

Impact of Covid-19 on UK Radiotherapy: 18 Months On

Action Radiotherapy & The Institute of Physics
and Engineering in Medicine
Flash Survey 8th - 19th October 2021

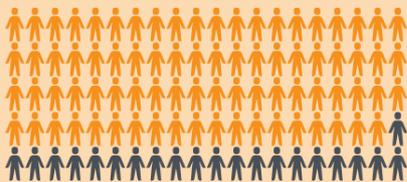
277 Responses

March 2021 the Institute for Public Policy Research report: Only a 14% drop in radiotherapy procedures due to the pandemic (least reduction in all cancer treatment modalities)

97% of respondents felt the current cancer backlog was either a serious or a very serious problem



Fewer than 1 in 20 radiotherapy professionals felt they could meet the government's aim of running the service at 110% capacity to tackle the backlog. 75% of respondents felt they could not even reach 100%



79% said that the pressure of the pandemic or the recovery has caused themselves or colleagues to consider leaving the radiotherapy profession

 **83%** say they saw an increase in the number of patients whose cancer had become incurable

 **90%** felt the Government did not recognise the significant role radiotherapy needs to play in tackling the cancer backlog

9 in 10 respondents felt they did not have enough workforce, with one practitioner feeling staff are being stretched 'to the maximum' and another calling current work patterns 'not sustainable' and warning 'we are heading for a crash'

10% reported their waiting lists were now more than 8 weeks

Flash Survey: 8th-19th October 2021

The charity Action Radiotherapy together with the radiotherapy professional body The Institute of Physics and Engineering in Medicine (IPEM) undertook a flash survey of radiotherapy professionals in the UK between 8th -19th October 2021, to get an updated understanding of the current issues being faced by the UK radiotherapy service and their patients ahead of anticipated winter pressures. We also sought to get an understanding of what solutions radiotherapy services can offer to help deal with the COVID-induced cancer backlog and whether they are being harnessed.

The survey was conducted using Google Forms and contained 34 questions. The survey was distributed to radiotherapy professionals via the Action Radiotherapy Daily News email list, by the Institute of Physics and Engineering in Medicine's (IPEM) weekly news and through the social media accounts (Twitter, Facebook and Instagram) of both organisations over 8 days.

Two previous surveys undertaken in 2020 and May 2021 produced highly representative real time data as confirmed by the fact that the survey results matched government data activity data published several months later.

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Summary of Results

Current status

- 97% of respondents felt the current cancer backlog was either serious or very serious
- 83% of the workforce reported an increase in the number of patients whose cancer had become incurable; increased by 10% from 6 months ago. 89% reported a shift to later stages of diagnosis in patients in the last 6 months, an increase from 70% over the last 6 months
- 10% of respondents reported waiting lists for radiotherapy at over 8 weeks, with a further 10% citing 6-8 week waits

Concerns

- Fewer than 1 in 20 radiotherapy professionals felt they could meet the Government's aim of running the service at 110% capacity to tackle the backlog. Over 75% felt they could not even reach 100%
- 89% felt the Government did not recognise the significant role radiotherapy needs to play in tackling the cancer backlog. One respondent cited a '*complete lack of understanding of the role of radiotherapy by government and higher-level management*'.
- There is a general sense of RT having been sidelined for a long time. 80% of RT professionals reported that they feel RT was not going to get the funding it needs from the Government's additional health and care funding settlement.
- 79% of RT professionals responded that they, or someone they knew, were considering leaving the RT sector, up from 65% 6 months ago

Solutions

- Workforce: 9 in 10 respondents felt they did not have enough workforce, with one responder feeling staff are being stretched '*to the maximum*' and another calling current work patterns '*not sustainable*' and warning '*we are heading for a crash*'. More support staff also needed.
- Equipment: 53% felt that with modest investment in new and additional equipment radiotherapy could have a significant impact on the cancer backlog
- IT: 65% felt they did not have sufficient IT equipment, with one respondent lamenting that they waited over 3 years for a piece of software that dramatically cut the number of work hours required and cost less than one round of a chemotherapy drug
- Bureaucracy: 61% felt that bureaucracy was holding them back from tackling the backlog including the current purchasing rules and tariff funding system.

Written examples within our findings painted a shocking picture of a radiotherapy service in urgent need of investment for kit and workforce. There were clear warnings from our results about a shortage of physicists, engineers, technologists and therapeutic radiographers who play a vital role in cancer care. If this small but specialist services has capacity bottlenecks or staff redeployed services are severely disrupted. We also heard concerns about bureaucracy which holds back the most advanced forms of care and prevents machine upgrades. Just one example was the requirement that machines be conducting 9000 fractions (or treatments) in order for cases for new machines to be considered. At a time when cancer services are overstretched by winter pressures and facing huge backlogs examples like were very concerning.

Introduction

The ongoing Covid pandemic has created a massive backlog in healthcare, leaving millions of patients without timely access to treatment and pushing the provision of vital services to the limit. The cancer backlog is the deadliest and the most time critical, since for every four weeks treatment is delayed, survival can drop by as much as 10%¹. With winter here, it is now widely expected that the NHS will face additional pressures, exacerbating the current crisis.

Radiotherapy is integral to tackling the cancer backlog. At a cost of £4-7k per patient it is the most cost-effective cure and is needed by one in two cancer patients, and in 40% of cures. Radiotherapy is also recognised as one of the most Covid-safe cancer treatments, as it does not require the use of immunosuppressant drugs or need ITU or surgical intervention. However, radiotherapy has traditionally had a low profile among policy makers and consequently suffers from chronic under-investment, resulting in facilities relying on outdated machines and staff feeling overworked. Given the importance of radiotherapy in fighting the current cancer crisis, this survey set out to get an updated understanding of the current issues being faced by the UK radiotherapy service and their patients ahead of anticipated winter pressures.

The COVID-19 pandemic had an undeniably huge impact on cancer services, creating backlogs, pent up demand and reducing capacity though COVID related risk mitigation. Action Radiotherapy and the relevant professional bodies have been working hard to track the impact on radiotherapy services through multiple waves of the coronavirus. Part of this has involved regular surveys of the radiotherapy workforce to measure the impact on the frontline and the tremendous efforts being put in to tackle the cancer backlog.

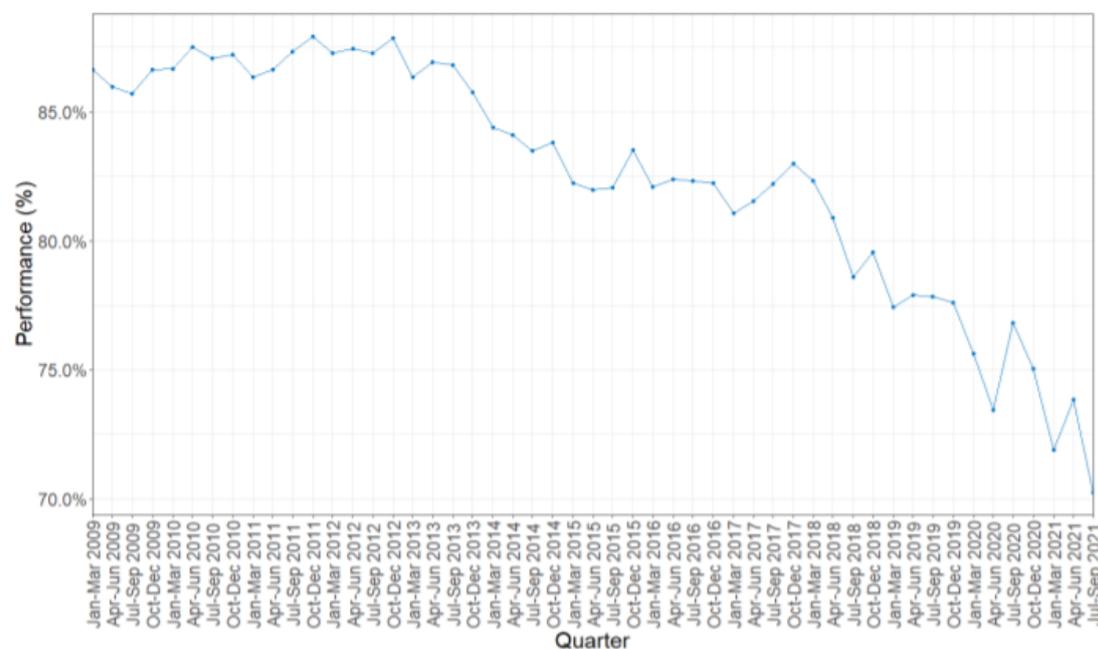
Very early on in the pandemic it became clear that radiotherapy should carry on and not be avoided or delayed as was initially thought in the first UK national lockdown and NICE guidance (March 2020). Radiotherapy was quickly internationally recognised as one of the most COVID safe of all cancer treatments and cancer experts have since called for radiotherapy to receive greater priority as a solution to the cancer backlog. The UK radiotherapy workforce worked individually and collectively to bring in innovation and flexibility to rapidly adapt complex workflow patterns and deliver effective

¹ Hanna TP, King WD, Thibodeau S, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. *BMJ* 2020; 371: m4087.

care during COVID-19 and support patients. The frontline workforce stretched and flexed themselves to the limit during the pandemic, even with many staff redeployed to COVID-19 wards.

UK Government figures recorded 40,000 “missing” cancer patients from the first wave. Taking into account treatments and follow up that were postponed and subsequent waves, this number could be even higher. In response to the pandemic the Government have provided additional funding to the NHS and set a target of 110% pre-COVID levels of treatment for hospitals to catch up with backlogs. However, a recent report by the Institute of Public Policy Research (IPPR) suggested that even if

Figure 7: Proportion of patients receiving first definitive treatment within 62 days of urgent referral



hospitals could work at 105% capacity, it would still take 10 years to catch up. The cancer waiting times figures released on Thursday 11th November covering the period up until September 2021 show an all time low in all main indicators, including the 2 week wait for referral and 62 day for first treatments. This Government data demonstrated in graph (labelled figure 7) showed a concerning picture that cancer system was not coping once patients from the backlog entered the system. We were also concerned to see Government data showing that the biggest drop of all the three main treatments (surgery, chemotherapy and radiotherapy) was radiotherapy. Radiotherapy is the one COVID safe, cost-effective cancer treatment that can be substitute for surgery to bring down waiting lists it.

