Written evidence submitted by Prostate Cancer UK (EPW0032)

Prostate Cancer UK Submission
Please note, the Health & Social Care Committee's Planning Grid has been used to structure and frame this response. As such the questions suggested have been included across each commitment and addressed where appropriate or possible. Additional points or questions have been introduced to ensure relevant details are covered.

Organisation
Prostate Cancer UK represents and advocates for the interests of those affected by prostate cancer, including those at risk of the disease, those suffering from it, and their families and loved ones. This consultation is a key opportunity to detail our assessment of the Government's commitments to the NHS workforce and the causes of their being met or failed as they relate to prostate cancer. We also take this opportunity to highlight areas for change and improvement that would benefit those groups mentioned above.

Key Recommendations

1 A systemic change to pensions arrangements for consultants so senior staff are not disincentivised from working
2 A long term and coordinated approach to nursing which reduces the reliance on international recruitment
3 Workforce planning in readiness for new treatments which require advanced services should be devised now to cope with the upcoming increase in demand
4 Clinical Nurse Specialist career and skills development made available irrespective of geography to address predicted increase in prostate cancer cases.
5 Health Education England spending budget needs to be a minimum of £200m

1. PLANNING FOR THE WORKFORCE

Commitment:

- Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

Including evidence on:

- Current levels of staffing
- Whether workforce targets set for various staff groups has been met, including Government targets:
- increase in the number of students in medical training of 1,500 a year (from the Conservative's 2017 Manifesto Commitments)
- 50,000 more nurses (from the Conservative's 2019 Manifesto Commitments)
- 6,000 more doctors in general practice (from the Conservative's 2019 Manifesto Commitments)
- 26,000 more primary care professionals (from the Conservative's 2019 Manifesto Commitments)

Summary Response:

Prostate cancer is the most common cancer in men in the UK.[1-5] Coupled with the NHS Long Term Plan, endorsed by the government, to see 55,000 more people in England surviving cancer every

year with three out of four of all cancers detected at an early stage (stage one or two),6 the recruitment and retention of staff working in urology and associated roles is a matter of national urgency.

In 2018 Health Education England estimated that, to provide a world-class service for NHS cancer patients, the cancer workforce in seven priority professions related to diagnosis and treatment would likely need aggregate growth of 45% by 2029.[7]

As detailed in the NHS's own Cancer Workforce Plan[8] of 2017, the seven priority workforce areas identified national action required to support the delivery of "a clear and compelling strategy to radically improve the prevention, diagnosis, survival and experience of people affected by cancer in England."

Those workforce areas were: Histopathology and health care scientists, Gastroenterology, Clinical Radiology, Diagnostic Radiography, Medical and Clinical Oncology, Therapeutic Radiography and Nursing (CNS).

Within those professions we would take this opportunity to highlight **Radiologists** and **CNSs** as of crucial importance to prostate cancer treatment, care and support (among others) but demonstrative of critical issues affecting the NHS workforce.

Clinical Radiologists

The radiology workforce is crucial in achieving better and earlier diagnosis of prostate cancer and will also facilitate the delivery of advances in radiotherapy treatment in the future. However, the Royal College of Radiologists 2020 census revealed that the NHS radiologist workforce is now short-staffed by 33% and if nothing is done to improve staff recruitment, this shortfall is forecast to hit 44% by 2025. In addition, more than half (58%) of radiology leaders say they do not have enough staff to provide cancer care safely.[9]

Moreover, there are significant regional variations in workforce shortages across England. Clinical radiology workforce shortages are highest in the East Midlands and the Northeast, both of which stand at 43%. The East Midlands also has the lowest number of radiologists (whole-time equivalent) per 100,000 population, currently at 6.8 – the European average is 12.8 radiologists per 100,000. [10]

These regional inequalities should be addressed, through specific workforce policies and planning, as a matter of urgency to ensure all men have access to safe timely diagnosis and treatment no matter where they live.

