

Written evidence submitted by Group 3 (ECS0040)

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

Group 3

Minesh Patel: We've got quite a good amount of time, so hopefully we can get through all of the different topics. Before I introduce the topics, and housekeeping about how we will run the discussion, I thought we could do some quite introductions. So if we just go round, and people can say who they are, and a bit about your specific role.

Participant A: Thank you. I'm a haematology clinical nurse specialist. I've been nursing for 12 years now, predominately in haematology for 10 years. I've also recently completed my nurse prescribing, and I currently do three myeloma nurse led clinics as I predominately specialist in myeloma patients.

Participant B: Hello. I'm a medical oncologist and I work in South West England. My specialist interests are urological malignancies, predominately bladder and prostate cancer, and I'm also an academic so I spend at least half a week doing early phase clinical trials.

Participant C: Good afternoon, everyone. I'm the Macmillan Lead Cancer Nurse at a London DGH, and we have about 2500 new cancer patients a year. I am responsible for all of the specialist nursing team, the service development, patient experience and all of the things that goes with delivering the service from the pointy ends, as I like to say- so I'm more focused from the diagnostic point than on the front end of the pathway.

Participant D: I'm a haematology consultant, I have been for about 10 years. I'm also the Clinical Director for Cancer Services of one of two recently formed units in a Trust in South East England.

Participant E: I'm a clinical oncologist based in Yorkshire. My clinical interests are in hepatic, biliary, and endocrine tumours, including thyroid, but I also have strong research interests.

Participant F: I'm a clinical oncologist based in London, I specialise in breast and thyroid cancers.

Participant G: I'm a Consultant Clinical Oncologist. I'm just newly appointed so I've been in post for a few months, and recently, towards the end of my training I worked with the Royal College of Radiologists and NHS England. It happened to be right at the peak of the pandemic, so I had a bit of background in what was going on behind the scenes, rather than on the frontline during that. I treat head, neck and lung cancers.

Minesh Patel: Thank you everyone for those introductions. We seem to have a real mix of experience and different roles, and people who specialise in different types of cancer, so hopefully that should make for a really interesting discussion. We've got four areas to cover, and the first is around workforce. Then we have living well with and beyond cancer, diagnostics and finally innovation and technology. I thought we could aim to spend 20 minutes on each topic. Starting off with workforce, which is obviously a big topic, we know that there were challenges prior to COVID which have been exacerbated due to the pandemic. I'd really like to understand about what your current experiences of staffing levels when it comes to providing cancer patients with quality, tailored care and support. The second key question in this topic is whether you feel people have access to the right professionals on the different points of their cancer journey. So, does anybody want to kick off on sharing their experiences, and what you think the current picture is like, as a front line professional?

Participant E: Frankly it's pretty dire at the moment, and I think that goes across the board. Certainly in non-surgical oncology, all professional groups are really, really stretched. Obviously, my personal experience is as consultant but in our region, it goes across nursing, therapists, radiographers, physicists and anybody else that we need. There are just not enough people to do the work. The workforce is pretty demoralised so not only are there not enough people already and huge numbers of vacancies, but people are leaving early because they're just totally demoralised with the way that things are going. I'm aware of numerous colleagues, who are considered to be national key opinion leaders in their field, who have retired in their fifties in the last year, because they've just had enough and they can't take it anymore. And numerous further colleague that I know are feeling like that. I'm sorry to start off on a negative, but things are pretty dire out there. I'm aware that in local services it's getting to the point where whole services... for example, at one local centre the whole breast cancer service is at risk because they just simply don't have consultants to lead the service anymore.

Minesh Patel: Thank you, and no apology needed. We want this to be a frank and open discussion about what's actually happening on the ground. What you've said echoes what we have heard here at Macmillan.

Participant C: Just to carry on from Participant E's sentiments. I've just moved into my 23rd year in cancer, and cancer has changed and it's unrecognisable from what it was when I started, but the delivery structure that is there hasn't actually changed that much. OK, we've introduced lots of new people and roles, but it hasn't necessarily kept pace with how oncology or how haemato-oncology has changed over that period of time. I think we've been very focused for the last 10-15 years or so on the national targets and structuring your teams around how you meet them and get people through the pathways, but I think that there hasn't been enough recognition of what else has changed. So if we look at the extra time that we're giving the patients, the new treatments that have come along, the way we're able to offer complex regimens and give people an opportunity to have further modalities of treatment- where 10 years ago we didn't have them on the table- then the resources haven't increased to meet the complexities and the offers that we're giving to patients. And all of the holistic and psycho-oncology and emotional and physical aspects of cancer have evolved for patients. If we want to be very crude and pick something like breast cancer, where 10 years ago metastatic patients had a median length of survival, which is far less that it is now. And when you pick up that group of patients now, and you're keeping them alive for 5-7 years longer than you may have done in the past, then you're introducing a whole complexity of needs for those patients, for everybody from consultants, to their CNSs, to their support workers, and there is also access to radiotherapy for those who might not have been around to have it in the past. And I'm not sure that the system recognises that. If we think about the last five years In particular, there's been a huge push towards the diagnostic part of the pathway, and I wholly support that move, but actually what we've done is we've picked the pool of people who currently exists and asked them to deal with that as well. So now you've got the number of people on the two-week referral going through the roof, it's going up and up each year, and we're asking the same people to see those patients at the point of access to the system. As a result you will proportionally get more diagnosed, not necessarily a higher rate of diagnosis, but proportionally more diagnosed, and you're then asking consultants to flip from the front end of the pathway to the back end of the pathway to treat those patients. You're just robbing Peter to pay Paul the whole time, rather than investing the system. And then locally for us, we become reliant on things like Macmillan or other charities to try and prop up a system, support which should actually be coming from central funds. You're having to beg and borrow and try to prove that patients have needs, and that you're trying to improve a service for patients. And all that happens is that every year you take a step backwards, and you're running to

the point that Participant E mentioned where a service can't meet the needs of the patients. Numbers are going up, resources are going down and you can't access the skills gap, so it becomes a service that is skeleton and sometimes not safe. Sometimes all that seems to matter is whether you met your monthly output; did you manage to meet the target rather than how good was the service that was offered and what was the quality like? So you might say 'great we met our targets for that month' but what does it really mean? I think all of those changes has really affected the quality of care that we're able to deliver to patients. I just think that we are asking more and more of the same pool of people and there is only going to be one result, and without going over what Participant E has said, but that's people leaving the service. So that would be my view of workforce. I'm just not sure how we get that message across to central government; that with cancer you can't have your cake and eat it. You want us to meet the targets, you want us to provide the best service in the world for patients with cancer, but if you're not prepared to invest in that you're not going to get it.