There was a strong feeling in all previous surveys we undertook that this vital role was lost on key decision makers in Government and NHS leadership. Overall referrals and patient numbers still remain down and NHS cancer data shows that we are still regularly breaching capacity. By this measure as the number of patients from the backlog presents to the NHS and winter pressures increase there will be a need to summon more capacity. Previous surveys had shown the extent to which the workforce were already overstretched. In carrying out this survey there were a number of important factors we aimed to measure. 1) the capacity in the system 2) the current pressures on workforce and equipment

and 3) the whether radiotherapy services can play the vital backlog beating role we need them to with current resources.

We undertook this survey to measure the ongoing impact on services and workforce pressures in light of the Government’s ambition to ‘catch up’.

Current Government Published data on Radiotherapy

Only provided until May 2021 at time of publishing: National Disease Registration Service (Public Health England) Radiotherapy data ²



² www.cancerdata.nhs.uk/covid-19/rtds

Survey Results: Multiple Choice Questions

There were 277 responses submitted to the flash survey, with two incompletes due to not working in a radiotherapy centre, so 275 have been analysed for this report.

Respondents

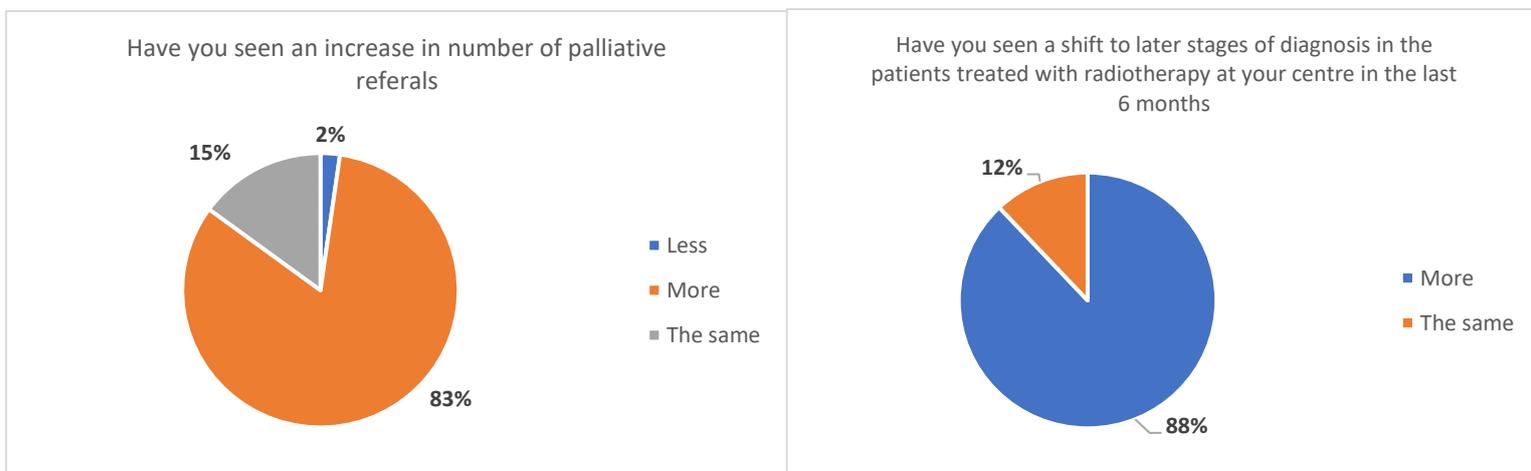
88% of respondents work in the NHS and represent all parts of the country and devolved nations. 8.7% worked in the private sector. **44%** of responders are therapeutic radiographers (who make up 50% of the radiotherapy workforce), 22% of responders were clinical scientists. Multidisciplinary professionals were represented including medical physicists, dosimetrists, clinical oncologists, and engineers. **21** clinical oncologists (doctors) responded. 18 respondents held a management role in radiotherapy. The full break down of the respondents can be found in [Appendix 1](#).

The cancer backlog

Respondents were asked to rate how serious a problem they thought the COVID induced cancer backlog was for cancer services. In total, **97%** felt it was either a very serious (58%) or serious (39%) problem.

A shift towards incurable patients

As a result of concern that delays to treatment may cause a shift to more advanced cancers, we asked respondees if they had seen an increase in the number of patients with incurable cancer receiving palliative radiotherapy. 83% (183 responders) who answered this question said they had seen an increase in the number of palliative referrals. This percentage had increased 10% from 73% in the last 6 months.



It was felt that there had been an overall shift towards later stage diagnosis in response to further questions, with 89% (190 responders) saying they had seen a shift to later stages of diagnosis in

patients in the last 6 months. This had increased 19% from 70% over the last 6 months. This suggests the frontline are still seeing more advanced and incurable patients, and the situation is worsening even now 18 months into the pandemic.

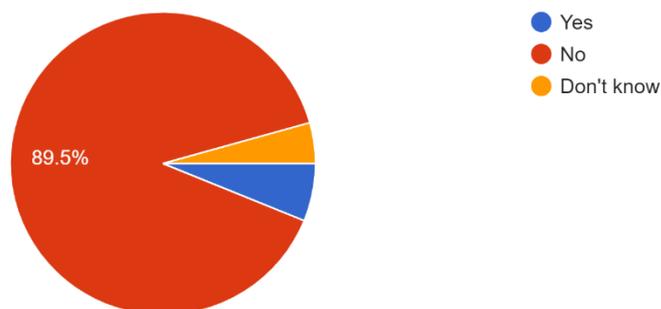
Increased activity in radiotherapy

During the pandemic, we know that radiotherapy has been used instead of surgery and chemotherapy in some instances. Frontline reports had also indicated that radiotherapy was starting to see some of the “missing referrals” come through for treatment. In the previous question, we had asked about how advanced these cases were. We also asked if there had been an overall increase in activity levels. **44%** said they had seen an increase in activity compared to non-COVID years, **28.7%** said it had been the same and **20.4%** said they had seen less activity.

Recovering the cancer backlog

The Government set hospitals with an aim of running at 110% pre-COVID capacity to tackle the backlog in their “Build Back Better: Our Plan For Health and Social Care” report. We asked if this 110% target could be achieved with current levels of funding in radiotherapy. **87.6%** said it could not be achieved and less than 5% felt it could be done. Asked about reaching the 110% pre-COVID capacity target in their individual department **89.5%** said it would not be possible.

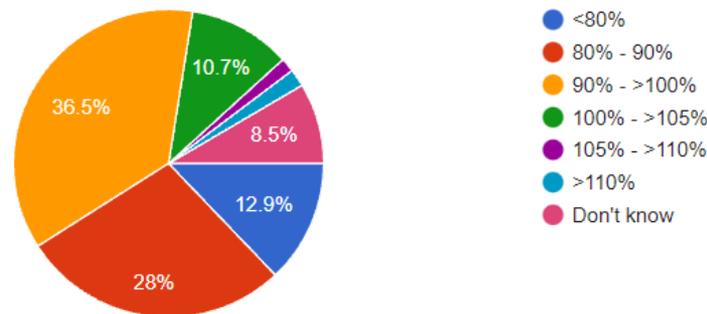
Can the department you work at reach 110% pre-COVID capacity with current levels of resources?
276 responses



To get a further indication of the level that radiotherapy services could reach, we asked responders to estimate what percentage could be sustained with current resources. **77% of the 275 that answered did not feel they could reach even 100%, and 87% did not feel they could reach 105%.** We note that a recent IPPR report suggested that it would take 10 years to recover the backlog if services could work at 105%. The majority responding to this survey did not expect to even reach that number. Shockingly, 14% felt they could not reach 80% capacity, 30% said they would likely fall between 80%-90% and 39% said they would between 90%-100% pre-COVID capacity. Only 6 participants (2%) felt they could reach the 110% pre-COVID capacity target identified by the Government to catch up.

In light of the Government ambition of reaching 110%, please estimate what level of pre-COVID activity levels you feel your service is able to sustain with current resources?

271 responses

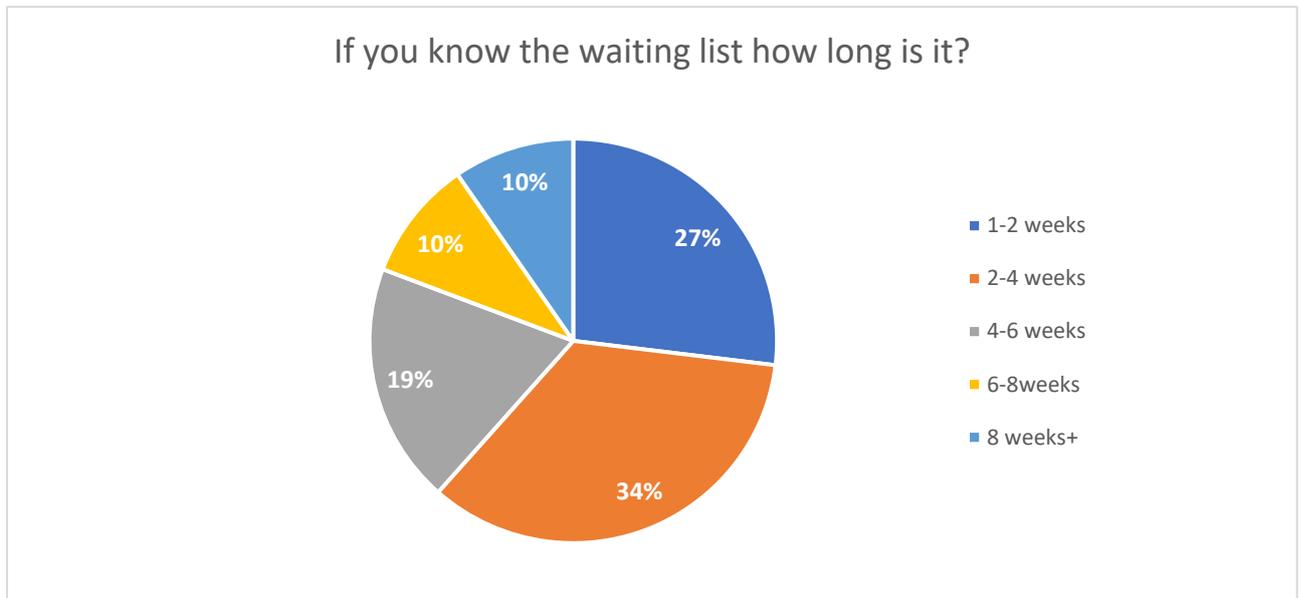


Responders were also asked for their comments on the steps that would need to be taken to get to the 110% pre-COVID capacity target. Responses included:

- “More staff and more linear accelerators.”
- “We don't have enough machine space or staffing levels to run at that level.”
- “Removal or redesign of block contracted payment structures to reflect the additional, complexity and urgency of activity.”
- “Current establishment is substantially below (60/70%) recommended levels, so achieving 100% capacity is a challenge, let alone 110%. I'm not convinced this is achievable across the whole of the UK, in all RT services at current staffing levels, while maintaining patient safety and innovation (SABR rollout etc) demands. We need to collectively increase system capacity but this will need significantly more staff, which don't now exist in sufficient numbers for recruitment. COVID, Brexit and Govt policy are major barriers to overseas recruitment. We need to train substantially more new staff across all professions, accepting this will be a drain on resources in the short term. Any impact of this will not be seen for 3/5 years but this is the best way forward long term, even if it doesn't fully address the problems now.”
- “Things that won't happen, mainly because finance won't flow to radiotherapy.”
- “Funding for LINAC replacements.”
- “Fund AI introduction for contouring in NHS.”
- “Training of radiographers and Physics staff.”
- “Support oncology trainee number expansion.”
- “Expand diagnostic CT/MRI provision, radiologists and pathologists (to speed up whole pathway).”

Radiotherapy department waiting lists

We asked responders if they were aware of their department’s current backlog of referrals/waiting lists. Of the 52 responders who were aware of their department’s waiting list, we were concerned to hear that 10% had a waiting list over 8 weeks and a further 10% had waits of between 6-8 weeks.



Radiotherapy needs to play a vital role tackling the cancer backlog

We asked if responders agreed with the statement “*the current radiotherapy service is equipped to tackle the cancer backlog*”. We found that **89.8%** (247) responders said they **did not agree** with this statement.

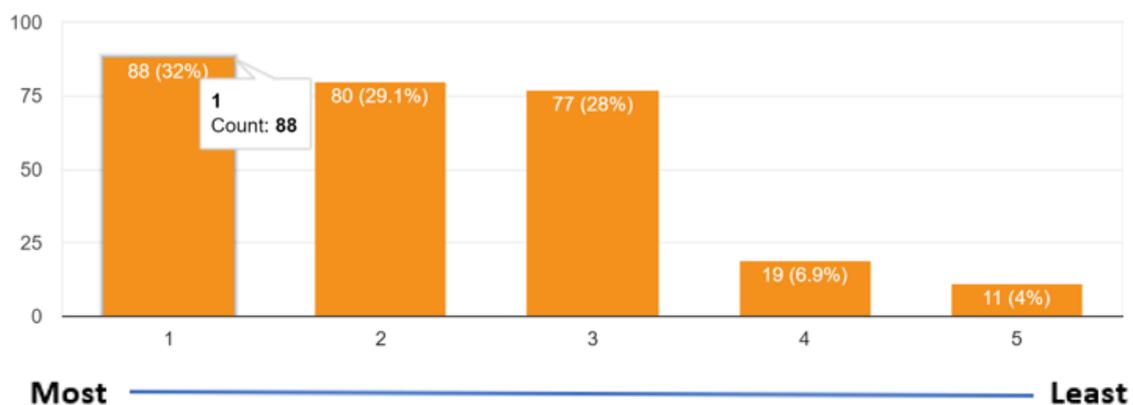
We then asked how strongly people agreed with the statement “*With a modest investment in new and additional equipment radiotherapy could have a significant impact on the cancer backlog?*” and **53% rated either the strongest agree or agree** with this statement.

To what extent do you agree that bureaucracy impedes your centres ability to tackle the COVID induced cancer backlog

A pattern in previous surveys held by Action Radiotherapy was complaints that red tape or restrictions which could be defined as “bureaucracy” was preventing them from tackling the COVID induced cancer backlog. We asked responders to scale from 1 (most) to 5 (least) the extent to which they felt impeded by this. 61% fell into the top two categories agreeing that bureaucracy holds back their ability to tackle the backlog.

To what extent do you agree that bureaucracy impedes your centres ability to tackle the COVID induced cancer backlog? e.g. Purchasing rules, tariffs

275 responses



We also asked responders to give us examples and quotes included:

- “Commissioning, approvals for machine replacements, ICS approvals of plans, competing for resources with other hospitals.”
- “Even though radiotherapy is the most cost effective treatment for cancer, compared to surgery or chemotherapy, radiotherapy gets unfavourable tariffs, less investment, low funding compared to surgery and chemotherapy.”
- “Long/complex business cases for essential equipment replacement.”
- “Tariffs not fit for purpose, inability to fund innovative ideas.”
- “Purchase/tender process.”
- “The amount of time that takes to get a business case approved is far too much.”
- “Delays in recruitment, difficulties in gaining agency staff due to funding and payment processes and regulations.”
- “Access to funds directly from the government, regional influences do not allow individual trusts to benefit.”
- “Barriers to implementing SABR.”
- “Complete lack of understanding of the role of radiotherapy by government and higher level management. Maybe they would invest if they realised that RT is more effective and more cost effective than chemo but they don’t want to know.”
- “Replacement of old equipment - business cases take a long time to be considered.”

- “Block tariff means unable to build business cases. Need to over-recruit to radiographer positions but difficult.”

Purchasing rules preventing machine upgrades

A regularly reported problem within earlier Action Radiotherapy surveys was that purchasing rules and funding mechanisms prevented radiotherapy centres from upgrading to the most COVID safe advanced radiotherapy machines. 63% of the 169 responders to this question felt that purchasing rules were preventing their centre from upgrading equipment and therefore hampering their ability to obtain the most advanced and COVID safe radiotherapy.

Stereotactic Ablative Radiotherapy (SABR)

The use of advanced precision radiotherapy with SABR, prior to COVID-19 had been actively restricted by NHSE to just over half of the radiotherapy centres. However, this technology was ideal during the pandemic, reducing the time patients spent in the hospital, improving survival, and acting as a substitute for surgery. Following an open letter to the Secretary of State for Health, signed by the radiotherapy community, NHSE announced in November 2020 the expansion of the use of SABR for non-small cell lung cancer and those with lung, lymph nodes and non-spine bone oligometastatic disease. This brought forward this expansion to all centres to be achieved by April 2021. An answer to a written parliamentary question stated that £13M was made available to half of UK centres where SABR had previously not been commissioned or had been stopped previously by NHSE³. Our survey in May 2021, after this NHSE target deadline, found only 72% of respondents said their department was able to deliver SABR. An answer to a written parliamentary question on 27th September 2021 said that all radiotherapy providers were delivering SABR for lung cancer patients⁴. We wanted to find out what progress had been made on the delivery of SABR for lung and other indications. This current survey found that 13% of responders said their centre was still not delivering it for lung cancer, and 48% were not delivering it for lymph nodes. Half of the responders were not delivering it for other indications such as non-spine bone and prostate cancer.

| | Is your centre using SABR for any of the following? | | | | |
|-----------------------------------|---|-------------|----------------|-----------|----------|
| | Lung | Lymph nodes | Non-spine bone | Prostate | Other |
| Yes | 232 (87%) | 123 (52%) | 118 (50%) | 131 (57%) | 89 (52%) |
| No | 12 (5%) | 72 (31%) | 73 (31%) | 79 (35%) | 63 (36%) |
| No, but expected in next 3 months | 22 (8%) | 41(17%) | 45(19%) | 19 (8%) | 21(12%) |

³ <https://questions-statements.parliament.uk/written-questions/detail/2020-12-09/127529/>

⁴ <https://questions-statements.parliament.uk/written-questions/detail/2021-09-17/50968>

Respondents were asked to give reasons that their departments were not able to deliver SABR in either of the above circumstances. A summary of the reasons is given below:

- Machines not being commissioned.
- Still waiting for funding to upgrade radiotherapy machines (Linac).
- Staffing issues.
- Commissioning delays.
- Had to redeploy staff to do this and utilised charity money.
- Not enough planning slots, radiographer and physics team shortages, and radiotherapy machine shortages.
- Prostate SABR has only been delivered as part of a [clinical] trial, it is not standard.
- Awaiting funding and full support for implementation.
- Lack of funding and equipment.
- Time being taken for QA.
- We should have more SABR treatment areas but have been unable to due to the pandemic slowing down the process.
- NHSE commissioning won't allow it. A convoluted peer review process with poor support has slowed implementation.
- Machine/Staff availability.

This feedback was at odds with the promises made by NHSE. From the feedback, it appears that implementation is being prevented by a lack of investment in staff and equipment for radiotherapy and by bureaucracy.

Separate and independent feedback from a UK private healthcare provider reported a massive 500% increase in referrals for SABR (mainly for oligometastatic disease and prostate cancer treatment) and an astonishing x3 fold increase in self-payers, suggesting patients are having to pay themselves to receive this more COVID secure SABR treatment.

Sufficient capacity levels

Respondents were asked whether they had sufficient levels of equipment (treatment and planning), funding for staff training, investment in IT systems and workforce. 38% did not have sufficient levels of equipment, 30% did not have sufficient planning equipment, 70% were concerned about a lack of funding for staff training, 65% did not have sufficient IT and 90% did not have enough workforce. It had been previously noted that 23% reported poor or very poor basic IT and this had not changed in the first year of the pandemic.

