

Written evidence submitted by Cancer Research UK (EPW0043)

Summary

- The NHS cancer workforce suffers from chronic shortages across the whole pathway which are a significant barrier to achieving the Government's cancer ambitions and improving outcomes for cancer patients.
- Addressing understaffing in the cancer workforce is of increasing urgency. There are around 375,000 new cancer cases in the UK every year (2016-2018)ⁱ. But an ageing population means growing demand for cancer services, and by 2035, we expect to have 500,000 new cancer cases in the UK a yearⁱⁱ. Recruiting and training the health workforce is a long process, with it taking a minimum of three to five years to train newly qualified staff as specialists in key cancer professions. Action is therefore needed now.
- Chronic shortages throughout the cancer workforce are not a new issue. The first ever comprehensive cancer strategy in 2000 identified NHS staff shortages due to years of underfunding and underinvestment in the NHS.ⁱⁱⁱ However, consecutive Governments have failed to rise to the challenge and provide the long term investment and planning needed to grow and train an NHS cancer workforce that can meet patient need. Though there has been some welcome investment in recent years, that has been piecemeal and lacked the strategic, long term action that is fundamental to building a cancer workforce fit for the future.
- The Government's forthcoming 10-Year Cancer Plan has the potential to be a major milestone for cancer patients, signalling a renewed drive and setting an ambitious roadmap towards better cancer outcomes. This opportunity must not be wasted.
- In order for the 10-Year Plan to be successfully delivered, it must be matched with a long-term plan to expand and train the cancer workforce. There is precedent for this; in 2017, Health Education England's Cancer Workforce Plan was published to support the delivery of the cancer strategy. It is vital that a workforce plan is published to support the delivery of the 10 year cancer plan – it is difficult to see how our ambitions can be delivered without it. Crucially, this workforce plan must be fully funded and include projections of future skills and numbers needed to deliver the 10-Year Plan, otherwise we will not know if we are recruiting and training the right number of staff in the right cancer specialties to deliver on the plan's ambitions.
- In addition to *expanding* the cancer workforce it is also crucial that we *maximise the potential* of the NHS cancer workforce to deliver world-leading cancer care and build the right skills for the changing nature of cancer care. For example, it is likely the cancer workforce will need to be upskilled in order to facilitate the adoption of new innovative treatments, approaches and technologies as well as to ensure that the benefits of health data and a learning healthcare system in the NHS are fully unlocked.
- Maximising the potential of the current cancer workforce is also important to help improve outcomes for patients and increase capacity. Skill mix approaches should continue to be developed, tested and adopted to ensure patients are being offered the best care possible, as well in the short- to medium-term to help increase capacity, address the cancer backlog and create more time for patient-facing care.
- It is vital the Government takes action now to ensure the NHS has a cancer workforce – both in numbers and skills – to deliver on our national ambitions for cancer and give people affected by cancer the world class cancer services they deserve. We have therefore proposed a number of

recommendations for action regarding investment, planning and innovative approaches to roles key to cancer care. Action on all these fronts is necessary in order to deliver the best possible care for cancer patients.