Minesh Patel: Thank you, that was really powerfully put and I was stuck by what you were saying about the focus on the targets and the impact that have can have on being able to provide good quality care for patients.

Participant G: I think what has really struck me, having recently started in my post in September, is that there is actually quite a lot of variation across the different subspecialities within cancer in terms of staffing. For example, I work in head and neck and lung cancer and we, in this relatively small centre that I work in, are very well-staffed in terms of consultants and specialists nurse backup. My workload is still heavy, but there are enough people to help spread the load and I think that patients get a good experience. But my colleagues who work in breast and prostate cancer, which has the biggest volume of patients, are really struggling with the lack of a single nurse specialist, for example, to help with the service. The consultant workforce is supported by locums, who can of course take time off whenever they want to with little notice and are very useful to help support the service. But it's not their job to be relied on into the long-term. There is such variation across the different cancer types that the quality of care that patient receive is so varied and I find that a real struggle to feel comfortable with, even though the area that I'm working in is very well supported. I feel very lucky, but actually it just doesn't feel equal and I'm sure that goes across different centres, as well as within centres.

Minesh Patel: Thank you for sharing that and it's helpful to hear about how it's manifesting itself across different cancer types.

Participant B: I would personally agree with everything that has been said. I know that the way that prostate cancer patients get treated in my centre, where we have larger numbers of staff doing it because we have larger numbers of patients, is different to how it's managed up the road in District General Hospitals. It's not because of the quality of the staff, it's about the number of staff and the flexibility in smaller units to deliver the same service. So I do think we get quite significant inequity in the way that we deliver what we would view as standard NICE approved treatment options. The other thing that stuck me about what people were saying is that you can measure most of this stuff, I mean my trust talks about having a 10% year on year increase in the number of doses of anti-cancer drugs that it gives, 10% every single year. It goes up again and again and again. You can measure how many nurse specialists there are, and how often they actually get to see their patients. But the driving metric is always- and there is no bad reason for it necessarily- how quickly can we diagnose people? How quickly can we get them onto their first treatment? But a lot of us are dealing with the second, third, fourth line of treatment and there aren't appropriate ways of measuring how that part of the pathway is working. So we're on the receiving end of cancer waiting times in that sense. You can predict some of it for the future as well, I think. We know where we would need to

be in five years' time, and we could do workforce planning for that. I'm not suggesting that people aren't doing that, but as we've come out of the pandemic, I think it's fair to say that that kind of national planning has, understandably, not been at the front of people's minds for the last couple of years. And I think a reassessment of services is appropriate in that sense.

Minesh Patel: Thanks, and the next section focuses on living well with cancer, and I think that's interesting in terms of the things that we measure as our successes when it comes to providing good cancer care.

Participant D: Really just to echo what many people have said. We are desperately short of staff across the entire range of different specialties and different roles. We're in a slightly odd position in that one of our hospitals links to a tertiary centre in the east, and the other hospital links to a tertiary centre in the west, so we have entirely different service provision in the same trust coming from each side, and neither do it particularly well. And we've been rather blocked from doing something about that. But our cancer centre is probably operating with about 40% of the oncologists that they actually need to provide the basic service, never mind a good service. And it's horrific. They're all working 14-15 PAs, often in compressed job plans because it's the only way that they can stay sane. They are seriously burnt out after COVID and are just trying to keep the ship from sinking. And you try to talk to some of them about how to improve things, and nobody has the headspace to even start to tackle that kind of thing. We've now got a bad reputation within oncology in general, so the registrars are asking not to be posted there. I've had consultants at the cancer centre telling the registrars not to apply for consultant posts, that would have taken some of the pressure off their own jobs, because they're so worried about them really. And that's happening everywhere. I don't want to go through every single role, but it's the same with the CNSs, and the leadership team, and everyone else all the way down. People don't get HNAs, the most basic things, it takes us 48 hours to answer phone calls from patients who are desperate to know stuff. And just to echo what the others said, often when the alliances come and speak to us about staffing, they talk to us about diagnoses and that completely ignores relapsing. As somebody said already, every single relapse increases the complexity of that patient, and how much time you need to spend with them, and they get frailer and frailer each time and that is not recognised. Thank you.

Minesh Patel: Thank you for sharing that and recognising what you were saying about the impact on cancer care with some of the pressures you can imagine. There are definitely some common themes emerging from this discussion which might not come as a surprise to anybody in this group.

Participant E: I just wanted to pick up on something that Participant B said about workforce planning. I think there's been an utter failure of workforce planning. The Royal College of Radiologists has, for many years, conducted an annual workforce census, which provides really high-quality data about where the workforce is at, how many vacancies centres are carrying, how many colleagues are likely to be retiring in the next few years. This has all been fed to decision makers over numerous years and nothing has been done about it. This August was the first year that we had an increase national trading numbers in clinical oncology, when it's been flagged for the best part of a decade that we're running out of people to do the work. It takes a minimum of five years to train a clinical oncologist. Starting this year is not going to solve the problem overnight. And the same goes in other staff groups. We've tried to do things differently, we've looked at our Skills Mix, we've looked to moving what have traditionally been considered medical roles out to other allied health professionals such as nurses, pharmacists, radiographers but there aren't any of those people either, to do those roles. So it just feels like we're spiralling into the abyss, really. It's really quite frightening; the total failure of workforce planning.

Minesh Patel: Sorry Participant E, from what you're saying then those gaps, in terms of provision is across different role types and across the board.

Participant E: Absolutely, there is not group that are flush with staff that you can look to plug gaps. Everybody is struggling.

Participant F: For the London point of view I would pretty much echo what everybody has said. I actually put my hand up to say exactly what Participant E said about workforce planning. For years now, we've been hearing that there's going to be a shortage of clinical oncologists, a report comes out every year saying that we're going to be this percentage down of clinical oncologists in five years. The most recent report, I believe, said that we would be down 25% for clinical oncologists. As Participant E said, this is the first year we've had an increase in the numbers. Locally, we've struggle with improving our skill mix compared to some of the other trusts that have done this really well, and there's almost been a resistant to diversify our skill mix. So this idea of having nurses and radiographers in a slightly different role, and taking on those jobs that were considered to be that of a doctor beforehand, I think other trusts have done a better job in pushing that. We've struggled in that, I have to say, in our local trust and that's been very much at the executive level. What everyone has said is exactly what I've found in both of my trusts regarding the increase in diagnostics, this move to early diagnosis, but no staff to actually do it. The new pathways that are being generated for trying to pick up cancers that are usually found quite late, so pancreatic and ovarian cancers, there are once again no staff to actually look after those pathways. So these are then being looked after by current staff members, or are usually falling onto acute oncology pathways which are themselves massively understaffed and are usually nursing led, which is not entirely fair when they are not necessarily trained for that. We've had a massive shortage not only in frontline staff- so radiographers, doctors, nurses- but the ancillary staff as well, for example, in administration. And given in an oncology appointment when you're consenting a patient, there is a lot of new administration work that you have to do, and the new IT systems that you have to deal with, it can take up to an hour, and we just don't have enough people to do it. It's going to get worse and worse. In the last six months I've seen a dramatic increase in the number of patients who we are having to see and consent for treatment. I don't know what the answer is, but it's going to be a difficult one.

