stuff, but there are software updates and lots of IGRT facilities. The radiotherapy equipment is insanely expensive, you know, the bits that go on the bed are very expensive.

**Jane Dacre:** Thank you.

**Participant A:** We've talked about gut feeling and what we think patients should come to a cancer diagnostic centre with, but actually should we put the shoe on the other foot and ask whether the patient thinks. And with the advent of the rapid diagnostic centres, should we be going even closer to the community that we serve. I suggested setting up an aisle in the local Asda, in order to access the community that would have a very high level of pathology- a mobile chest x-ray as they come through the door, because of the high population of smokers. I think we need to go to our local population, rather than have the local population trying to get to us. We know how difficult it is to park at a hospital, let alone to get a face-to-face appointment with a GP. So there should be more patient power to be able to access the help that they need.

**Jane Dacre:** Thank you, that's really helpful. I'm so sorry for the speed at which we're whistling through all of this stuff, and I appreciate that you're probably getting tired, but we've got one more section to go and that's about innovations. So one question that we have is whether there's an equal investment and drive to roll out innovations across the country, or is it patchy? Our other question is

around availability of innovations, and one thing that came up in our patient roundtable were that patients demanded to be transferred in order to get an innovative treatment that wasn't available in the first place they went to.

**Participant B:** I made the comments on genomics earlier, that still stands, and what I would say is that technically genomics is very equitable because the whole country is being divided into seven genomic hubs, and that is working very well. The danger is that with the lack of staffing and workforce that we've already alluded to, being equitable is very difficult because it's very similar to what has just been said about high tech imaging and treatment equipment. It will go to the best and biggest university-based centres, so your community hospital in the middle of East Anglia is unlikely to be able to provide the service that a big teaching hospital like Imperial can. At the moment that isn't happening, but there is a real danger of it happening, and now is the time to sort it out. Secondly, and this is something people may touch on, there is a widespread delusion that artificial intelligence will answer every single workforce problem that have every come about in the world of diagnostics. That we will not need a pathologist, or a radiologist, or a radiographer or a specialist analysis. We won't need anyone, and a magic machine will sort all of that out. That is an absolute delusion. It will be useful, but it will help people to do their job more efficiently rather than solve the problem. But that's held at very high level, that opinion.

**Jane Dacre:** I have heard lectures at a very high level espousing that particular myth, so I think that you're getting a lot of support around the room here.

**Participant B:** I will finish one final comment on AI. There is a genuinely held view that the more you speak to a company that has been heavily involved in it, DeepMind and things like that, they are inversely more excited about how it's going to solve all of the problems of pathology. Let me be clear, DeepMind are doing fantastic things but they follow the line of it will be supportive and make work much easier, and not that it will answer the problem. If you go to a start-up they will tell you that they'll have it diagnosing cancer in six weeks.

**Jane Dacre:** If I push you a little bit further, what about investment in all of this new stuff. You talked about the genomic hubs, has there been an appropriate investment in innovations.

**Participant B:** So, the genomics investment in the hubs has been good in terms of the actual kit to do the genomics testing. The problem is genomics testing kits are really sexy and gets you on the front pages of newspapers, and gets your face seen- if you happen to be somebody who needs that for various reasons- but the nitty gritty that other people have alluded to, things like transporting the tissue from the community hospital to the diagnostic hub, is not sexy. It costs money and that is very badly resourced. Pathologists drawing round the tissue to show you which bit needs doing is not resourced at all. The extra radiologists and radiographers needed to run the ultrasound guided clinic to get the piece of tissue, the extra tissue, from the breast biopsy is badly funded and not resourced. So the sexy bits of kit, have no problem at all with funding. However, the nitty-gritty is not funded at all. There's a lot of good working going into artificial intelligence, and it will make a difference, but it won't answer all of the problems.

**Participant D:** I would like to note the huge variation in the quality of radiotherapy; whether it's technology, like the linear accelerators themselves or the imaging and the technique that is used across the country. This means that often patients need to move to another area, that could be far away, to get the right treatment. Examples include stereotactic radiotherapy, which is more targeted, and right now there is a program to roll it out, but it is done very, very slowly. Proton therapy for some cranial tumours and paediatric tumours, is only available in two NHS trusts, and

otherwise you have to go privately. MRI based therapy, is again only provided privately and we know that those advanced technologies result in better outcomes.