There were a number of comments received in relation to the above question including:

- “Normality is to stretch people and kit to their maximum with little or no investment in future planning or upgrading equipment.”
- “No new machines, no staff that is fully trained.”

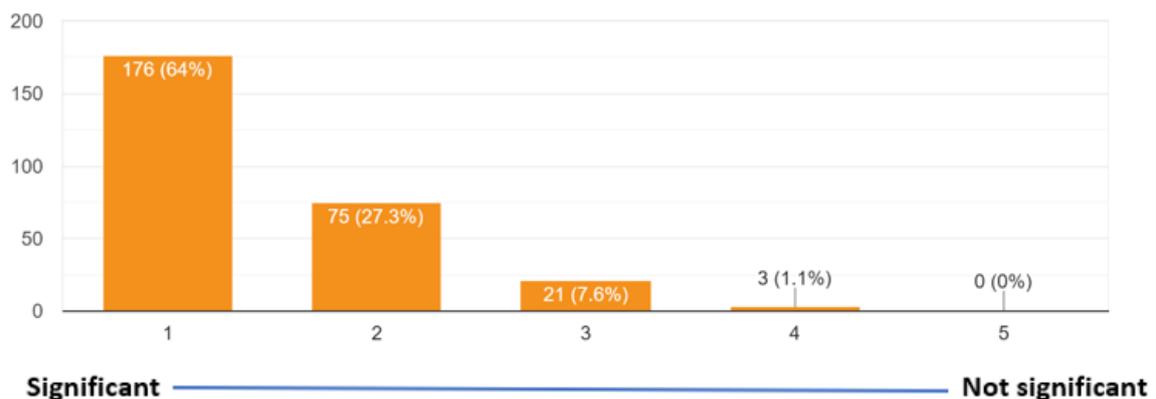
- “The service has been 'hollowed' out over the last 10 years.”
- “More funding is needed in all of those areas.”
- “Lack of staff funding for training. Therefore, staff paying hundreds if not thousands out of own pocket. Machines that are out of date. Consistent staff vacancies.”
- “Very poor IT and a lack of dedicated team to push this towards; struggling to retain staff and recruit. Wages do not reflect the work being completed. The level of responsibility and stress does not equate to other employment so not surprised staff members do not wish to stay. Work hours are becoming worse and being expected to stay late/not have adequate breaks/infrastructure so nowhere to go for a break or time out. Staff members are already at burn out.”
- “We have waited over 3 years just to purchase a piece of software that will have a dramatic effect on man hours (PSQA and audit) and is less than 1 round of a chemo drug. No staff no money and no help.”
- “Aging equipment, insufficient staffing levels.”
- “We still have one 15 year old machine, one about to be replaced, and another at coming up to 10 years old that is starting to have more frequent breakdowns. Our planning equipment is state of the art, but we often struggle with sufficient licences.”

Radiotherapy needs to play a significant role in order to bring down backlog waiting lists

There was an overwhelming feeling among responders that radiotherapy needs to play a significant role in tackling the cancer backlog. 64% said radiotherapy needed to play a very significant role, and a further 27.3% said it needed to play a significant role.

How significant a role should radiotherapy treatments play in bringing down cancer backlog waiting lists caused by the pandemic?

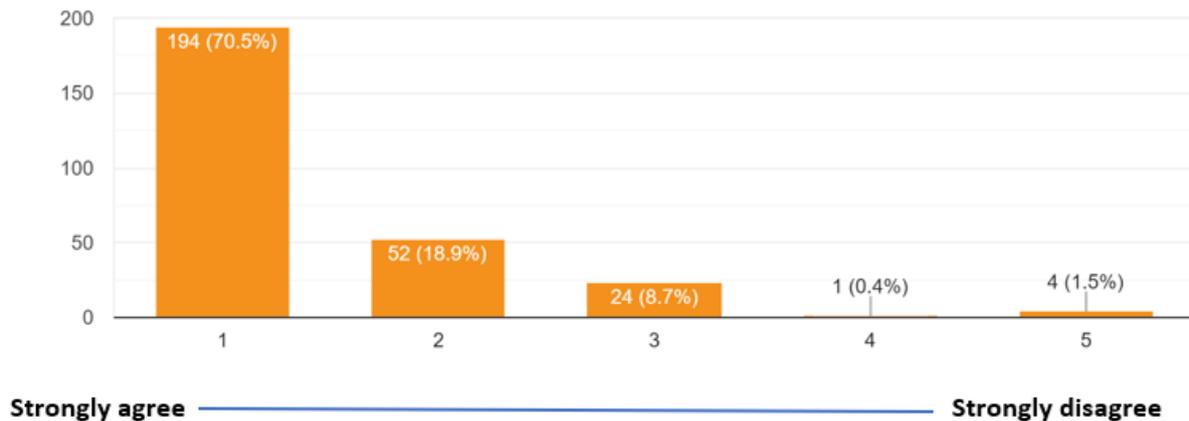
275 responses



A startling 89.4% felt the Government did not recognise the significant role radiotherapy needs to play. When asked, 70.5% picked the highest level of agreement and 18.9% picked the second highest levels of agreement with the statement: “The Government and NHS leaders do not sufficiently recognise the key role radiotherapy has to play in tackling the cancer backlog?”

How strongly do you agree/disagree with this statement: "The Government and NHS leaders do not sufficiently recognise the key role radiotherapy has to play in tackling the cancer backlog?"

275 responses



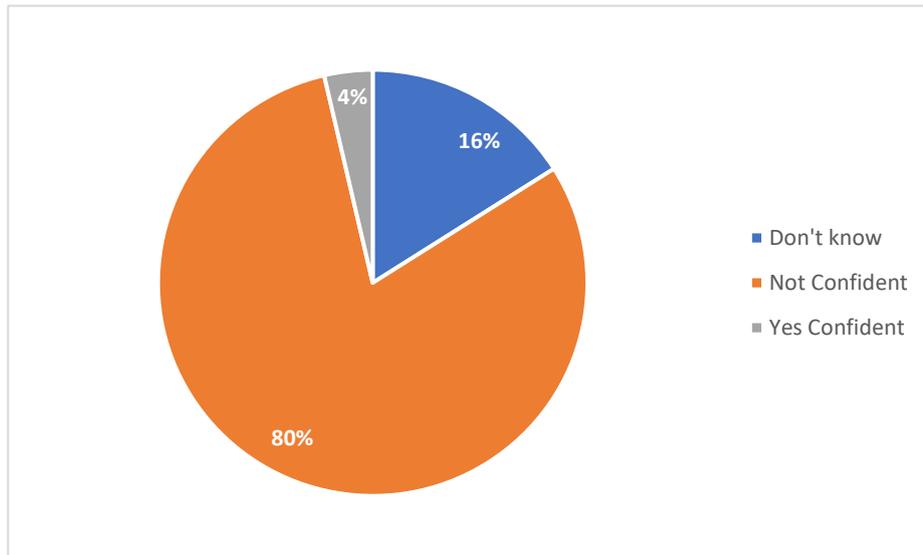
We asked responders what immediate innovative solutions could be implemented in radiotherapy to help tackle the COVID-induced cancer backlog and **received 143 written responses**. These included:

- Hypofractionation schedules, SABR.
- Capital investment in modern machines and planning systems.
- AI for contouring, ProKnow for better connectivity and peer review.
- More widespread commissioning of SABR to all sites, investment in research into SABR/hypofractionation.
- Specific investment in technologies such as SABR.
- Auto-contouring tools for radiotherapy planning. Software and staff to commission auto-planning tools e.g. dedicated funded Physicist in each department to look at efficiencies in treatment planning.
- Artificial intelligence software.
- Allowing a bespoke development-friendly multi-year financial settlement that is independent of the rolling 6 month budgets that do not encourage improvement or development. This would cover oncological, radiographic and physics staffing, imaging and treatment machines and enabling technology. It can be done on a partnership basis between Trusts, piggy-backing on the ODNs and securing a unified National Radiotherapy Service - which could lead the way on care-focused management within the NHS.
- Better working as a Network - utilise any workforce / capacity within the region, but recognise that this may not be appropriate for many patients.

Radiotherapy staff do not expect to get the investment they need

A staggering **80.4%** (221) of responders said they did not expect radiotherapy to be allocated the funding it needs from the Government's additional health and care funding settlement announced in September 2021. There was an overall feeling of having been overlooked in the past and absolute pessimism that they would once again be overlooked in the future.

In September 2021 it was announced there would be £4bn additional funding for tackling backlogs, including the cancer backlog, under current arrangements how much confidence do you have that radiotherapy will receive sufficient levels of funding to deal with the backlog?



Comments on the above included:

- “Radiotherapy is forgotten by the government.”
- “Radiotherapy is FREQUENTLY side-lined, with funding given to diagnostics, surgery and chemotherapy.”
- “It is cheap to deliver radiotherapy, but investments are seldom made.”
- “Cancer did not feature in last spending review so a little sceptical.”
- “Radiotherapy is the end point of the treatment pathway and if imaging services / surgery/ expensive chemo take the lions share we will be the Cinderella cancer service as usual.”
- “Historically we have been underfunded, so I don't see why it would change now. There was even a government petition but this was fobbed off.”
- “Radiotherapy is rarely used to its full potential, it often feels a forgotten treatment option.”
- “This Government has shown it does not consider radiotherapy (see comments by PM re not knowing difference between therapeutic radiotherapy and diagnostic radiology) I imagine this money will be swallowed by chemotherapy and other treatments.”
- “Very outdated equipment is still being used, I am not confident.”
- “Radiotherapy is not well understood by hospital leaders and therefore the money generally does not come to radiotherapy.”
- “How thinly is that £4bn going to be spread? I am extremely sceptical that radiotherapy will receive anything more than peanuts.”