Recommendations

- The Government's forthcoming 10-year Cancer Plan should be followed by the publication of a plan for the cancer workforce as part of robust delivery planning. This cancer workforce plan must include projections of future skills and staffing numbers needed to deliver the strategy, as in the 2017 Cancer Workforce Plan. Crucially, this workforce plan must be underpinned with the long-term investment needed to deliver it.
- In order to deliver on the opportunities that skill mix approaches provide for the cancer workforce, national and local health leaders should tackle the barriers to adopting them:
 - NHS Trusts and Health Boards should consider whether they can backfill the roles of upskilled staff and, if not, take steps to enable this.
 - Local and national health leaders must show leadership to bring the health workforce with them as they drive the implementation of skill-mix approaches by putting improving quality of care and staff wellbeing at the centre of the case they make.
 - Health Education England should design training courses flexibly to maximise their availability. This may include e-learning or modular courses that reduce the geographical and financial barriers to participation.
- To address barriers to NHS staff participating in research:
 - The UK Government and Devolved Administrations should uplift long-term funding for the National Institute for Health Research, Chief Scientist Office, Health and Care Research Wales, and the Health and Social Care R&D Division. At a minimum, these funding increases should be in line with broader uplifts in public R&D investment and keep pace with future increases in inflation.
 - In line with the Academy of Medical Sciences' proposals, the UK Government and Devolved Administrations should implement fully funded pilot programmes that offer a proportion of health service staff (including those in under-represented professions) contracts that include dedicated time for research.
- To unlock the potential of new innovations and technologies, system leaders need to invest in staff training and skills to support adoption as well as innovation by ensuring staff have protected time to dedicate to upskilling. This will rely on Government investment to expand the workforce to create time for training.
- NHS England and Health Education England must also focus on upskilling the NHS workforce's data skills to ensure health data is accurately recorded.

Commitment 1: Ensure that the NHS and social care system have the nurses, midwives, doctors, carers and other health professionals that it needs.

Was the commitment met overall or is it on track to be met?

1. In recent years the Government has taken some positive steps to grow the NHS cancer workforce.
 - As part of its 2017 Cancer Workforce Plan delivery, Health Education England (HEE) has created innovative new routes into the cancer workforce.^{iv}
 - The 2020 Spending Review committed £46 million for workforce training for cancer-related specialties. This included 245 new trainee posts, including 110 radiology posts.
 - It was recently announced the diagnostic and cancer workforce would receive an additional £50 million for education and training for 2022/23.
2. However, these commitments, while positive, have not delivered the long term investment and planning needed to ensure the NHS cancer workforce has the right number of staff it needs now and into the future. **Therefore, despite some progress, we do not believe this commitment has been met or is on track to be met.**
3. Years of underinvestment and a lack of strategic, long-term workforce planning had led to one in ten posts across the NHS in England being vacant in 2018/19, with predictions that this number would rise to almost one in seven by 2023/24 if no action was taken.^v Across NHS England there were 100,192 vacancies from October to December 2021^{1vi}; we have heard consistently from NHS colleagues that these shortages impact the whole cancer pathway, with shortfalls evident across all cancer professions.
4. Health Education England's 2017 Cancer Workforce Plan committed to expanding the cancer workforce's capacity and skills by 2021. This included commitments to increasing net trainee numbers to ensure we have the right numbers and skills for the future and better use existing supply with actions to support growth and transformation. HEE's strategic framework for the cancer workforce built on this, showing that to deliver world-class cancer services for all patients, growth of at least 45% was needed over the next decade.^{vii}
5. Almost 6 years later, the failure of Government to match the ambitions of the Cancer Workforce Plan with concerted, long-term action has meant that chronic shortages across the cancer workforce are still evident. While there has been some progress in growing the cancer workforce, CRUK modelling^{viii} has shown that we are well off track to meet the 45% target required to deliver world-class cancer services for all patients. These shortages remain a significant and persistent barrier to meeting the UK Government's cancer ambitions and improving cancer outcomes for patients.
 - According to the Royal College of Radiologists (RCR), the radiology workforce across the UK is now short-staffed by 33% and needs almost 2,000 more consultants to meet safe staffing levels and pre-coronavirus levels of demand for scans. Without more training, investment in new models of care and better retention and recruitment, by 2025 the radiologist shortfall will hit 44%.^{ix}
 - The 2020 RCR clinical oncology census found that the consultant clinical oncology workforce has a shortfall of 17% which could rise to 29% by 2025. This has risen from 10% in 2015. It also found that vacancies were increasingly difficult to fill, with 55% of

¹ Total workforce vacancy FTE in NHS England, Oct-Dec 2021. Please note, due to the complex nature of how NHS vacancy data is defined and collected, all data sources should be treated with a degree of caution. These data do not indicate how much of the reported substantive gap is filled by temporary staff.

posts being open for over a year, compared to 29% in 2015^x – meaning across England oncology departments remain persistently understaffed and unable to match capacity with patient need.