Overall investment in the clinical radiology workforce is needed in order to meet the Government's ambitions and prevent unnecessary delays in diagnosis and treatment of prostate cancer patients. Investment in clinical placements will be critical as it is impossible to instantly hire more consultants. Simultaneously, **efforts to recruit more staff must be joined up with policies to induce senior staff to stay in post for longer. Providing flexible working solutions and reforming the NHS pensions scheme are two such measures that would stem the erosion of the consultant workforce**. Where currently highly qualified doctors retire earlier than they would otherwise choose as they lack the incentives and support to meet the increasing workloads and pressures of their role.[11] These recommendations were outlined by the BMA two years ago, in their report *Consultant Workforce Shortages and Solutions: Now and in the Future,* and bear highlighting once more.

Commitments on radiotherapy have not included molecular radiotherapy technologies (also known

as radioligand therapy). The 2021 Royal College of Radiologists report *Review of Molecular Radiotherapy Services in the UK* concluded that there is no clear "ownership" of molecular radiotherapy, with responsibility lying with clinicians in various roles.[12] This lack of a consistent approach means molecular radiotherapy is lacking the vision and joined-up approach present in areas such as external beam radiotherapy. NICE is currently appraising Lu-PSMA-617, a molecular radiotherapy treatment for advanced prostate cancer. If this is approved the demand for this service is likely to far outstrip current capacity. **Molecular radiotherapy and other potential new treatments must be included in future government assessments of NHS workforce planning, as the requirement for specially trained radiologists is set to increase further.**

CNSs

In regard to the nursing workforce and the commitment to recruit 50,000 more nurses, the Royal College of Nursing itself said in March this year in response to a government claim to be on track to 'deliver 50,000 more nurses by 2024':

"The government has not been transparent about how it calculates the numbers genuinely needed for safe and effective care. Independent health policy experts share our concerns about the workforce not growing at the scale and pace needed for health and care services. This is a political target in the absence of a proper health and care workforce strategy."[13]

This concern is shared by the Health Foundation's report of 2020 that the 50,000 target aside from being missed is itself "insufficient to meet increased demand" and that there "there needs to be a shift in focus, away from a single top-down target to a more sustainable, long-term approach."[14]

Further, a recent analysis by the King's Fund has found that recruitment is having no clear impact on actual vacancy numbers or on the shortfall of nurses in the NHS (as predicted by the Health Foundation's report). The data in the report illustrates that demand for nurses is increasing more quickly than supply, meaning that the government is not getting enough nurses into the NHS, despite their claims to be making good progress towards hitting its 50,000 target. For example, the South-East grew its full-time equivalent workforce by 17% yet its vacancy rate grew by more than 12% While the East of England grew its workforce by more than 20% and its vacancy rate still grew.[15]

This poses a fundamental question about whether meeting the target will achieve meaningful change when the data suggests that hitting the target will not solve the issue of workforce shortages.

On the nursing workforce, top-down targets mask important considerations in attrition as outlined above. Variations in demand in terms of speciality and region, are missed and short-term fixes through international recruitment are incentivised which as has been experienced recently is subject to forces outside of the control of NHS management. Once again, the policy recommendations for increasing recruitment and retention are well documented but bear repeating.

A coordinated approach to recruitment is required, taking demand into consideration that captures variations in regional differences and specialities. Similar to radiology, the approach must work to value and retain senior staff, so their expertise is not lost or disregarded.

Finally, pressure can also be alleviated **by opening up clinical tasks to junior staff and allied health professionals reducing the burden on consultants**. For instance, by allowing therapeutic radiographers to prescribe independently. The RCR has seen this as a reasonable method of relieving clinical oncology workloads.[16] Equally training CNSs as independent prescribers or to carry

out tasks such as Local Anaesthetic Trans-Perineal Biopsy can offer professional development that supports retention.[17] This must though, be part of a wider investment in the growth of the CNS workforce and matched by pay and recognition, so nurses and junior staff are not being asked to do more for the same pay. Overall, finding more of these opportunities that are safe and quality assured can provide greater relief to an overstretched workforce.

As highlighted at the beginning of this section we have chosen radiology and nursing as two key professions illustrative of the wider issues facing the cancer workforce. There are similar findings in medical oncology and pathology among others. All of which are crucial to deliver safe and effective treatment and care for prostate cancer patients.

Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?

Was the commitment effectively funded (or resourced)?

Did the commitment achieve a positive impact for patients?

Was it an appropriate commitment?

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2. BUILDING A SKILLED WORKFORCE

Commitments:

- Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.

- £1 billion extra of funding every year for more social care staff and better infrastructure, technology and facilities.