Minesh Patel: Thank you. It's really helpful to hear you talk about the challenges with ancillary staff and how that has a knock-on effect.

Participant A: I wanted to echo what everyone else has been saying, that staffing is dire across the whole trust, I think particularly for nurses. In a ward there are two nurses covering a night shift of 32 patients which is diabolical really. It's unsafe. There's nothing we can do about it; we're trying to pull staff from here, there and everywhere to try and cover it. For cancer patients it's just not acceptable. If this was your family member, you'd want them to come in and have chemotherapy and be looked after properly by dedicated staff, who do not have low morale and who are not struggling to get through the day. I've not been nursing as long as some of the professionals here, but this is not an enjoyable workforce at the moment. The wards are that low in staff, that CNSs are being pulled in to work on the wards, to give the chemotherapy and to give the stem cell transplants. The takes us our of our CNS role, so the new cancer patients aren't meeting a CNS because we're not available as we're trying to keep the ground running. Just seeing about what has been said in the chat about the CNSs trying to capture the data, for our team we are scraping every bit of data that we can possibly get in our won nurse clinics to prove to higher management that there isn't enough of us. It's a continuous battle of trying to prove your work, which can be draining. We know as CNSs that we are very adaptable, we can go onto the ward and be a band 5, we can go and be an auxiliary if we need to be, but we can also go and be an ANP if we need to be, we can do nurse led clinics, we can do

prescribing- I myself can prescribe chemotherapy- so we are quite adaptable to the workforce. But sometimes we find that we're a little bit, not forgotten about, but may be relied on too much to fill the gaps here, there and everywhere. So that's from a nursing perspective.

Minesh Patel: It's really helpful, what you're saying about how when you're pulled into other stuff, then people might not have a CNS with them when they start treatment. Last week, when we had a similar discussion to this with people who either had a cancer diagnosis, or were recovering from a cancer diagnosis, and all the people in my group mentioned their relationship with their CNS. So it's incredibly important that people have that support.

Participant B: I just wanted to make the point that training programmes have taken something of a battering over the last couple of years. There are obviously good reasons for that, but I think the people that are coming through, the consultants that we'll try to appoint in the next year or two, will have had quite a strange and certainly unusual training programme. It won't have been normal. It's not entirely clear what impact that will have, but I think that the quality of training and the way that those staff are coming into new jobs needs some thought. The other thing that other people have touched on is the way that there is a tendency to use nurse specialists in evermore increasing and complex role. In my practice now we have nurse specialists prescribing and delivering a lot of the chemotherapy, and other anti-cancer drugs, and it's fantastic. They're really good and we couldn't run our clinic without them. But that's an organic evolution. We employed them because we needed someone to give the treatment, and it works really well, but you become critically dependent on the staff quite rapidly. We have designed our solution to that problem in our trust, and you get the sense that everyone is doing similar things across the country without a joined-up approach for how you have nurse prescribers for chemotherapy, for example, with standardised training and an understanding of what that role actually means. So I think some thought into that, and thinking about the roles that are actually being delivered now... a nurse specialist is a very diverse thing in terms of what they are delivering and I think people think about it as this homogenous route, when actually it can be all sort of different things. It should be thought of in more detail in that respect, because most of our services are propped up by it.

Minesh Patel: That's really helpful, thank you. What I'm taking away is that that flexibility of roles is definitely a useful thing, but problematic in other ways, and there is a challenge when you haven't got standardised roles. The management of staffing without definitions and clarity in terms of specific roles can be complex.

Participant D: Something that occurred to me recently is the difficulty in employing people from overseas. There is not enough people in this country to fill these roles, there are not enough training oncologists, not enough trained haematologists, not enough nurses etc. We went out to get a staff grade for haematology, and interviewed last February, and that person has still not come through yet because we are still going through sponsorship and the visa. And that is a year and that role has been sitting empty. And that is something that is desperately difficult to deal with when we've got somebody who is entirely capable of doing the job. And thank goodness that they're so motivated, and have hung around for an entire year, and hopefully she'll be arriving within the next 8 weeks. But that's ridiculous.

Minesh Patel: Thank you, and yes, another pressure overlaid on top of everything else that's happening at the moment.

Participant E: I just wanted to echo that point. The issue is not, I don't think, lack of funding and we have funded vacant consultant points all around the country. It's getting there. There are just not

enough bodies to fill them. It's exactly as Participant D said, we've had numerous overseas colleagues interested in doing the job, but it's nigh impossible to get them into the country now. Part of that has clearly been exacerbated by COVID, and the complexities there, but there are other issues around securing visas and other complications that have made it increasingly difficult to get those colleagues who are motivated and want to come and work with us into the country. For a number of colleagues it has taken a year, from accepting a job at interview, to actually arriving.

Minesh Patel: Wow, that's staggering that it's taken that long, and perhaps naively I didn't appreciate just how long some of these waiting times are to get people into posts.