6. Long-term workforce planning to ensure enough staff are being trained in the key cancer professions to meet future demand is essential to improve outcomes. The proposed amendment to the Health and Care Bill by the Rt Hon Jeremy Hunt MP and Baroness Cumberlege would have been an essential step towards meeting the Government's commitment to ensure the NHS has the staff it needs. That is why Cancer Research UK, alongside over 100 health organisations, supported the amendment, which would have strengthened workforce planning by mandating regular, independently verified projections of the future supply and demand of the health and social care workforce. The amendment would have created a national picture of the health and care staff numbers needed now and in the future, making it more likely the right numbers of staff would be recruited and trained.
7. The amendment was rejected by the Government on the basis that it is already doing substantial work to improve workforce planning. However, the Health and Care Act only sets out a requirement for the Secretary of State to publish a report describing the system in place for assessing and meeting workforce needs. This provision is entirely insufficient and fails to achieve what it needs to as crucially it will not provide the assessment of workforce numbers needed when planning effectively for the future.
8. In addition, the Department of Health and Social Care (DHSC) has commissioned Health Education England to refresh Framework 15 to examine the drivers of workforce supply and demand. DHSC has also commissioned NHS England to develop a long-term workforce plan which the Framework will feed into. It is not clear that either of these plans will include robust assessment of the current NHS workforce or modelling of future needs to inform strategic workforce planning decisions at all levels.
9. The Government's forthcoming 10-year Cancer Plan for England has the potential to offer an ambitious vision for cancer services and transform outcomes for people affected by cancer. However, to achieve the 10-Year Plan ambitions, it is crucial it is matched with a long-term and fully funded plan to grow and train the cancer workforce.
10. In 2017, Health Education England's Cancer Workforce Plan was published in order to support the delivery of the cancer strategy. The Workforce Plan acknowledged that without expansion in numbers as well as ongoing investment in NHS staff, the cancer strategy could not be delivered. As such, to ensure the success of the Government's forthcoming 10-year Cancer Plan, it is vital that modelling of future cancer workforce needs are published to follow the 10-year Cancer Plan, to ensure the NHS cancer workforce has the right number of staff in the future to deliver the ambitions of the Plan. Without robust modelling, we won't be able to take an evidence-led approach to addressing staff shortages in the cancer workforce and they will remain one of the biggest barriers to the Government's commitment to improve cancer survival - an ambition at the heart of the 10-Year Cancer Plan.
11. **CRUK recommends that Government's 10-year Cancer Plan is followed by the publication of a plan for the cancer workforce as part of robust delivery planning. This cancer workforce plan must include projections of future skills and staffing numbers needed to deliver the strategy, as in the 2017 Cancer Workforce Plan. Without future projections of staff numbers and skills, we will not know if we are recruiting and training the frontline staff and specialists needed to**

deliver the 10-Year Plan's ambitions. Crucially, this workforce plan must be underpinned with the long-term investment needed to deliver it.

Was this effectively funded?