- Supporting moves towards prevention and support, we will go faster for community-based staff. Over the next three years we want all staff working in the community to have access to mobile digital services, including the patient's care record and plan, that will help them to perform their role. This will allow them to increase both the amount of time they can spend with patients and the number of patients they can see. Ambulance services will also have access to the digital tools that they need to reduce avoidable conveyance to A&E.

Summary points:

- Health Education England (HEE) spending budget needs to be a minimum of £200m
- CNS career pathway and skills development urgently needed to address predicted increase in prostate cancer cases.
- Training and developing skills for nurses and community HCPs for post treatment support and care
- Opportunities for CPD, training and upskilling are made available to all equitably, ensuring that there is no "postcode lottery" in terms of care and treatment being provided to men in different areas of the country.

Help the million and more NHS clinicians and support staff develop the skills they need and the NHS requires in the decades ahead.
Was the commitment effectively funded (or resourced)?
Prostate cancer is the most common cancer in men in the UK accounting for 27% of all new cases of cancer [1]. Ensuring that we have a skilled and dedicated workforce to meet this demand is imperative, with training provision properly budgeted for by the Government and Department of Health and Social Care. This becomes even clearer considering that the Royal College of Nursing in March 2022[2] highlighted that 30% of the current specialist cancer nursing workforce are due to retire in the next 10 years. Similarly, the oncology workforce has struggled to keep up with the increasing demand, exacerbated by the pandemic. In 2020 the RCR[3] reported that [the clinical oncology] "Workforce growth is forecast to slow down from 3% per year seen over the past 5 years to 2% per year in the next 5 years". This predicted slow growth, equates to future cancer services and care becoming more precarious without significant investment, making staff retention and skills development a matter of

urgency.

The 2021 Autumn spending review, included a welcome reference to "building a bigger better trained NHS workforce"[4] that included funding the training of the biggest undergraduate intakes of medical students and nurses. However, six months on and despite calls for more detail by over 50 cancer charities (including Prostate Cancer UK) under the banner of One Cancer Voice, the budget commitment continues to be unclear, non-specific and provides no further clarity on the how much 'hundreds of millions of pounds' in additional funding over the spending review 2021 period is to be provided. As a consequence, we are not able to state whether the budget allocated is sufficient to help the million+ clinicians and staff develop their skills.

The October 2021[4] spending review allocated 2.3billion for community diagnostic hubs. But no clarity has been provided on how the proposed increases in number of tests completed to diagnose faster will be achieved by an already stretched and limited skilled workforce. This is of particular concern as there may be continued delays in diagnosis and access to tests as there are limited radiographers and histopathologists to operate machinery and interpret results.

This issue will lead to a blockage in the prostate cancer pathway, delays in diagnosis and potential later stage diagnosis, which we know impacts survival outcomes. This should be addressed by the Government immediately in order to help support earlier diagnosis and their Long Term Plan ambitions.

The NHS Confederation have noted that without a clear view of future workforce supply, it is more difficult for NHS leaders to plan to increase services[5].

It is of concern that the budget for HEE is yet to be finalised. We urge the government to provide a budget so that HEE can formulate how they will address the above, and be able to properly respond to the question as to whether the commitment has been properly funded.

Did the commitment achieve a positive impact for patients?

The Secretary of State for Health and Social Care announced in November 2021, that a new workforce framework is due in Spring. We await the publication of the plan to understand what action will be taken by the Department. We would highlight though that it is only through taking a long-term strategic approach that the NHS will be able to develop a sustainable approach to recruiting, training and retaining the cancer workforce we know we need to meet the future increase of men with prostate cancer.

HEE[6] stated in its 21/22 strategic objectives that it will increase the supply of people trained to fill the roles required to enable delivery of the Long Term Plan outcomes for cancer and diagnostics.

The objectives also stated that prioritising the reporting of radiographers to support cancer and diagnostics. This is a welcome commitment to help support earlier and faster diagnosis of men with prostate cancer, which is essential to improve survival rates. Unfortunately, no detail is provided as to how this will be achieved and what budget will be allocated for training and upskilling staff.