Participant C: I just wanted to pick up two things. One was on Participant B's points about the use of other professionals to manage the workload. I have nearly 40 CNSs to report to me, and I will champion all of them to advance their practice and their careers in nursing, but I think we have to be really careful that it doesn't come at a cost. It's fine when it's within scope. Our structure, and how we manage patients, has always had the clinical oncology team working with those patients, and we want to be 100% clear that the nursing roles in these teams cannot come at the costs of the patient, and the experience and knowledge that those nurses can offer patients. I'm saying this as a nurse, I do champion the nurses role, but it can't be just to plug a hole, it's got to be used and utilised correctly, and work as a blended part of that team and not something that's replacing the type of experience and resources that you need to make the decisions for the patients all of the time. The second was what Participant E slightly alluded to, and we may discuss this a bit more later, but I have a big concern around education of the cancer workforce. There's been a huge shift in the last years with money being pushed towards Health Education England and letting them come up with ideas about how we might be able to train up the NHS workforce. And because that has happened, it's taken the focus a little away from cancer. So where had been able to work closely with academic providers to provide baseboard cancer education, and had contracts with them to fund education, the pot has now primarily gone over to HEE now, and it looks like it will carry on life that for a while, so it's much more difficult to maintain that relationship. As an example, there is a huge emphasis now on apprenticeships, where nurses can do an apprenticeship towards becoming an advanced nurse practitioner, which is a good idea, but because of the way it's been structured by HEE, it's really hard to do bespoke cancer apprenticeships. So you can do a nursing apprenticeship, which for me has a risk of pushing a nurse out the other end, who can sit and to an FTS clinic of 200 patients a month, and that might be an attractive pathway for CNSs because they see an endpoint in becoming an AMP. But I want my nurses here who have got that experience, and are already working in the complexity of diagnosed patients, to advance their practice and I'm not sure that the system has been rejigged to cater for that group of people. I think it's catering better maybe for nurses in general, but I think cancer nursing, and cancer workforce in general, has been lost in that shift.

Minesh Patel: Thank you, some really interesting points around HEE. I'm going to move us on now to the next section, which we've started to touch on a little bit. It's all about when people are being treated for cancer, the quality of their care and making sure that people have the right support to have a good experience, both during their cancer treatment but beyond that as well- if they move on to recovery from their cancer. A few of you have started to touch on this a little bit, talking about how challenges with workforce can affect the quality of care that you can give. A few of you mentioned examples around delivering health needs assessments, so this is just an opportunity to explore some of this in a bit more detail. So the first question is, in your experience that cancer patients receive a personalised care plan following their diagnosis? We're keen to get thoughts on that, and if people aren't getting a personalised care plan, what are the challenges behind that.

Obviously workforce is a big one, and the capacity and bandwidth of teams, but are there other factors that might be causing people to not get that quality care and that personalised level of care.

Participant C: I don't want to hog this, I'm sorry, but it was in my head from the last question so I thought I will just keep going with it. I think it's really really difficult to have a non-discriminatory process for doing these personalised care planning for patients, because it's so reliant on the workforce that you have within an individual tumour site, and sometimes in an individual hospital- so a centre might have a very specialised workforce for a group of patients and they are able to deliver this. I absolutely, hand on heart, see that the staff are accessing the patients to try and deliver this. There is a big issue with timing, especially at the very early part of the pathway. So we would have 90% of our interactions with patients being offered an HNA happen quite close to the diagnostic consultation, where they've been given their diagnosis and/or their treatment plan. But what happens in a lot of cases, almost 65% of cases in my trust, is that patients do not identify needs because they don't know what they are. And because the resources are so tight, that might be the only interaction that the CNS, or one of the team, has with the patient before they go ahead and start the treatment. I've got an experience in chemotherapy, and like Participant A, I sometimes have to have to roll up my sleeves and go and help if things are bad, like during COVID. Again, if I use the breast patient analogy, I'll go and sit with a breast patient having their first course of chemotherapy, and half of the conversation would be dealing with their needs. And I will go back and look at the last months breast HNA completion rates and see if we were compliant with our targets, and how many of those patients went on to identify some issues and needed a personalised care plan drawn up for them. And actually it might be sitting at around 15-20%, and that doesn't sit right for me, when I'm sitting with the patients and knowing that at least 60% of the patients that I'm sitting with are raising issues with me. So it all boils down to the timing. Again, it's a bit driven by targets because the framework for delivering path guide care is that it should be done within 31 days of a diagnosis, so the staff aren't getting an opportunity to find another point on the pathway, where they can interact and maybe identify the needs at that point in time. It's also a bit of a blanket approach and it might not, for example, be appropriate in skin cancer. We have a lot of skin cancer patients who don't go down an oncological line, who have an excision biopsy, they get their results back and they're told 'yes it was skin cancer, and we will see you again in three months time.' There is no interaction with that patient, but there's still an expectation that they will get an offer of some form, but even if you do get the opportunity to offer the patient something, the majority of them will not identify a need for you to go on to complete a care plan. Because there is so much focus on trying to do this work, sometimes I think the most important bits, looking after patient health and wellbeing and the opportunity to do these assessments midway through the treatment to see where they're at, gets lost because you have to choose the bits that you might want to deliver in a consistent way. There aren't enough opportunities to interact with the patient. There is absolutely no slack in the system to be able to create another opportunity to do this work on a separate occasion. I don't think it's consistent, it's certainly not in my organisation. Sometimes the compliance is good, but I'm not sure it's actually affecting the patient's quality of care and identifying their needs at the right time.

Minesh Patel: Thank you, really helpful opening remarks to this section. I didn't fully appreciate that timing point and how that can affect the quality of that assessment, and how far and meaningful is it, if it is carried out at an earlier point when somebody is less aware of their needs? Thank you for sharing that, and there were definitely a few nods when you were talking.

Participant F: A slightly different point, and it may be slightly different to what you're asking so apologies for that that. But I've found that the patients who are initially diagnosed within the

standard pathway, take breast as an example, either self-presenting to the GP or being referred from the GP, their pathway is very defined, and they get a proper care path and a proper care plan. Where we find that it's lacked a little bit, I think, is in those patients who get a recurrence or a relapse. Those patients don't always necessarily get treated, or get exactly the same plan, as they would have done when they were initially diagnosed. Part of that might be down the pathway, and also the waiting time, so it's focused on that initial two-week pathway, and then the diagnostic pathway after that. A lot of our nursing staff obviously spend a lot of time within the surgical clinics dealing with that workload and getting them through, and then seeing them thereafter. Those patients who then relapse- breast obviously get quite a lot of relapses, more so than thyroid patients-will just see me. There may be a nurse there, there may not. But they don't always necessarily get the care plan and the support that they should do, when they are first diagnosed with a metastatic, or if found local, and I'm taking steps to try and improve that. And then the next step, where they do start to get a proper care plan is when they're starting to approach community, end of life hospice teams, and that's when we start to involve those community teams and we're looking at advanced care planning. So it feels that there is a little gap in the middle; you've got that initial diagnosis, the end of life bit, but that relapse bit in the middle isn't always covered quite as well.