Workforce

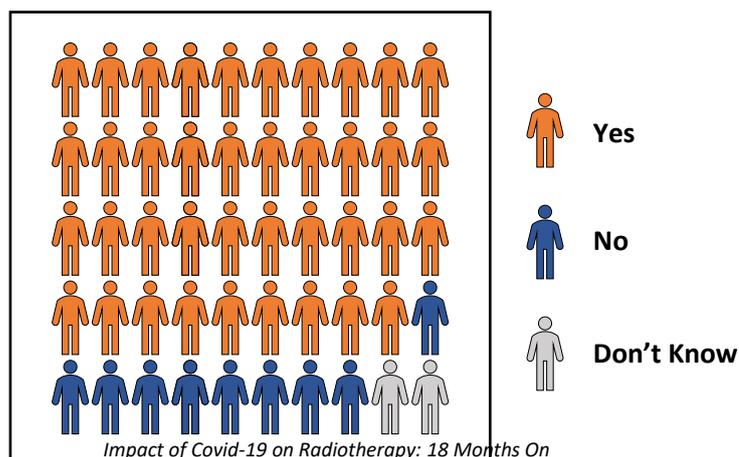
There was a consistent theme among responders that whether it be overall shortages or the impact of feeling the pressure of decades of underinvestment, the workforce has felt the backlog significantly. **91.3%** felt the Government does not understand the role of the specialist cancer workforce. **92%** felt the Government does not understand the impact workforce challenges have had on efforts to tackle the COVID induced cancer backlog. **64.5%** said the pandemic and cancer backlog had a negative impact on their mental health.

Comments from participants on workforce situation included:

- “Workforce is feeling stressed.”
- “Staff are exhausted across the professions. Please can we have more of them to share the burden and we won’t have as many leaving.”
- “Current working patterns are not sustainable. We are heading for a crash.”
- “Investment in future staff is essential. Better pay is essential. Politicians need to understand there are more than just doctors and nurses in the NHS.”
- “Pre-covid our service capacity could not meet the demands upon it. Staff are absolutely wrung out, tired, emotionally drained and feel utterly ignored.”
- “The government has no idea what radiotherapy is, a press visit every 5 years does not help funding or staff morale.”
- “A very real trickle of people leaving could become a flood.”
- “I have applied for a job outside radiotherapy due to stress.”
- “It isn’t sustainable. We are tired. Our work is getting more complicated with more - tighter targets to meet. It’s unsafe and unfair on patients and staff.”

In May 2021 we asked survey responders if the additional pressure caused by the pandemic or recovery had caused them or a colleague to consider leaving the radiotherapy profession: 64.9% responded yes. In this October 2021 survey, we asked the same question and found the situation had become even worse and now **79% answer yes they or someone they work with had considered leaving the radiotherapy workforce.**

Has the pressure of the pandemic or the recovery caused you or any of your colleagues to consider leaving the radiotherapy profession?



What else would you like to tell us

We concluded the survey by asking if there was anything else the responders would like to tell us. Here is a selection of the responses:

- “Government need to realise radiotherapy is the most cost-effective treatment available for cancer and better funding for radiotherapy is needed, more staffing and better equipment.”
- “I have worked in radiotherapy for 30 years. Apart from the period when NOF money was made available, we have been ignored as a service and as key professionals within the cancer workforce. Fiddling while Rome burns has been the philosophy for too long, particularly with respect to the workforce challenge which is no longer looming - it has arrived.”
- “I'm worried how much lower this government can push us before we all crumble.”
- “Not enough support for staff, the government don't care about us unless it's for a headline in the newspaper.”
- “New ways of training up current staff are needed in cancer care as well as funding for the latest treatments.”
- “Bullying is very common and nothing is done about it when you speak up.”
- “The heartbreak of a relative with cancer during Covid will only ever become clear to politicians if they find themselves or their relatives at the back of a very long queue for treatment, or mourning the loss of a loved one who wasn't treated in time.”

Appendix 1: Survey Results: Free Text Answers

As part of the survey, respondents were asked questions with the free text answer option.

What needs to happen to get to 110% capacity?

More staff

More radiographers

More staff, back up services e.g. admin; support staff; building resources - adequate facilities for staff- not enough clinic rooms, space for staff to have breaks due to covid restrictions, has been a historic lack of investment in radiotherapy in my trust - toilet facilities are terrible for staff and patients, no safe parking for staff to work these expected extended hours as finishing late in the dark; failed use of best resources - e.g. mri scans for planning purposes so treatments are mri fused; funding to push new techniques and services e.g. surface guided treatment - more efficient but cannot afford this on all treatment machines, spaceoar minimise long term toxicity so reducing future demands on services, adaptive treatment

The backlog should start from diagnosis through to referral and more patients to be encouraged to see GP and Specialists in time to diagnose.

More staffing, more breaks, feeling more valued at work/by the government

A break for staff!!! We're tired and broken post-covid and the government continually throwing us under the bus. We need newer machines, more funding for courses and a greater shift towards staff wellbeing.

More staff including clinical oncologists

A lot more staff, we are working at reduced capacity because staff numbers are the lowest ever.

More staff, more machines, more money

Additional funding for staffing

Recruit more staff across all staff groups

Additional resources, alongside a reduction in useless corporate paperwork, and unhelpful processes

We need more staff & MORE LINACS! we don't have enough consultants or physicists to plan the patients we currently have. We don't have enough staff to run shifts, but we are at 100% capacity - how can we do more? Are the government going to support us with free parking? What about those who rely on public transport, is shifting to treat all these extra patients going to work for them? Are they going to encourage employers to give us on-site parking or do I have to walk through the city to get to my car in the offsite work car park at 9pm after a late shift?

Additional staffing, both radiographers and physicists.

More staff to run an extended day and more equipment (IT)

An agreed methodology as to how a 110% capacity service is measured. Clarity is required if it is number of fractions, amount of clinical hours treatment equipment is available for, if it is number of referrals etc.

Increase in staffing budgets (across NHS systems, not just in radiotherapy services)

Increase in availability of support services throughout care systems (e.g. availability of pharmacy, beds for unwell patients to be referred to)

Increase in the capacity and role of all practitioners

Make available cancer care coordinators

Consider providing temporary registration and employment for third year radiographers. NHS England to mandate that these radiographers are employed to bolster rotas.

Review of the complexity of radiotherapy techniques available which either requires significant investment to provide access to highly effective techniques (SABR/SRS/Brachytherapy) or a reduction in the quality of radiotherapy which can be provided.

Redistribution of patients across regions to the care provider that has capacity rather than is most appropriate.

Investment in emerging approaches to care, e.g. frailty, pre-hab, hypofractionation.

Removal or redesign of block contracted payment structures to reflect the additional, complexity and urgency of activity.

System led approaches to managing patients who have acute oncology complications so that care can be coordinated but not provided by the radiotherapy clinic - freeing the radiotherapy clinic to providing radiotherapy care rather than ad hoc acute oncology care.

Integration of new roles (physician associates, nurse associates, acute oncology paramedics, mental health nurses) in radiotherapy services.

Significant investment in imaging and radiology services.

Reduction in the clinical research activity to redeploy research clinical oncologists and MDT members to the clinical clinics.

Suspend clinical placements and requirements to educate student radiographers

Suspend apprenticeships and all workforce initiatives to release registered staff to perform clinical roles

Suspend some regulatory compliance requirements

Suspend biosecurity requirements in services

Overall an NHS wide approach led by the radiotherapy networks to a) distribute resources, b) redistribute activity across the regions, and C) hold services to account to achieve a defined 110% target"

More staff, more equipment

An increase in members of staff

More staff. Improved staff morale for existing staff. A lot of therapeutic radiographers are leaving because the pressure is so high. We are already a profession with limited numbers. We need to encourage students into our profession

An increase of at least 10% in staffing - that is about 21 radiographers in my department.

Need more Radiographers, Dosimetrists and Physicists. We have the capacity in CT and on the Linacs if we worked extended shifts, but simply don't have enough staff to work these extra shifts.

Another linear accelerator in satellite centres, increase in clinical oncologists, increase in therapeutic radiographers by 10%, more physicists to enable further standard techniques at the satellites

Staff and the RT system capacity to increase

Capacity has a limit, that's why it's called capacity. It's a ridiculous statement. You need to fund additional capacity, either by extending existing treatment hours or outsourcing to the private sector, which has variable capacity available. Accelerating the push to provide more SABR offers some gains, but planning capacity is severely limited. There are down the line planning options from the independent sector and abroad which could fill this gap under subcontract.

We don't have enough machine space or staffing levels to run at that level

Capital money and revenue money for equipment and staff. Development of engineering support staff will take the money and 6 to 12m to train.

More staff and resources across the patient pathway - radiographers, clinical oncologists, engineers, dosimetrists, support workers, finance

Combination of more radiographers to support different working patterns, e.g. significantly extended working day on CT scanners and treatment machines, significantly more dosimetrist and planning physicist capacity, quicker roll out of evidence-based reduced fractionation regimes, emergency measures to address Oncologist workforce pressures, understanding that all of these are needed in combination due to the multi-professional complex pathways in radiotherapy.

More staff to be hired

Considerable increase in resources (staffing)

More staff!

Current establishment is substantially below (60/70%) recommended levels, so achieving 100% capacity is a challenge, let alone 110%. I'm not convinced this is achievable across the whole of the UK, in all RT services at current staffing levels, while maintaining patient safety and innovation (SABR rollout etc) demands. We need to collectively increase system capacity, but this will need significantly more staff, which don't now exist in sufficient numbers for recruitment. Covid, Brexit and Govt policy are major barriers to overseas recruitment. We need to train substantially more new staff across all professions, accepting this will be a drain on resources in the short term. Any impact of this will not be seen for 3/5 years but this is the best way forward long term, even if it doesn't fully address the problems now.

More Staff, including radiographers, nurses, support staff, engineers, physicists and doctors to accommodate working weekends and longer days.

Existing staff vacancies need to be filled, more trainee funding to have a pool of people that could fill vacancies in future, staff support to prevent loss of experienced staff due to pressures and stress of covid, understaffing and being undervalued, dedicated

More staff, more funding.

Higher level of pays to increase staff morale

Extend working hours for all staff groups to increase the patient treatment day but this is not possible without further official consultation. Goodwill of staff is being pushed to the limit in terms of working extended and shifted days with no monetary recompense and it is difficult to take lieu time earned back because it leaves the standard working day short-staffed.