**Jane Dacre:** So are there examples of patients needing to move to get those treatments?

**Participant D:** Yes, absolutely.

**Participant F:** So the question on whether innovation is available to all patients equally, and the clear answer is no, and there are several examples. We know that when new drugs are introduced that the uptake is patchy, and it varies how quickly new drugs are taken up. If you speak to pharma colleagues they can tell you where drugs are taken up very quickly, and where they're not, and that's very clear. I once heard a presentation on data from the CDF which showed the clear differences in the uptake of drugs. So even for drugs that are licensed and considered a standard of care there is a variation in uptake. There was an example recently where a drug company made a drug freely available to the NHS, under pre-reimbursement scheme, and the drug is licensed but has not yet gone through NICE. Trusts are struggling to make that drug available to patients. It improves survival and it's a drug that myself and colleagues would like to make available, but we are struggling to onboard it because of logistical issues. I know that some colleagues in other parts of the country have absorbed that and can do it. So there are clearly issues in taking up innovations. Sometimes because the doctors don't know about a new drug, but they are in the minority. Often it's capacity and getting that drug into the system. I know we're just speaking about England here, but we are the United Kingdom, we all pay one tax, but we've got national level postcode prescribing. Currently, my Scottish colleagues have got access to a drug called Tucatinib for breast cancer, which is an important drug, but I haven't got access to it in England. So if you are a Scottish breast cancer patient with a specific breast cancer type, you're doing very well. You've got an additional treatment available to you, but if you are an English or Welsh patient you don't have access to that agent currently. I know that we have devolved nations, but we still have one taxation system paying for the NHS. There is disparity even at a national level, and as an oncologist I find that unacceptable. Why is that happening? Why do we have three NICE? That takes three lots of experts, three lots of reviews, all the documents and all the economics. The system means that our patients suffer, and we have lumpy access to innovations across the Four Nations. And then within the actual nations themselves, the ability to deliver those treatments and the uptake can be variable. Just on other point about innovations, I think when we think about innovation, we shouldn't just think about new drugs or new ways of doing things, we should also look at new ways of doing the same thing. For instance, where I am based, some of my patients can be treated at their place of work and they don't have to come to the hospital. We go in with our nurses, treat them, and they stay at work. It means that they remain economically active. They don't have to leave work to come to the hospital, and it makes a big difference. Similarly, we're providing care in people's homes. All our clinics and colleagues are under great pressure, so we need where possible to move the care to other places. So we need to think about innovation, not only in terms of drugs and systems and blood tests- which we could talk about for hours- but actually in terms of how we do things differently. So more phone appointments, better pathways so that patients aren't seen in clinic for results tests and don't come to clinic to find out we haven't got their scan result. So it's about doing things differently, and that's why I think it's important to learn from our colleagues in the defence around how they posture things, and how they use people in different ways. So I plead that when we think about innovation, we don't just think about drugs, but also new ways of doing things in different places and having staff in different roles.

**Participant E:** I'd absolutely echo most of what Participant D was saying in terms of the disparity of techniques of radiotherapy across the country. But it's not necessarily just the big bits of equipment-

we're never going to have a proton therapy machine in every department- but stereostatic is a really interesting example because that was only commissioned in a number of centres and our centre- despite being quite a big centre- wasn't commissioned to do stereostatic, so we aren't able to offer it to our patients. I'm aware that other centres started to develop their stereostatic services before they were even commissioned, because they just wanted to get going with it. So I think that there is a huge problem with commissioning and tariffs, and I think we need to be very careful with tariffs moving forward because the hypofractionated radiotherapy and the stereotactic radiotherapy is coming to the fore, but we have to be careful that we don't paper fraction, and it takes longer to do a SABR patient. It takes a higher level of expertise for a radiographer. It's very technically difficult, as well as a huge pressure on staff delivering a large quantity to radiation in one go. So I think the whole package needs to be looked at very carefully with radiotherapy fractions, so that we don't just do a massive disservice. We've already moved many breast cancer patients to five fractions, and this could happen with prostate cancer as well. There are some huge benefits to that happening, but we need to make sure it's done safely and with the correct funding. My final point is on the radiotherapy networks. It will be very interesting to see how they develop in terms of evening out that disparity, but I think you're always going to have that problem where patients have to move. I can't offer brachytherapy at the moment to my patients, which means that hardly any of my patients get offered brachytherapy because they would then have to travel for treatment. There is evidence to say that a brachytherapy boost at the end of an external beam course of radiotherapy for some patients would give them a survival benefit, but very few patients get that where I am from because they are not willing to travel.

**Participant A:** I think on an even more basic level the NHS has so much data, but so little information. We can log-on to our Hotmail or Gmail accounts anywhere in the world, but yet if a patient has a CT scan 3 miles away in a different county, I will not have access to that scan. I will have to delay for the acquisition of those scans and import them to our system. I'm sure that we all have stories where patients have had blood tests at more local centres and we just can't access that. It all takes time and effort rather than just a seamless integration of one NHS technology. So I think before we start doing complex things, we need to fix the basic things first of all.