Participant E: I'm going to make a very similar point to Participant F, in that the development of a personal care plan does seem very front loaded. It happens at diagnosis, and as Participant B said, often patients don't necessarily know what their needs are at the point, because it's all so new to them. And it doesn't get revisited. Things change, patients relapse, and it's not predictable. Having a care plan that you set up at the point of diagnosis, suggests that you can predict what's going to happen and clearly you can't. My experience is that patients often run into further problems, things change all the time and they never go as you would want them to go. And accessing support is difficult when they're in the middle of the pathway. The incentives are to do these assessments at diagnosis, but the support is not there later on. Your second question was on the wider team, and we I think we certainly have big issues accessing appropriate support from other teams. My biggest bug-bear, is around access to dietetic support, which seems to be phenomenally difficult, and it's hard getting funding for those posts and justifying those posts. For a lot of my patients getting appropriate dietetic support and good nutrition probably makes more difference to them than a lot of the chemotherapy that I can throw at them, that frankly just makes them sick. And making arguments to get that sort of input, which you know could make such a big difference to a group of patients, just seems almost impossible to negotiate.

Minesh Patel: Thank you, and on that second question, people should feel free to come in on that as well, about how different teams are working, or the different challenges in getting the work joined up, to provide the right support for patients.

Participant D: It sounds like you guys are actually all doing this a lot better than we do, to be honest. I'm not sure I know the numbers off the top of my head for our cancer services across the board, but I know that in haematology HNAs are done in less than 50% of people at all, nevermind repeated HNAs. It's really just because we do not have the staff to do it. Up until very recently we had a single CNS covering 6000 patients in our clinic, that's it, so that person was covering in-patients all the rest, and we are slowly but surely trying to work on that. I do agree that access to other services is very, very scatty, and it's virtually always a bolt-on to their normal day jobs, so dietetics, physiotherapy. One of our particular problems down here is psychological support for cancer patients. There is none, absolutely zero, and it's something that we have gone round and round on for 10 years, and we still have not been able to resolve it- mainly because of the state of psychiatric support in the

community and how poorly resourced they are. So it's very difficult to access any of these things. Our patients don't get a written care plan in haematology, and it was actually a year ago that I managed to convince the trust that everyone should have a letter sent to them after the clinic. Prior to that they were getting no written information whatsoever, apart from the bits and bobs that we give them for chemotherapy, but I'm afraid it was never in a more joined up fashion than that.

Minesh Patel: Thanks, and those numbers that one CNS nurse was supporting is staggering. My mind was slightly blown by that.

Participant A: Just to pick up on the point about the personal care plan, I think it is very much a team effort and I think a lot of it falls back on the CNSs. Having a good CNS team can help be the backbone for the consultants. For us, we've now made our team disease specific CNSs, and this allows my to focus on one speciality rather than all haematology patients. So I focus on myeloma patients, we have a lymphoid, an AML CNS and a non-malignant CNS- we've got about six in our team now. We've also got a band 6 for work process development, in case anybody goes off sick or are going towards retirement, so that we can train them up to step in our role. I think that in order to provide a personal care plan the holistic needs assessment needs to be done at the point of diagnosis, and like everybody has rightly said, that is does change as they go through their treatment. So what we tend to do in our trust is have a follow up holistic needs assessment with the CNSs, where we have our own clinic code and we phone these patients just to check-in with them, see how they're doing, and try and capture any holistic needs that they have from that point, and then try and support them the best we can. The services are limited. We don't really have a psychological service and there is a 6-7 month waiting list for cancer patients, and it's not fair if that's your relative and they're waiting for some psychological support. We also don't really have physiotherapists, as an outpatient service, to support myeloma patients, and dietetics is again a problem. These can help patients stay on treatment, if they're able to have this extra support, and it's all about looking at the holistic needs of patients as a whole picture and having each of these support mechanisms in place, like psychological support, physiotherapy etc. That helps cancer patients carry on their treatment pathway without as much of a bumpy ride. It also helps to manage their treatment better, without having to stop treatment because of external things like they're not eating well or mentally they're struggling. So these are the sort of things that we really need to consider as part of our service. What we do have in our myeloma clinic is access to a renal consultant, who is in our clinic weekly for our myeloma patients, as part of a joint team effort. We also have a palliative care consultant, he was in-person in the clinic, but he's not more virtual because of COVID. We also have a nurse prescriber and a pharmacist non- medical prescriber in our clinic. So we have had to grow that over a few years, and the only way that we've been able to do that is by the CNS team using clinic codes, showing our activity and generating income- banging the drum really. So that's what I wanted to mention about how we look in haematology, and the lack of support services. Something that is really utilised over in Nottingham is something called the Maggie's Centre. We don't have one of those here, and I don't know why because it would be absolutely amazing, but having holistic therapies for cancer patients is just brilliant. It something that would help them mentally and help them to stay on treatment. It's an external thing that higher management don't really prioritise, but if you look at the greater picture this would make their care more personalised.

Minesh Patel: Thank you. Really insightful and it's great to hear about how it's working with your area, and the follow up checks for patients sound great.

Participant G: Thanks. I'm echoing what everyone else has said really, but I remember something that patient said when they were giving feedback about the service that she'd received- she was a young breast cancer patient, who had had all of her curative treatment and then had a relapse not

long afterwards, so she'd been through the 'we're going to cure you approach, and then the I'm sorry this is incurable approach.' One of the things that she said, which struck me, was they we're really good at explaining the treatments you're going to give and the side effects, but what we're really bad at is saying how we're going to look after them and how we're going to manage the side effects. And it really struck me that we do spend a lot of time talking to people, and trying to prepare them for what's ahead when they start on their treatment journey, and having that personal care plan at the start does go some way to addressing that. But it's not useful, and it's not going to be helpful, to have that personal care plan if you then can't back it up with 'this is how we're going to manage it, and if you tell us what your needs are this is how we'll help you to manage those needs.' I think the lack of numbers in those allied health professions to help patients manage either the side effects of treatment, or to maintain good nutrition to help them to tolerate their treatment, or help them to cope psychologically, is affecting patient care. If we can't offer them help to get through it, then actually the use of that personal care plan at the start is quite limited. I think, again, it comes back to what I was saying at the start about how there is such variation, between subspecialties in oncology as well as between different centres and regionally around the country. We've got a psychologist here. We have a dietitian here, but the dietitian here can only treat head and neck cancer patients because they have the greatest need from a dietetic point of view, and that's what she's appointed to do. But when I see a patient in my clinic with head and neck cancer who I can refer to the dietitian, and then the next patient I see is a lung cancer patient who has the same needs, but she can't see them, it feels very difficult and very unequal. Again, we've got some patients who are really struggling psychologically, who we prioritise understandably to see our psychologist, but he's a sole practitioner. I might have somebody come to the clinic who is really struggling, an hour after I've received an email saying 'Thank you for referring Patient A, I can't accept anymore patients for now' and I really struggle with that. Whilst the personal care plan is an ideal, and it's useful for the patients, it almost feels like we do them a disservice if we ask them what they need and then we can't provide it.