There are several technical challenges, and the IT infrastructure is not set-up well enough to support 100% capacity let alone 110%. We are required to work from home to comply with the Covid safe office working arrangements or because the area on site does not have the physical capacity to fit everyone in but IT frequently lets us down forcing us to work even longer to complete the same amount of work that we were able to achieve working.

More staff. Better leadership

Extra linacs (not likely to happen quickly) so more realistic to get more staff and/or overtime required e.g. longer treatment days

More staff: Physicists, Radiographers, Dosimetrists and Clinical Oncologists.

Extra staff to run Linacs and CT scanner longer

More trained staff to cover longer hours

Financial support, running with an approx. 10% reduction in workforce

Pre-covid workloads were just manageable. But treatment machines were running at their capacity. The treatment machines at my department do not have an extra 10% capacity available. We would need an extra linac. But would need additional radiographers to run it. Clinical oncologists cannot cope with the current workload and are not marking up patients in a timely manner. So, there is currently no possibility of increasing capacity. We need more oncologists to enable that.

First of all, staff need to feel motivated and thanked for all their efforts through the pandemic. Staff are too tired to work weekends to free up the backlog of patients, need more staff, better pay and incentives to current experienced staff to stay.

So much more funding, staffing of specialist groups is a very severe concern.

Funding for more staff

Staff or investment in technology like AI/auto contouring...

Further hypofractionation, additional staff and retention of staff

There is no possible way we could do this at my department. We would need more staff and more linacs, so therefore more funding. We are currently not even working at 100% capacity due to staff shortages.

Further staffing

We need 110% of resources to run a service at 110%.

Given linac limitations this would require weekend and evening working, but we would need staffing for this.

We would need to recruit to all current vacancies and then increase the workforce by around another 15 radiographers to bring us in line with the average staffing for a 4 linacs department. At the same time the need to increase IT technologies to improve throughput e.g. AI for outlining organs at risk. Clinical Oncologists and Medical Physicists and Clinical Technicians need additional staffing. In order to meet the additional capacity required it is not a case of going from 100% to 110% as the standard is that a department should work at 87% to allow for essential functions to take place e.g. equipment maintenance, education... so the rise in capacity they are expecting is closer to 25% than 105 very disingenuous of them.

Another thing they could do would be to actually pay us an appropriate wage. We are currently paid less than our colleagues in Scotland and our pay over the last 10 years has gone down by over 14% in the last 10 years in real terms while wages in the private sector wages have risen by between 4.4% and 11%. While not directly related to managing the capacity required morale is very low and staff are showing signs of exhaustion, stress and crying in the department, sickness levels are rising and job satisfaction is as low as I have ever known it. "

Greater investment in staffing levels and equipment

More staff first of all and more machines as well

Greater personnel investment, as treatment techniques are also getting more advanced at the same time, requiring even more support.

more staff resources, innovation in technology and simulation, increase in student training places

Huge recruitment issue. There are too many jobs with no radiographers to fill them

more staff to increase working hours

I would recommend an increase in remuneration for NHS funded neuro SRS treatments in the private sector upon contract review, particularly in Gamma Knife departments.

More staff with the appropriate skill levels and more equipment funding. Its no-good funding staff at lower bands who don't have the skills or training needed.

If we work longer days or weekends we need more trained staff, but from where? Staff are already overworked and morale is low so how do we ask them to give more, that more likely to see them leave not stay! When/how do we have our LinAcs serviced?

More staff!!

Improvement in staffing and equipment! Currently struggle to staff machines 9-5

more staff, extended days, i would imagine weekend working, further implementation of shorter treatment regimes.

Increase in all resources, staffing and equipment

More staff, longer hours, more collaborative care management are needed to speed both access into the rad department but most importantly CT access and Dosim etc.

Increase in band 5, 6, 7 staff

More staff, more equipment, more space for these extra staff - no good cramming people into unsafe conditions. Much of the work cannot be done from home.

My old trust had a portal so you could log into work stuff from home. My current trust will only let you login via trust laptops. If they break or the person who has it has to isolate then it can screw up rotas and increase the number of people at work - increasing contamination risks.

We desperately need more staff last year about 10 people applied for each position of the STP and jobs are constantly being advertised for role.

The person specification needs to be adjusted. People who have actual experience aren't getting interviews when phds fresh out of uni are.

The PTP scheme is kind of a failure. It should be advertised far more and an awareness of its existence should be the focus of a campaign; especially in schools"

Increase in funding/bank staff

More staff, more linac capacity, more OPA clinics for consent ad referral. None of which are a 'quick fix. Staff are tired and can't keep working overtime, can't keep giving up their weekends or evenings to work longer days

Increase in recruitment of radiographers and dosimetrists

More staff, more treatment slots

Increase in staff, increased working day, weekend working.

More staff. Can't run staff flat out for ever.

Increase in staffing

More staff. More linacs

Increase in staffing

More staffing and equipment

Increase in staffing - investment in training - additional resources

More therapeutic radiographers

Increase in staffing - Physics/Dosimetrists & Radiographers

Increase in number of student Radiographers

Increase in pay to encourage staff"

More treatment time on machines = longer working hours. We have no spare capacity to reach 110%. Need 10% more salaries & willingness of staff to work those hours

Increase in staffing resources is needed, especially for clinical scientists and radiographers

1) Funding for LINAC replacements 2) Fund AI introduction for contouring in NHS 3) training of radiographers and Physics staff. 4) Support oncology trainee number expansion 5) Expand diagnostic CT/MRI provision, radiologists and pathologists (to speed up whole pathway)

Increase in Workforce and equipment.

QC and vital maintenance time is being taken clinically. This is causing extreme increases in stress for support staff such as Physics, Engineers, booking staff and Radiographers.

Increased funding for tech and staffing

Related service costs, additional planning resource

Increased funding in multiple areas including buildings, machines, staffing, resources, training, advanced practice roles. Reintroduce NHS paid degrees and Bursaries returned to previous levels, more AHP/ nurse advanced practice/ consultant roles. Increased pay for NHS jobs. Greater investment in promoting various roles in cancer care.

Staff and improved management of the department

Increased funding so that we are able to recruit / train more staff

Staff increase will be needed plus extended hours to deliver the additional treatment numbers. Due to being part way through a replacement linac program this also means capacity can only come through extending hours on existing machines.

Increased funding to allow longer hours? ad hoc clinics

Staffing needs to increase

Increased service hours, increased staffing and behinds scene support (engineers and physics)

there aren't enough staff most weeks to run the normal service as it was intended, staff already cover the loss of staff due to maternity, annual leave, sickness and professional leave with no replacement staff. there isn't extra capacity within the current staff numbers to increase workload. There is also the issue of not enough radiotherapy equipment, Ct scanners or even workstations and desks for any extra staff to work at.

Increased staff and resources

Trained staff

Increased staff WTE within planning & dosimetry definitely required, Enhancements for Technical staff to work extended / unsocial hours may be beneficial, possibly additional treatment Radiographers to allow shift working.

We have too many staff being given band 7 roles which then takes them off the treatment floor. Meaning if they are to help cover, they can't do certain parts of the jobs due to a loss of their competencies.

Increased staffing

We need more linacs and therapeutic radiographers

Increased staffing both clinical, technical and admin.

Increased equipment provisions

Development of AHP staff to support medical colleagues

Development of services to support more efficient ways of working

We would have to extend the department hours to increase capacity across the service. I expect as we already work 8-8pm on the treatment units, that this will mean a 6 or 7 day service. We would need additional staff to safely run this service. Pre-treatment would also need additional staff to cope with the additional patients.

Increased staffing levels

Increase in staffing and resources

Increased staffing resources and increased machine resources for smaller departments where extended working days are not a viable solution to increase capacity.

More staff as we are running at maximum 3 staff per machine doing extended hours. The benefit of additional machines will allow for greater capacity. But right now with limited staff, it's hard to treat patients at the capacity we have now

Increased staffing to ensure safe working practices. Current sickness/burnout/covid isolation is a real issue. Additional PPE extends the time of each appointment.

More staff in all areas

increased staffing, or otherwise money to pay for overtime at all staffing levels; however, given effect on physical and mental health of extensive extended hours over a long period of time, the second option isn't viable over the long term

More staff quicker processes e.g. hypofractionations

Invest in more staff and more equipment (Lin acc)

More staff throughout the department. An additional linac

Investment in staff and equipment

More staff to increase machine time out of hours

Investment in staff and whole infrastructure. 110% capacity = overworked staff and equipment. We're tired, we're sick of being taken advantage of and we can't continue

More staff to introduce shift work

Investment in staffing

More staff to run machines to full capacity

Lack of staff, lack of machine capacity - need more of both!!

more staff working sensible hours

Longer shifts on existing Linacs will result in OT and unsociable hour payments

More staff! Greater support from primary care and social care services.

Many more staff - radiographers, physicists, dosimetrists and Clinical Oncologists

More Staff, a lot of staff are off with stress.

More clinical staff, admin support, nurse specialist training and funding

More staff, better use of AI techniques, increase of consultant radiographers to take consultant oncology work

More Clinical Oncologist time required. Or tools to allow time savings e.g. auto-contouring tools to allow faster mark up for Radiotherapy treatments.

More staff, extra linac

More clinical scientists and more consultant oncologists.

More staff, increased pay to aid retention and overall morale, increased funding

More clinical staff, access to Radiotherapy scanner. We currently book into a diagnostic scanner.

More staff, more clinical hours, more money

more funding for more staff, equipment and increased pay for retention

More staff, more equipment, bigger centre? New hospital site. Weekend working?

More funding for staff so current staff can take their annual leave when they want it to prevent burnout. Current staffing is not able to cope with the backlog as it stands now, they are exhausted and moral is rock bottom.

More staff, more equipment, shift work (if anyone agrees)

More funding particularly for extended hours staffing

More staff, more infrastructure, more robust and agile workforce across all the radiotherapy professional groups and support teams

More funding, better, more up to date equipment to avoid machine breakdowns constantly.

More staff, more machine time, more investment in software systems

More funding, more staff

More staff, more resources, more funding

more funding, more staff, more training, greater awareness of roles and responsibilities

More staff, paid overtime, diagnostic support

More investment in education, both at university and via apprenticeships, with clinical educator roles being created to support clinical staff in managing the increased student numbers required.