**Jane Dacre:** So the shiny things versus the important, but basic, stuff.

**Participant C:** I just want to talk about innovation in terms of quick wins as well as big wins. Picking up on what Participant F was saying about postcode prescribing, I think I know the drug that you're talking about and we were lucky enough to get that locally and I can't tell you the amount of work we had to do to get it. Never underestimate the patient conversation, because as soon as patients knew that we could access the drug I had a sudden influx of metastatic patients that want this drug, and therefore my caseload jumped up accordingly. The only time that I think it's important that people travel- though I don't think it ideal- is clinical trials. In metastatic disease we actively promote clinical trials and there are nuances in research- we've long moved away from one model fits all. The nuances of smaller trials means that you now have more of a larger portfolio with smaller numbers, and I think there is a need then to consolidate that so patients can access clinical trials in a bigger portfolio- and there may be a need to travel for that. I do think that there were few silver linings to COVID, the procrastination of processes in the NHS that can sometimes drive you doolally were suddenly able to change overnight. We'd been wanting to do video consultations for years, and suddenly within a week, I was able to attend anywhere and given a password. Instead of patients waiting for hours at a pharmacy hatch, we suddenly had a drive thru. So there are things that we absolutely do need to pick on. As I said, I'm a firm believer in empowering patients and during lockdown I wrote an app for my patients. I've shared it with my wider nursing community and they



can buy into the app, they just need to change local information about contact teams and hotline numbers. So with innovation, we need to be looking at things that patients can take into their own homes, rather than purely relying on the health care team in primary and secondary care. I think with innovation it's the quick things that can be done, and embracing those, as well as the bigger things like fancy kits and drugs. But again, never underestimate the patient conversation that goes on outside the hospital.

**Participant F:** I think the other thing that we can be really bad at is working together across the county, and you might be able to use your good offices for this. We've heard that some centres don't offer brachytherapy and some don't have SRS, so how do you get people to work closely, even if it's the other end of the country. So we have clear pathways, so that patients can travel from Gloucester to Bristol and have places to stay so that they don't relapse- which can cost the NHS more money or die earlier. How do we enable trusts to pair up to deliver innovations? We all have referral systems, but they're all fairly informal. How can you pair up oncology centres, to make sure that patients have a pathway to get that treatment that's not available locally, where they can have somewhere to stay and be able to get treatment. I remember when I was at a previous hospital, patients who were having a particular type of radiotherapy were provided rooms for them to stay in. So we need to look at how we do the simple things that mean patients can get access to innovations even if it means travelling. I think if we're looking at about improving the survival rate of patients, this is part of the piece.

**Jane Dacre:** We've got a few minutes left, and I know we have hands up, and I also wanted to hear a little bit about equality. In the patient roundtable, we had a comment from a patient around skin colour and being allowed onto a clinical trial.

**Participant D:** The remote patient monitoring aspect in oncology is really important; it is what sends patients into hospital unnecessarily. I think there are successful pilots in the country, so when a pilot is successful in one area why can't we just scale that up to other areas? There is technology out there which can prevent people coming into the hospital, and we know that lengthy stays results in people getting thrombosis and other hospital related infections. So that's my first point. One equality and diversity, I think that the way we design the trials needs to change. We are moving towards more real-world data, which means that we are gathering data from more diverse people. The trials that we have been doing up to now have only been applicable to certain white populations and they're not applicable to, for example, black and ethnic minorities. And we know that these populations have the worst outcomes in certain cancers, like breast cancer. So we need to wide the inclusion, and technology can help us do that. The remote technology can help educate patients and provide that information so that they can access those trials.

**Participant E:** Just a quick response to Participant F, I think the radiotherapy networks are key to that buddying up system, but they need funding. Patients can't afford to travel to different centres and that's where the lack of equity is. The only patients that get referred to Bristol are the ones that are going to be able to self-fund to get that there. And that's wrong.

**Jane Dacre:** We're going to be heading back soon but is there anything that you would like to add, or that I've missed.

**Participant F:** You mentioned ethnicity on access to trials.

**Jane Dacre:** One of the participants in the roundtable commented on not being able to access a trial because they had dark skin, I'm not sure what the trial was. It made us worry about whether there was reasonable access for people from different minority groups to clinical trials and to innovations.

**Participant E:** My previous role was in research, and I've never seen that as an exclusion criteria.

**Participant C:** I was going to say the same. I was a research nurse for 15 years and I've never seen an entry criteria, or exclusion criteria, that talks about skin colour.

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