12. Along with long term planning, sustained investment in medical education and training is one of the most important steps needed in growing the cancer workforce to meet patient need. However, in recent years there has been insufficient funding to grow the cancer workforce to meet the demand for cancer services and meet this commitment.
13. Before the 2021 Comprehensive Spending Review (CSR), CRUK modelled the long-term investment in medical education and training needed to grow the cancer workforce by 45% by 2029 – as estimated by HEE as being necessary to deliver world-class cancer outcomes. This modelling estimated that the Government would have to invest an additional £216 million in medical workforce education and training over the Spending Review period for key cancer professions^{xi}.
14. At the 2021 CSR, the Government made a welcome commitment to “provide hundreds of millions of pounds in additional funding over the SR21 period to ensure a bigger and better trained NHS workforce”. The Government has since announced an additional £50 million for the diagnostic and cancer workforce in 2022/23.^{xii} This is very welcome, and a vital step in the right direction to ensure that we have the cancer workforce needed to meeting growing demand for services. However, this is a long way from the £216 million we estimated would be needed across the Spending Review period^{xiii}. On its own, this investment is not a long-term solution to shortages in cancer workforce - it must be sustained and increased throughout the Spending Review period.
15. As outlined above, long-term workforce planning is essential to ensure enough staff are being trained to meet future demand. Further, it is crucial if we are to maximise NHS spending by ensuring it is spent efficiently in the right places. For example, improved workforce planning would reduce the need for agency staff and outsourcing in the NHS by reducing gaps in the workforce. In 2019/20 alone, £6.2bn was spent on agency and bank staff in hospitals in England to cover the gaps in the NHS workforce. In 2020, national health services across the UK spent £128 million on outsourcing the reporting of scans to the independent sector – equivalent to the combined salaries of a third of the current consultant radiologist workforce. This has risen over 58% since 2018.^{xiv} Insourcing and ad-hoc locum costs accounted for a further £78 million. This is a stark demonstration of the cost of underinvestment and lack of strategic planning for the cancer workforce.

Did it achieve a positive impact for patients?

16. A well staffed and resourced NHS is vital to delivering world class cancer care. However, today chronic workforce shortages across the cancer pathway are the principal factor limiting recovery from the impact of COVID-19 on cancer services and improving outcomes for cancer patients in England.
17. The impact of shortages in the cancer workforce has come into sharper focus with the strain put on the system by COVID-19 and the resulting backlog. A survey conducted by CRUK of 900 cancer patients from December 21st 2020 - March 25th 2021 found that 33% of patients who provided a rating of their overall care before and since the start of the pandemic said it had got worse.^{xv}

18. In February this year, performance against all Cancer Waiting Times was below the target level for each standard, with the 62-day performance target being met for just 62.1% of cases compared to a target of 85%. However, this was a problem even before the pandemic, with cancer waiting times targets being routinely missed in all four nations for a number of years. In England, almost 55,000 patients should have been diagnosed quicker or started their treatment sooner in the last six years but were not because the NHS continued to miss its target to treat 85% of cancer patients within two months of their urgent suspected cancer referral.^{xvi}
19. Diagnostic workforce shortages are among the most significant barriers to the Government achieving the NHS Long Term Plan ambition to diagnose 75% of stageable cancers at stage I and II by 2028, for which, based on current trajectory, we are well off track.^{xvii} Staff shortages limit our ability to innovate and be ambitious on early diagnosis. For example:
- The Faster Diagnostic Standard (FDS), the target for ensuring people receive diagnosis within 28 days, has been introduced too low at 75% rather than 95% due to chronic staff shortages limiting diagnostic capacity. This target has yet to be met nationally, but even meeting it could still leave 55,000 people a month waiting too long.^{xviii}
 - Due to shortages in the endoscopy workforce, FIT screening for bowel cancer had to be introduced in England at a less sensitive level than in Scotland. This means that more than 1,000 cancers and nearly 7,000 potentially pre-cancerous growths might be missed every year, compared to if England use the same sensitivity as used in Scotland.^{xix}

Commitment 2: 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 met overall or is it on track to be met?

20. Adopting skill-mix approaches in the health workforce means designing the roles and responsibilities in a team around the needs of the patient, and ensuring you have the right skills at the right level to meet those needs.^{xx} This means understanding those needs and what a healthcare professional's role involves, and considering if other members of the team have the skills (or could be upskilled) to take on certain tasks.
21. Skill-mix approaches also provide opportunities for the cancer workforce. Understanding the balance of skills needed in a team frees up staff to focus on areas that are best suited to their skills. Macmillan Cancer Support found that many specialist nurses spend a lot of time on administrative tasks that could be done by a support role, freeing up the nurse to focus on clinical work.^{xxi}
22. Tested examples of skill-mix approaches in the cancer workforce include:
- **Reporting radiographers:** Take on interpretation duties for some images that would traditionally be interpreted by a radiologist.
 - **Clinical endoscopists:** Do some types of endoscopy without needing to be medically trained, thereby releasing gastroenterologists and GI surgeons to do more complex procedures.
 - **Biomedical scientists:** Undertake some steps in the preparation and interpretation of histopathological samples.