More staff. But capacity needs to be defined carefully. The reduction in fractions for breast and prostate means number of patients treated, not fractions delivered, is the more appropriate metric.

More investment in staff and resources

More staff. currently running at 50% staffing in both dosimetrists and scientists. CCO's are struggling to cope too

More investment in staff to run extended hours

More staff. More linac capacity.

More Linacs, more radiographers, consultants, physicists etc

More staff. We're currently unable to run the treatment machines at full capacity/efficiency due to lack of staff. Increases in pressures/expectations ultimately led to more staff leaving making the problem worse. Recruitment is difficult in the SE of Eng due to standardised wages and higher cost of living.

More linacs, more staff, more money

More staffing across the board (radiographers, planning staff etc). More radiotherapy equipment (CT SIM, Linacs etc)

More linacs, more staff, more outpatient clinic availability.

More staffing resources including funding for over-time.

More machine time, more staff

More staff to extend days & do weekend servicing / working to maximise machine capacity

More machines and staff - we ran at over 100% capacity before covid.

More trained staff and/or more training to existing staff so that responsibilities can be cross covered.

More money towards staffing not only radiographers but also clinicians as patients are generally more unwell and require more frequent reviews

More trained staff/funding for current staff to work overtime

More qualified staff

National machine replacement program, more staff (recruitment & training), updated planning systems and oncology IT - we've been running on empty for the last 10 years - planned sustained investment in the service required and adequate support services SACT, transport, and associate medical services - dental support especially for head & neck work

More radiographer, replace old machines

Need to accelerate hypo fractionated regimes and reduce 31 days or 62 days targets to 21 days or 50 days respectively

Need to employ more staff so we can work an extended day

Need to increase the staffing levels 3-fold

Patients will be delayed.

More radiographers to staff the Linacs

Probably to extend working hours however staff are exhausted and won't appreciate this, more linear accelerators to reduce pressure and we need more staff and a pay rise.

More radiographers, more admin support

Realistic numbers of staff to not only treat patients but to develop services and quality care

More Radiographers. Years of dropping student numbers has led to a reduced number of Radiographers in the profession. People are leaving and they cannot be replaced.

Funding for equipment to be able to work more efficiently. More reliable equipment as well. More ICT support.

Recruitment to all staff groups

More referrals, diagnostic tests, oncologists, linacs, radiographers, physicists, dosimetrists

Skilled staff and reliable equipment

More resources

Staff - we are particularly short of Clinical Oncologists and Therapeutic Radiographers. Our Clin Oncs have too many patients in too many clinics on too many different sites. Improved IT only goes so far. We have delays in patient pathways due to delays in getting PET-CT scans for example which are required to accurately plan the patient treatment.

More resources, predominantly people with the correct skills (they aren't available), a more holistic approach to staff, the service relies on more than just therapists

Staff and recruitment issues Funding to support.

More specialist staff

staff increase

7 day working?

Staff longer hours or reduce quality and safety

Staff. Linac replacements. Extended days

>10% extra staff, mainly, but not only, radiographers. Suspend SBRT roll out as many centres only now are trying to complete/start the process now. Financial support for technology upgrades.

staffing increase

Staffing investment

More staff

Longer shifts? Run a later shift rather than working an hour of overtime

System re-structure, improve the efficiency of workflow, increased staff

more staff (all staff groups), more money, more machine capacity

The Christie should NOT BE CLOSING linear accelerators & reducing front line radiotherapy staff numbers at the busiest site.

This is incredibly short sighted and driven purely by the bottom line.

The opening of Macclesfield satellite centre has complicated things because the Trust has decided that the two machines will have to be funded by the main site staffing budget.

To do so they will have to close two machines at the main site operating at 100% (not just leaving them idle but essentially taking them out of commission) and staff two satellite machines operating at a lower capacity (80% leaving the surplus work to be picked up at main staff when staff are working 8-8 and beyond with already vulnerable low staff numbers and operating under pressurised, exhausting conditioned.

This with 15 fewer radiographers (relocating to Macc) and with an emerging picture of more complex, advanced cases, patients needing more care and interventions, each patient taking longer to treat.

Finally, dictating that staff will have to move to Macclesfield against their will creates an environment of mistrust and disaffection and increases the likelihood of valuable, competent, experienced staff leaving the department.

Therefore to get to 100% Macclesfield should open and the main site should retain both Linacs, with the staff budget increased to man all machines adequately. But to do that we either need to get the media involved or the DoH should get its act together and direct the Trust to do so.

More staff (all disciplines) and more linacs

There is a serious lack of all 3 of the healthcare professional required to deliver radiotherapy i.e. therapeutic radiographers, healthcare scientists and engineers and clinical oncologists. There is also a lack of access to the modern software and equipment used in delivering radiotherapy treatment. Urgent investment is needed in these areas.

More staff (therapeutic radiographers, planners, oncologists, nursing staff and admin) to enable us to work extended hours safely.

Things that won't happen, mainly financial.

More staff across all specialities, more kit for treatment.

Urgent training and recruitment plus staff retention strategies

More staff across planning, physics, treatment as well as medics. More planning terminals. Another linac.

We have an acute staff shortage so we can't increase the hours we run our radiotherapy machines. In fact we struggle to maintain current levels. Shortage of therapeutic radiographers and clinical oncologists both requires practical complex technical skills. Bursaries for degrees would help attract mature students again, who are an important source of new radiographers and cannot afford university fees or debt.

More staff and less exhausted staff

WE need 10% increase in the number of physicists, radiographers, and we need an uplift in the funding for radiotherapy planning software (cost is pay per patient) to increase capacity

More staff and more linac hours

We need funding to employ more staff

More staff and more linacs!

We need more qualified staff.

More staff and more linear accelerators.

We need more staff and more equipment

More staff and more machines. Both of these require much more funding.

We would need additional staff to cover longer hours and there is a risk of losing some experienced staff with childcare/ older relative caring roles in working extended hours

More staff and more money to encourage current staff to do overtime.

More staff and more robust partnership between nhs and private healthcare providers to clear the backlog.

More staff and overtime pay

Are there any barriers that prevent you delivering the best patient care that could be defined as bureaucratic?

Not really it is a system and money issue that impedes us most

Hierarchical frontline workforces reduce agility in departments

No

Managers not letting people progress and constant pressure to work more and take on more.

Allocation of funding is the largest barrier. Large amount of money for new radiotherapy satellite centre but no money to staff it, therefore, capacity not increased in any way. Proton beam centre somewhat overstaffed while photon department struggling.

Funding for new machines and improving our departments

Insufficient funding

Staffing either due to shortage or exhaustion

Low staffing

More funding is needed for more Therapeutic Radiographers

Due to the high cost of RT equipment, financial and procurement processes are lengthy

Access to funds directly from government, regional influences do not allow individual trusts to benefit.

Management of 2 NHS trusts on our site are in conflict. This causes us many delays and logistic problems. Serious parking issues for staff which could be resolved by more thoughtful management. Having to use private facilities on site and the associated logistical difficulties. Digital patient notes would save so so so much time and money.

Replacement of old equipment - business cases take a long time to be considered

Authorisation to employ additional staff

Before looking at staffing increases needed to tackle the future we have to be fully staffed or the Trusts policy is not to even look at business cases for the increasing workforce. With a global shortage in the profession we will struggle to fill all vacancies so the Trust never have to look at increasing the workforce, catch 22. But just because I can't recruit at band 5 does not mean that I have enough band, 7 staff, to provide a quality service.

Trained staffed, and the ability to be able to obtain funding for these. This crisis is also hitting at a time when the change in student funding is also manifesting in a lack of newly qualified staff available to recruit.

Brexit affecting timelines for linac replacement.

Purchasing rules, trust seeing us our department as 'coping' even though we are not, unable to fund more staff as the trust don't actually understand how many staff are really required

Politics

If your department has not been delivering SABR please say why?

If your department has not been delivering this please say why?

Equipment, software and staff training

Better care for patients

We are delivering but without the resources eg physicists, radiographers, consultants working unpaid overtime, and radiotherapy software paid at a loss to department

Not enough staff time to develop new services and maintain current levels of patient care

Linac replacement programme imminent

Machines are not commissioned, also there is limited cover from Physicist and Oncologists

NHS England restrictions

Not enough staff for commissioning and not enough machine time for physics to work

Funding and staffing shortfalls

Proton Beam Therapy Centre

Staffing

Prostate SABR has only been delivered as part of a trial. It is not standard.

Not enough planning slots, radiographer and physics team shortages, and Linacs

Awaiting funding to upgrade to linacs

A very recent addition. Had to redeploy staff to do this and utilise charity money

Bureaucratic implications hold this back as well as staff availability

Wales processes to slow

Resources, change of management, lack of ability support from commisioners.

In implementation stage still

Clinical set up

Resources

Lack of training and staff

Money for staff and equipment

In setup stages (delayed due to COVID)

Time being taken for QA, mentors not being available, QA requirements not clear

Newly implemented technique, however it is very resource intensive.

We should have more SABR treatment areas but have been unable to do due to the pandemic slowing down the process

Lack of staff, lack of clinician input in the developing phase, poor mentoring support and covid

Lack of investment and training

We did not have a CtE contract for SABR, although we did for SRS, so we have started from scratch with assistance of fantastic mentors.

We were not allowed to. now allowed. takes time to train and set-up

Lack of staff to set up the service

Lack of investment, shortage of staff, NHS England restrictions

As a satellite we deliver a subset of our parent hospitals treatment sets

Issues with implementation

Only just achieved the capability and Physics support.

It's only just being introduced in the next few months haven't had the staff available to make it happen fully

Awaiting equipment upgrade / subsequent training

Delays in WHSCC approval.

Hold ups in implementation due to staffing and training issues

No consultant trained

Unsure - but we have to be signed off for each site & pass QA

we are commissioning other sites but due to staff pressures and machine swap out program are limited on the capacity we can devote to this.