Minesh Patel: Thank you. So a lot of this is leading back to what we were discussing earlier about the capacity of staff, and making sure that there are enough resources to deliver the care that we want for our patients.

Participant B: This is possible just echoing to a degree, but I think part of this is about adequate staffing, but some of it is also about the requirements about curative treatment being relatively easy to deliver. So if you have a care plan that says 'you're going to be seen in this amount of time, you're going to get a biopsy in that amount of time, and your treatment will start by this point, and then you'll have follow-up after that,' and we have targets enforcing a lot of that, so it's a relatively easy thing to write and aim to stick to. It becomes much more diffuse if you're talking about a patient that is three years down the line and they're relapsed, and the aims of the treatment are now palliative. They've got lots of needs, in my practise it'll be around incontinence and sexual function, and I think that very often we don't have any drivers that forces the provision of those aspects of care, in the way that a person has to have their scans done in a certain amount of time where they were first diagnosed. So I think that some of it is about the drivers in place that would push adequate staffing if you had to deliver it. The effects of a lot of this is the different status that palliative care services, such as hospice are, have compared to the rest of the NHS, and the fact that there is inadequate provision for palliative care, and that it's sits in this slightly odd session outside of the trust, makes it hard to commit to providing appropriate care in that setting, once patients get to that point. It's a particular problem trying to deliver what we all think is required.

Minesh Patel: Thank you, and some of what you were saying there echoes what Participant F was saying about some of the challenges that can happen if somebody relapses. Thank you for sharing that.

Participant C: I know we need to move onto the next bit, but just quickly. I mentioned earlier about the need for central government to be involved, but it strikes me from what Participant A was saying, and from what other people were saying in the chat, about what they can't get access to, and for me trying to get the commissioning bodies to engage on how they might fund us for those services has been absolutely impossible. The trust are telling us 'sorry have a look in the bank, there's not a penny to be had to pay for it, because the commissioners won't commission this type or work.' They want to commission something that's deliverable in terms of targets. You can't have 900 quality targets; you can only have two or three- they won't let us have all the ones we want to deliver care for patients. They want to try and get some kind of numeration. I don't know what it's like in the rest of the country, but as London moved towards integrated care systems for managing patients, then it's actually diluted, even more, the access you get to be able to influence how things might be commissioned. I don't know in what direction that needs to come from; whether it goes up to central government to come back down, or whether we need to go through the ICSs and influence up. I'm not quite sure, but it's going to be really difficult to improve all of these elements that are not being met, until there's a sector by sector approach, or a region by region approach, to say 'this is what we want to get right for our local population, we recognise that there is the gap and it needs to be invested in.' I do think that the will and the desire to do all of these things for patients is there, it's just the funding and the resources that is not.

Minesh Patel: Thank you, and I agree with what you said there about there being a will but making sure that we've got the right things in terms of funding and making sure that people have the right incentives and motivations. I'll now move us onto the next section, which all around diagnosis. We've touched upon this in the sense that a lot of the focus is on the point of diagnosis, and that can have an effect in terms of quality of care and the supported provided in the cancer pathway. The first question in this section is around the government aims to achieve a 28 day target from screening to diagnosis and to diagnose a higher percentage of patients at stage one or two. Do you feel that this target is being met? The second question is around diagnostics equipment, and whether that is equally distributed and accessible across the country. So two quite specific questions there, but again we're asking for reflections on how you feel the diagnosis part of the pathways is working for your specific areas.

Participant E: I guess this has all been turned upside down by the pandemic, hasn't it? I mean there was a significant period of time when very little screening was happening at all, and diagnostic services were very tricky, and we're still catching up on that. So taking a longer-term view on this is difficult because it has been an exceptional two years. I think most of the time we're nowhere near achieving the 28-day target between screening and diagnosis. And my experience on the ground is that we're not seeing more stage one or two cancers, we're seeing more advanced disease that's more complex to treat and that get more and more difficult- I think that's a pandemic effect. In terms of access to diagnostic equipment, I think it is variable across the country, and we are poorly resourced compared to the rest of the world. I was looking at some data from the OECD before the meeting started, the most recent recorded data is from 2017 but I don't imagine things have gotten any better, but at that stage the UK had 9 CT scanners per a million population, where there average in Europe is about 20 and in the States it was 43. Similarly for MRI, we had 7 per million of the population in the UK, but the European average is about twice that at 15 and in the USA it's 38. So across the UK we are badly under resourced in terms of diagnostic equipment, and there is

variability across the piece as well. Having done some work around trying to get access to radiology investigations for clinical trials, the CT scanners in my centre are the busiest in the country in terms of number of scans undertaken per scanner, per year. So there is inequality from a pretty poor baseline.

Participant B: I was just going to make note of what I think is fairly well established; that there is a national shortage of radiographers. So you can do all the scanning you like, but there are just not enough radiologists. Certainly in my trust we're doing a lot of outsourcing of reporting, which is a poor use of money, because the quality of the reports that come back are simply not as good as when we get our own radiologists to do it and that's inefficient. Interestingly, I got involved in some work around bladder cancer diagnostic timelines for NHS England, and the numbers are not great in terms of 28 day timelines. They were getting worse before the pandemic, they've carried on going down since then, so it's not solely due to the pandemic, it was going downhill beforehand. We're now going to try and catch up, which is clearly going to be difficult. It's probably about machinery, but it's also about having enough people to actually report the scans. We're also doing more complex imaging, so if you decided to do a PET scan, or if you've done the CT scan that five years ago wouldn't have happened, that adds to the timeline, it adds to the cost, it adds to the workloads on the radiologists. So all of that adds to the increasing complexity of what you've actually got to do in order to get the diagnosis.

Minesh Patel: Participant B, just to ask a quick follow up. Is it the complexity of doing those tests and the lack of radiologists which were contributing to the drop in levels pre-pandemic, or are there other factors at play?

Participant B: Inevitably it's complex. I don't know what drives the lack of radiologists particularly, I don't know that the underlying reason for that is. Again, if we use bladder cancer as an example, we seem to need to do PET scans now in a third of patients, but we didn't do that five years ago. So again it's this idea that you've got more and more work to do just to actually get to the same point of, here is the diagnosis.