23. Progress has been made in adopting skill-mix approaches. For example, the proportion of trusts and health boards using radiographer reporting rose from 72% to 82% in the five years to 2020.^{xxii} In the context of severe radiologist shortages, this is important and shows that there has been some welcome progress in adopting these approaches.
24. However, in the face of long waiting times and the COVID-19 backlog, it is vital that this progress continues. In order to deliver on the opportunities that skill-mix approaches provide for the cancer workforce, national and local health leaders should tackle the barriers to adopting them, which are explored below.
25. To implement skill-mix approaches you need to be able to backfill the roles of those undergoing further training. This is the case both for when they are training, and for when they take up their new responsibilities. For example, radiographer reporting is used to manage shortages in the radiology workforce. But realising its full potential is hampered by radiographer shortages.^{xxiii} Problems with backfilling radiography roles can be partially mitigated by upskilling motivated support workers to acquire images, as support workers are typically easier to recruit.^{xxiv}
- **NHS Trusts and Health Boards should consider whether they can backfill the roles of upskilled staff and, if not, take steps to enable this, for example, by recruiting more support workers.**
26. For skill-mix approaches to fully realise their potential, local and national health leaders need the support of the cancer workforce. **Local and national health leaders must show leadership to bring the health workforce with them as they drive the implementation of skill-mix approaches. Improving quality of care and staff wellbeing – not cost – should be at the centre of the case they make.**
27. Inconsistent access to training and development opportunities is a common barrier to adopting skill-mix approaches; many staff are unwilling or unable to pause their careers and stop earning for prolonged periods of time. To address this, training courses should be designed to maximise participation and availability. **HEE should design training courses flexibly to maximise their availability. This may include e-learning or modular courses that reduce the geographical and financial barriers to participation.**

Did it achieve a positive impact for patients?

28. At their best, skill-mix approaches can deliver measurable improvements for patients, staff and finances.^{xxv} They can improve the care cancer patients receive by allowing for a better alignment between the workforce and the needs of service users.^{xxvi} In the short- to medium-term, they can also help to increase capacity and address the cancer backlog by ensuring staff time is spent most efficiently. However, this alone is not enough to bridge the staffing gap and tackle long waiting lists - the need for cancer workforce expansion and funding is unavoidable.

Was it an appropriate commitment?

29. Government must also consider the important role that participation in research conducted by the NHS workforce can have in delivering better outcomes for both staff and patients. The enthusiasm for research in the cancer workforce offers a significant opportunity to expand the NHS's capacity to deliver life-saving and innovative research that drives forward improvements in care quality and patient outcomes.

30. However, this opportunity is limited by the scarcity of support and resources available to NHS researchers, with 60% of NHS research directors saying there is insufficient funding to support research,^{xxvii} a lack of resources to invest in capacity building is a fundamental limit on the NHS's ability to innovate. This scarcity explains why NHS staff struggle to secure the resources required to have dedicated research time, free from the overwhelming clinical duties that both justify and inhibit health innovation. Our report '[Creating Time for Research](#)' found that this lack of time was the most common barrier to NHS staff participating in research,^{xxviii} which, in turn, constrains the NHS's capacity to deliver research studies that could innovate and improve the health service. Inadequate research funding also explains why some NHS researchers are forced to self-fund their research through mechanisms such as annual leave.^{xxix} This cost imposes an additional barrier to entry that could deter NHS staff from becoming researchers, thus making it harder still for the NHS to expand its research capacity and promote innovation.^{xxx}