A number of reports have been published about the disparity of skills and availability of opportunities for CNSs nationally. Macmillan's 2017 report[7] highlighted the need for better use of skills, planning and time for service development. Specialist nurses reported that "nurses on wards tend to be the staff that we will need to train and support to come into CNS roles with the right skill set. But it's much more difficult for ward staff to get cancer training compared to CNSs."

This clearly indicates a need for better skills training for ward staff.

The report goes onto highlight that education and training were strong themes, with many professionals emphasising the key role these play in retraining staff and ensuring the workforce has the necessary skills to support people with cancer throughout the pathway.

GPs also highlighted how problematic the gaps in key roles in primary and community care are becoming, particularly because cancer is becoming a long-term condition. There was an appetite from some GPs for better resource, alongside the suggestion that primary care workforce development for cancer should match that of other conditions such as asthma and diabetes. The need for community and primary care health professionals to be trained to support people with cancer is keenly felt post-treatment. One GP explained that there needs to be 'more community/practice nurses with a knowledge of cancer care so care can be provided more locally to the patients'.

Was it an appropriate commitment?

HEE, 2018[8] have previously estimated that the NHS will require an aggregate growth of 45% in its cancer workforce to deliver world-class cancer services by 2029. CRUK in their 2020 workforce report[9], estimated that to achieve this level of growth across the seven key cancer professions, an additional investment of between £142m and £260m would be required in staff training and education.

We wait for clarity from the Department of Health and Social Care on what the budget allocated will be and would strongly urge the government to address this issue as a matter of urgency.

The latest Workforce Race Equality Standard published in 2021, (WRES)[10] states that Black and minority ethnic nurses felt that they were not given equal opportunity of progression at work: 40.7% believed their trust provided equal opportunity compared with their White counterparts at 88.3%.

This disparity of experience needs to be addressed as part of skills workforce planning, with specific policies on CPD applications to be reviewed to ensure inclusivity and opportunities for staff of culturally diverse backgrounds to be equitable.

The workforce in this specialism provide complex care but has appeared to evolve without strategic intent. Consequently, many in these roles are caring for patients with a range of diseases. As prostate cancer incidence continues to rise[1], **consideration of strategic planning should be given to patterns of care delivery and the future workforce.**

Capacity to provide cancer nursing care needs to be addressed nationally and locally. Despite the known benefits of access to a CNS, the distribution of specialist nurses and incidence-to-nurse ratios vary enormously indicating that there is likely to be inequity of access. Furthermore, uro-oncology nurses have the highest mean new patient/incidence (159 per WTE) and two-year prevalence (247 per WTE) of specialist nurses in England[11]. This work indicates that unlike other cancers, prostate cancer nursing care is rarely provided by a prostate CNS. Only 2% of the specialist nursing workforce in England is prostate specific – approximately the same number as a rare cancer such as sarcoma.

As prostate cancer is the most prevalent cancer for men and is growing in incidence this is of great concern and should be urgently addressed

From a broader workforce perspective, retention of staff in specialist areas is a key concern. Autonomy and empowerment have been identified as key 'magnet factors' in attracting and keeping high quality staff (Armstrong and Laschinger, 2006).[12]

Research conducted by HEE and a consortium of Cancer Alliances in the North of England[13] to understand the landscape for CNSs found that there is a need **for better processes (systems and methods), improved communications; training and CPD;** improved clinical supervision, definition of roles, and career pathways.

Regarding the appropriateness of these commitments, this is unclear, as funding has not been identified and plans or strategies as to how to address skills and retention of staff are yet to be published.

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3. WELLBEING AT WORK

Commitments:

- Introduce new services for NHS employees to give them the support they need, including quicker access to mental health and musculoskeletal services.

- Reduce bullying rates in the NHS which are far too high.

- Listen to the views of social care staff to learn how we can better support them – individually and collectively.

Summary Response: We would encourage the fulfilment of any commitments regarding NHS cancer workforce wellbeing. In nearly all clinical settings the burden of prostate cancer care in an increasingly challenging environment has only grown more acute since before the start of the COVID-19 pandemic. Reconfiguring services in this context arguably creates an opportunity to enshrine employee wellbeing in the operation of NHS services.
Was the commitment met overall? or (in the case of a commitment whose deadline has not yet been reached) Is the commitment on track to be met?
Was the commitment effectively funded (or resourced)?

Did the commitment achieve a positive impact for patients?
Was it an appropriate commitment?
References:

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