Participant D: I certainly know that we are not meeting our 28 day targets. We are definitely improving quite rapidly, but we're way off, and it's variable within the specialties as well. So in haematology we are particularly bad, mainly because we are entirely reliant on others to deal with our diagnostics. The one thing that want to say is that I think 28 day target is exactly the right thing to be focusing on, I think people should be told that they have cancer within 28 days, but we are massively hindered by the two week target because of that. We should ideally scrap the two week target and move to the 28 day target, but of course the two week target is enshrined in law and therefore needs to be repealed before we can focus on 28 day. If I get a haematology referral for someone with limp and bumps I've got to see them within two weeks, and because of capacity it will be the end of the two weeks, I've then got to refer them to an ENT doctor or radiology doctor to get a biopsy done which is another two weeks before they can be seen and get the biopsy done. And then there is a fortnight for the report to come through, and that's the points where I know I need to start doing some staging work up because you can't be sure until then. It's little easier, if you've got a stipulated lung lesion because you know that person is probably going to have lung cancer and you can get on with all those other bits and bobs, but if you don't know what they've got to begin with then it's nigh on impossible to reach those targets. But the two-week target adds a delay at the beginning, certainly for our pathways, so I think that's important. We're fortunate that we're very close to launching digital pathology across the county, which will be a big game-changer in terms of turning histology around a bit faster and improving our workforce. But scanners, as everyone has echoed, is abysmal. We don't have enough CT time, we certainly don't have enough MRIs, our trust

worked out that we need five MRI scanners for one hospital and we currently have one and bit because it's broken most of the time. There is nowhere to build them, and there is no funding to build them either, so you're often relying on charities to come up with enough money, and it's £50 million for one scanner, nevermind finding the space to put it. I was really surprised when I started going to some of the radiology meetings, that there is not renewal fund in most trusts, so when scanners reach the end of their life there is not a pot of money waiting to replace it. You know it's going to break in 15 years, but you've just got to start from scratch. It doesn't make any sense.

Minesh Patel: Thank you and it's really good to get your views on those targets. At Macmillan we do a lot of work on their progress, so it's good to understand how they can potentially be hampering the ability to deliver effective care and treatment and diagnosis.

Participant B: I echo Participant D in that there has been a rapid improvement across my own trust, and from what I can see across London in general towards this. And that's probably a good thing in terms of the peak that we saw in the number of referrals since the lockdowns ended last summer, but I do think that it comes at a cost. I think patients are being pushed through it very quickly and not being afforded the right time to have a conversation, because it's such a huge push to get that answer out by day 28- some opportunities are lost to have a decent conversation with patients. I also think that there are wider ramifications of this target. I think that we are robbing Peter to pay Paul and that the succession plans, and later stages of the pathway are being impacted. So in my trust there has been alliance funding to try and improve the speed of diagnosis by loading the front end of the pathway. The posts are coming out at quite senior bands, band 7 and 8, and that probably doesn't reflect the work that they're doing if you compare them to a CNS working in complex cancer, and so those in the talent pool who could end up as good cancer CNSs are attracted to those front-end jobs. There are two issues with that; nearly all of the investments are going into the front end of the pathway, and because that investment is coming into the front end of the pathway it's robbing the talent from the pool who would eventually maybe become your cancer nurses. Now there is nothing to say that a person wouldn't do a job in the front end of the pathway, develop those interests and move into a CNS post in the future, but right now I think that staffing is a consequence of this rapid increase in being able to meet this target. I think sometimes that we have let our standard slip, because of the pressure that comes from services to try and get this target met. On the second part of your question, I think there is a really inequitable distribution of equipment. Sometimes in London, if a trust is doing really well in terms of a target, suddenly a £1 million or £5million appears from the alliance, or from NHS England to try and get more diagnostic equipment, because there is a perception that they're doing well. So you give them more equipment to get more patients through the system, but the hospital down the road that is struggling and actually needs the investment is ignored. They're told that you need to copy what the hospital down the road is doing, because they're able to meet their targets, rather than asking what the problem is. That hospital might have old equipment that is breaking down all the time and need investment. I can only speak for my region, but there's a real inequitable distribution of equipment, and as Participant D, said there is a huge reliance on people raising their own capital through charities.

Participant G: I just wanted to follow on from a point that Participant D brought up. We all know about equipment and radiology issues, but pathology is a real problem. From what I see, the patients aren't referred for the cancers that I treat, but with lung cancer particularly we are having in-house histopathologists make the diagnosis and then we're outsourcing the biopsies for drug sensitivity testing and next-generation sequencing. I don't know what that's happening. I don't know how the decisions are made about where these samples are sent, and they just universally seem to take weeks and weeks and weeks. We started a policy that we wouldn't see patients in oncology unless

they had all of their drug sensitivity testing results back, because it's the difference between having a conversations about chemotherapy and immunotherapy versus an oral tablet therapy. They're completely different conversations, the patients are overwhelmed. You can't give them an either/or, you need to them when they have all of their results and tell them what they're management plan is. But that means delaying seeing the patients, and giving them a treatment plan, sometimes for up to four weeks at a time. And the pathologists are tearing their hair out because they're desperate to help, and thy can't. So it's maybe not just an equipment issue, but it's a service issue, and I think it's just important to note that alongside the well document radiology issues, when it comes to diagnostics pathology workforce and equipment is also a big problem and it's causing delays for patients.

Participant D: just to come back on what Participant G said, we've created the genomic hubs now to try and standardise genetic testing for all of the different tumours, but they are massively overwhelmed. They weren't ready. They were launched and we were told that we have to send everything to them, and that it would all be wonderful, and now they're pushing all of the work back to us because that can't do it really. It is coming up, and it will all come online, especially when they standardise all the panels and get high through-put genetic testing that will really turn things around quickly, but every time you have to send something out of your hospital you add time. And then you don't have enough admin time for when it comes back, and we don't have electronic reporting properly set up. Then you start talking about all the different limbs within your cancer network, and how all of those get the results back again, so it really becomes difficult, and it adds delays.

Minesh Patel: So we'll move on now to the final stretch, and the last section is on innovation and technology. Some of this segues into what we were talking about just now in terms of the ability to access different types of kit across the country. So the first question is around your views on whether you think investment roll into innovative technologies and therapies is equal across the country. And then the second one is whether there's a good balance between supporting innovative technologies and treatment and then providing the core of cancer services and making sure that people can ultimately live well with their cancer diagnosis.