31. **To address these challenges, we recommend:**

- **The UK Government and Devolved Administrations should uplift long-term funding for the National Institute for Health Research, Chief Scientist Office, Health and Care Research Wales, and the Health and Social Care R&D Division. At a minimum, these funding increases should be in line with broader uplifts in public R&D investment and keep pace with future increases in inflation.**
- **In line with the Academy of Medical Sciences' proposals, the UK Government and Devolved Administrations should implement fully funded pilot programmes that offer a proportion of health service staff (including those in under-represented professions) contracts that include dedicated time for research.**

32. Another factor that must be considered is the changing nature of cancer care. Innovative and new technologies and approaches have the potential to ease pressure on the cancer workforce, for example by triaging patients to reduce demand for the areas of the workforce suffering from backlogs or reduce the administrative burden on the workforce. For example:

- **Colon Capsule Endoscopy (CCE):** When implemented on the symptomatic pathway, CCE can help rule out bowel cancer and triage patients, reducing the demand for a colonoscopy services.
- **Cytosponge:** If used to triage and prioritise patients for endoscopy who have already referred from primary care, the test should reduce UGI endoscopy demand.
- **Alternative Intelligence (AI):** AI may support clinical decision-making through decision support tools, such as tools to assist clinicians to order the right diagnostic tests or suggesting the relative value of different tests.

33. **However, for innovation to improve workforce capacity, system leaders need to invest in staff training and skills to support adoption as well as innovation.** While innovations have some potential in places to ease pressure on staff, without proper training they cannot be adopted in practice. A lack of protected time prevents many staff from undertaking extra training. In a survey of specialist cancer nurses, Macmillan Cancer Support found that over half (58%) agreed that workload pressure significantly impacts their ability to access training as they are unable to step back from clinical commitments.^{xxxi} The reality in many trusts is that staff do not time set aside for learning and development beyond mandatory training. The risk of service provision being prioritised over training is especially acute when services are under pressure.^{xxxii} The cancer backlog means that unless proactively encouraged, demand for cancer services may continue to prevent staff from accessing training, while setting unrealistic targets for the

recovery of cancer services with top-down drives to meet them risks discouraging a culture of learning and development.

34. **As new technologies are rolled out across the NHS, NHS England and Health Education England must ensure that staff are trained to use and adopt innovation in practice. This includes ensuring staff have protected time to dedicate to upskilling, which will rely on Government investment to expand the workforce to create time for training. NHS England and Health Education England should recognise and advocate that even under the current pressures, the cancer workforce needs to carve out time for training and development, while Trusts and systems should make sure staff are able to do so.**
35. Genomics is also rapidly changing the cancer pathway, with the potential to improve screening, diagnosis and treatments. **A healthcare workforce with role-appropriate and up-to-date genomics knowledge is needed to achieve this. The Government must therefore deliver a long-term workforce plan, as recommended above, including assessments of future skills as well as staffing numbers needed in the future to identify areas, such as genomics, where new and existing staff should be trained and developed.**
36. Underpinning the above advances is a reliance on high-quality, accessible health data. However, to fully unlock the potential of data to transform cancer outcomes, health data must be accurately recorded in routine clinical care and be capable of being accessed across the NHS as standard. However, at the point of care, where patient data is collected, often the NHS workforce is not trained with the right data skills.^{xxxiii} **Therefore, NHS England and Health Education England must focus on upskilling the NHS workforce in this area.**

About Cancer Research UK (CRUK)

Cancer Research UK (CRUK) is the world's largest cancer charity dedicated to saving lives through research. We support research into over 200 types of cancer, and our vision is to bring forward the day when all cancers are cured. Our long-term investment in state-of-the-art facilities has helped to create a thriving network of research at 90 laboratories and institutions in more than 40 towns and cities across the UK, supporting the work of over 4,000 scientists, doctors and nurses. In 2020/21, Cancer Research UK invested £421 million on new and ongoing research projects into the causes and treatments for cancer.

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