Participant E: With regards to the second question, I personally would argue that providing innovative technologies and treatments is part of core cancer services. I think may of use would aspire for that to be a core part of what we do, and there has been a long history in oncology of being very research and evidence driven, contributing lots of patients to clinical trials and recognising that often is the best treatment for patients to take part in the trial because there's uncertainty about the best way to do things, or because it means they have access to something novel that may well be better. So I think historically, we've taken the view that accessing these innovative things and new treatments is a core part of what we do. But I think that, ironically, that's becoming harder to do. Through the pandemic, and the success of COVID related research, I think that the health system generally is recognising, more than ever, the importance of research and that clinical trials and research should be a core part of NHS business. But I think ironically in cancer services, it becoming more difficult, because of a lot of the challenges we've already discussed: so the workforce isn't there, it takes more time to do new things and we don't have time to do that. Often it means having additional investigations, more CT scans, and we don't have the scanners to do that. So we should be doing these things, in the past we have done these things, but it's becoming more and more difficult to do that. We know that there is massive amounts of evidence that patients who are managed in research active centres have better outcomes, and we know we need to be doing this, but it's becoming harder and harder to maintain.

Participant D: I think when it comes to access to treatment, from the chemotherapy point of view generally everybody gets access to everything, certainly in my experience in haematology, because of the CDF. How stringently the CDF is applied, and your pharmacist applies them, might vary, so it can be a bit trickier if someone really needs to tow the lines with the rules- not that we don't. I think access to trials is quite variable as well. We're very good at recruiting into trials and we have a number of good centres around us. What would be helpful would be a more centralised list of trials, because it can be quite difficult, especially if you're trying to access a phase one or two trial for rare stuff like leukaemia, trying to find colleagues who are running these trails at that point in time that they are recruiting. A trials matching service would be good. I'm sure one of the others will talk about this better than I can, but radiotherapy would probably be the biggest inequality in terms of access to radiotherapy and radiotherapy techniques. I know that our cancer service just has a basic radiotherapy machine and therefore cannot do all of the fancy things that are done elsewhere. On the second question I think the one thing that none of us do especially well, are late effects and late effects clinics, which I don't think are done very consistently.

Participant F: My point was going to be largely around radiotherapy. So one example, is that research has absolutely revolutionised radiotherapy in say breast cancer, because in COVID it was fast forwarded where we managed to from three weeks of radiotherapy down to one week. That pretty much allowed us to keep treating where we wouldn't have been able to, given COVID levels, staffing levels, and patients having to stop their treatments. Now we can just do it one week. That's a UK based trial and that has changed breast cancer treatment in this country. SABR, whether that's lung SABR or oligometastatic SABR, that's taken way too long to leave designated centres, and come out into other big centres or even smaller radiotherapy centres. We all know what to do, we're all clinical oncologists, we've all been through the training, we just need extra training to be able to do it. Now that requires NHS England to allow it to actually roll out to other centres, it way too long for them to do that, and then to provide that training. And then the other difficulty is job planning within that, because it's not quick. It takes a lot of oncologists or consultant radiologist time to do that training and getting the time to do that is very difficult. It would be great to roll out more SABR, in more centres, I don't know if other people agree with that. I'm quite lucky in that I work in London, and I have easy access to Queen Square and Barts and I can refer people to gamma knife quite easily, but I'm sure that if the patients could be treated at a local centre for something like a small MET within their brain that would be preferable. Why can't it be done at a local centre? I think it's taking too long to get those newer techniques into departments, and we've really had to fight to get it. I'm not sure if that's the same for other clinical oncologists on the call.

Participant E: I very much agree with Participant F, and I think there has been a sense of wanting to control. My perception is that there is a lack of understanding from those who have control about what we're trying to do. As Participant E said, as clinical oncologists we're trained to deliver technical radiotherapy and there's really no reason why we shouldn't be moving forward, and rolling some of these things out to other centres more quickly, but there has been control over that. But equally, there is the challenge that all of these new techniques are more time consuming, and that comes back to the workforce challenges, that we just don't have enough people to be doing the complex planning. And not just amongst consultant oncologists, but amongst the physics and radiographer planning stuff that we need to deliver those things as well. So yes, I'd agree things could be rolled out more quickly, but it comes back to workforce implications again.

Participant B: I was just going to make the point that the balance is always going to be difficult as we assess things in different ways. If you get an expensive new drug, it goes to NICE, there's a time frame for doing it and you get a decision. If the decision is positive, then everyone gets to have it

from three months time and everyone is obliged to provide it, without necessarily any thought or planning for how that is delivered or where is the capacity for workforce. As we've heard for things like SABR, it's a completely different process and a completely different timeline, and it makes sense to assess these things in different ways. The other point that I was going to make, is I think there is some emerging technologies that are going to need to be thought about on the horizon. So things coming through like nuclear medicine, hot antibody drug conjugates and others, are going to potentially overwhelm medicine relatively quickly. And some of the newer type agents, if we can show efficacy in solid malignancies the potential workforce there is enormous. That's the longer term thing to think about, but it's likely that it will come.

Participant C: I think Participant B covered a lot of what I was going to say. I think it's fantastic that we have all of these new technologies, but I think there's a gap between them becoming available and people at the NHS England level understanding that the infrastructure isn't there to support what we have now. It's a bit like the analogy that Participant D had about CT scanners going down after 15 years, there's not enough planning conversations happening now about how we're going to facilitate these new technologies tomorrow, never mind in five years' time.

Hannah Lewis: I'm coming in to say that we have about three minutes left, but I also wanted to reflect on something if I could. A lot of you were talking about access to clinical trials, which I found really interesting, and I was just reflecting on the roundtable that we had last week with people who had lived experience of cancer services and someone told us that they weren't offered a place on a clinical trial because of the colour of their skin. I was just wondering about your experiences of diversity considerations when recruiting participants in clinical trials. I just wondered if anyone had any thoughts.

Participant E: I have a role within the NIHR, and this is a really big thing for the NIHR at the moment, we do recognise that there has been massive inequality in access to clinical trials. This was really highlighted during the pandemic, and a lot of the attention was paid to which sectors of the population were able to access vaccine trials. So yes, it's an issue that's being actively addressed. One of the problems is the current way that we monitor clinical trial recruitment. Demographic data isn't collected in that, so it's actually very difficult to know, quite how we are doing because we don't routinely collect that information. But there is a move within NIHR to change that so that we can report on all of those things. So age is an important thing, we recognise that teenagers and young adults don't often get offered trials in the same way that the rest of the population, and that's similar for different ethnic groups as well. So yes, I think it's an issue, but it's difficult to say how much of an issue. It's being addressed.

Participant B: That is basically what I was going to say. We know it's a problem. We are trying to measure it and I think we should be held to account for it.

Minesh Patel: That's the end of our discussion. I just want to thank you all for your input and for being candid and open about some of the challenges happening within your local areas. I know that everything shared today will be incredibly useful to help inform the eventual set of recommendations that we make. If anybody has any further information that they want to share with the panel, we will provide information how you can share this in follow up emails.

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