Consultant speciality

NHSE commissioning won't allow it. Convolutd peer review process with poor support has slowed implementation.

Not enough time to start a completely new service with no extra time/people and difficulties of linking in with other specialist MDTs

Resource/capacity for implementation. Covid resulted in a vast amount of fast change and in order to practise safely during times of heightened activity change development needs to be carefully managed

Not currently fully commissioned

Delay with medical physics staff

Capacity

Lung SABR has only been implemented this year

Training and competencies

Staffing for a time, referral mix the other

SBAR not commissioned

Staff, training, lack of development

Do you have sufficient levels of:

- **Up to date treatment equipment**
- **Up to date planning equipment**
- **Funding for staff training**
- **Investment in IT systems**
- **Workforce**

We are expected to do shift work to meet the patient demand. The replacement of linear accelerators is costly and timely and yet this isn't always appreciated. Hospital sites can be too small to support expansion. You need to ensure that increasing the size of a department is supported by infrastructure e.g. the correct number of toilets to ensure bowel prep can be undertaken. It seems that we can treat more patients easily by increasing working day hours, but it is the quality of the treatment technique that suffers!! Patient care is affected when the departments are busy!

I would like additional time on linacs, and for that to be properly staffed at the right grade to allow colleagues to research and develop during the day rather than when the long list gets finished an hour later than planned.

The Trust do not have enough funding for up to date planning system and treatment system. At the moment the network is thinking of replacing the existing radiotherapy machines, but no funding to get machines that are fit for purpose

We have enough of the equipment for the staffing we have but we are the worst staffed department in the country with 4 linacs

My old trust had roughly 55% of the recommended work force. Then 2 people went on maternity leave, and 2 of us left. At my current trust the situation is far better but there is still very little funding for training staff, particularly if we want to advance bands or go into more advanced roles e.g. no funding for dosimetrists to do a route 2

Normality is to stretch people and kit to their maximum with little or no investment in future planning or upgrading equipment

Staff is the critical thing. v short across all groups - radiographers, physics team and Drs

More funding to attract workforce into radiotherapy i.e. radiographers/physics/doctors

It is not just equipment required to clear back log, investment in patient support and carers important as many frightened of leaving homes, coming to hospital, body image issues, mental health issues. Investment for these patients to support them is required

Please see previous. In addition our planning department are constantly struggling with staff funding, this impacts on the amount of SABR patients we can treat. They need a massive injection of cash to bring staff numbers, training and experience up to a level that will allow greater SABR treatments to be planned.

No new machines, no staff that is fully trained

Some of the workforce are off sick hence lower levels

Procurement for new equipment is in progress

The service has been 'hollowed' out over the last 10 years

More funding is needed in all of those areas.

This is based on training equipment within university for student training

Unable to release potential of all new kit due to lack of sufficient staffing levels to carry out effective commissioning, research, audit, implement new techniques etc. ICT woeful

Staffing levels are currently dangerous. Funding is being reduced due to a lack of understanding surrounding reduced fractions but increased employment of difficult techniques.

Lack of staff funding for training. Therefore staff paying hundreds if not thousands out of own pocket. Machines that are out of date . Consistent staff vacancies.

Staffing is biggest issue

We have staff but just not always able to do what's needed

Staff cut as activity dropped due to change in shorter fractionations. Now we need that surplus to pick up the back log but its gone from the budget

Very poor IT and a lack of dedicated team to push this towards; struggling to retain staff and recruit. Wages do not reflect the work being completed. The level of responsibility and stress does not equate to other employment so not surprised staff members do not wish to stay. Work hours are becoming worse and being expected to stay late/not have adequate breaks/infrastructure so nowhere to go for a break or time out. Staff members are already at burn out.

More investment is needed in dosimetry planning equipment/software

Insufficient staffing and continuous turn over

An increase in Clinical Oncologist staffing is needed. A modest increase in Radiographers and Physicists would allow us to implement change more quickly. Currently change feels slow. Covering sickness (and other absence) in the Radiographer and Physicist workforce is challenging.

Funding for training is key

Previous rounds of funding have helped update our equipment, we just don't have the staff to fully utilise it.

Workforce is a major issue in our department.

Currently very short staffed

Machine upgrades delayed due to bureaucratic delays, SABR implementation delayed by the same issue. staffing big issue due to vacancies in all areas

Funding for training linac engineers is non-existent, but they hold arguably the most critical role in delivery of RT

We have a new centre, but a distinct lack of trained resources to use it. The pressure on the few staff we do have is palpable and WILL lead to people leaving the profession.

We have waited over 3 years just to purchase a piece of software that will have a dramatic effect on man hours (PSQA and audit) and is less than 1 round of a chemo drug. No staff no money and no help.

A big issue is that it is difficult to plan as funding is not predictable.

IT - had to go with in-house ICT as they were the lowest bidder. But they are appalling and cause us so many issues that we are now several versions behind the current treatment planning software & this is impacting on planning

This is both an trust choice not to invest in cancer treatment and a lack of availability of staff

Housing and cost of living is higher than London with no weighting, we are unable to attract staff and our workforce is always under tremendous pressure as we are short staffed

Cost is a major factor to updating equipment to the highest standards

Equipment and IT infrastructure is fine. The issue is staffing, especially as more people are being exposed to COVID and are forced into isolation.

Money is spent on covering current debt. Central programs for workforce development at lower bands (band 4 to 6) needs to be made by application to a central group, allowing each trust to focus on their requirements and show there needs for investment in staff.

General IT is in a perilous state.

Funding increase needs to be substantial. Where is all that money we saved with Brexit!!!

There is a lot of bureaucracy in allotment of funding for staff training and other training opportunities.

Mostly comes down to what funding is available.

Aging equipment, insufficient staffing levels.

High staff turnover due to poor pay compared to private sector and poor prospects for progression.

We do not have enough staff and are now looking overseas to recruit therapeutic radiographers

IT needs updating across the board and we have no funding for training

We used to have 4 linacs but now we have three (one being a 15year old linac) and the hospital won't pay for anymore because we've been able to maintain the service with 3 - they clearly don't realise that we have been working 7.45am-9pm to 'sustain the service' and are burnt out!

Those that have worked continuously during last 18 months are burnt-out because of having to cover for those not working

More basic computer systems e.g dual screen, fast and fully functioning PCs to speed up tasks and improve efficiency. More staffing required as currently not enough if need to work more extended days and more hours at weekends (already doing extended days and both weekend days)

We still have one 15 year old machine, one about to be replaced, and another at coming up to 10 years old that is starting to have more frequent breakdowns. Our planning equipment is state of the art but we often struggle with sufficient licences.

There are not enough people or kit

For intracranial SRS, have needed for several years to move to single isocentre technique. This needs 6 DOF couch, which we do not have, and appropriate planning software. Linac upgrade of stereotactic linacs keeps being pushed back, now 10 years old and replacement likely still 2-3 years off.

Main bottleneck is Clinical Oncologist time

Recruitment and retention of trained staff is an issue as is the time taken to train new staff

More radiographers are needed

Staff are leaving and not replaced - lots on sick leave

Severe shortage of trained staff in all disciplines, particularly Physicists and Oncologists

Staff with appropriate skills are hard to come by we also limit applicants by expecting a degree in all cases for engineering disciplines HNC is more than adequate

We need more staff and more equipment if we are expected to work at 110%

Will need more staff to run an extended service

The above question is too broad. sufficient for pre-covid yes. Sufficient to increase workload by 10% post covid - no.

The equipment we use can be old and was made in house the computers are old and slow with only 1 per machine with access to the internet

Educational establishments need to be suitably staffed and well equipped, just like clinical departments.

More investment needed

We will soon have four new machines but the Trust have chosen to have none matched linacs this will mean less flexibility of service for at least the next decade.

No idea how our treatment machines will get replaced when they reach their 10 year life end (as stated in the Radiotherapy Service Specification). The Trust doesn't have the budget to replace them.

Not enough staff for current work let alone extra or new work. late presentations mean much more complex treatments too

Our planning system and algorithms are over 10 years old. There is little motivation to change this.

Staffing levels and retention is a real issue

We have a rolling linac replacement underway but progress is slow due to funding. Staff training is well supported but this is via Trust charitable funds. New equipment such as SGRT is desired but unaffordable currently

Equipment resource is adequate until there is a breakdown.

You can have all the money available to invest in new equipment but if you don't have the staff to work the equipment it's irrelevant. Please could the powers that be appreciate staff more. I came back to the profession after a 10 year career break and I feel disheartened to carry on at the moment.

Department is consistently understaffed with vacancies difficult to fill with qualified staff

Please explain what a covid safe advanced radiotherapy machine? it really bamboozles me

Lack of RT staff to work beyond 10hr days (linacs could run for 12 hours if we had the staff to do this). Our IT system is painfully slow and not at all understood by the IT department in the trust.

It doesn't matter how good the tech is, if you don't have the skilled workforce to utilise it.

We have new linear accelerators but need new Superficial Xray unit and ultrasound machine

We have some new linacs. we are having to retire the oldest linac ahead of schedule as it is completely inadequate, it breaks down constantly, so we are having to work for at least 6 months to cover the replacement of this linac even though it is not due to be replaced yet. also, the computer systems we use are not fit for purpose, and impeding our move towards paper light working

Staff shortages, 2 old machines needed to be replaced

Not enough staff for sick cover, development work etc

Awaiting funding for some upgrades

IT is as good as it gets in the NHS but there are too many different systems that don't integrate with each other requiring duplication of work

NHS trusts don't have sufficient training budgets for conferences/courses

Radiographer vacancies difficult to recruit to

Workforce recruitment is very difficult at the moment, particularly in nursing and radiography staff

In your opinion, what immediate or innovative solutions can be implemented in radiotherapy to tackle the covid-induced cancer backlog?

This is a multifactorial issue and no one solution will fix what has been slowly ignored and underfunded for decades. It is a systematic issue and will take years to rectify with govt. will. We will get through the backlog because we are professionals and will prioritise patients above our wellbeing

Retaining the staff that we currently have.

Novel hypofractionation regimens where possible.

Those department with shortage of staff should hire more staff or work longer (which means paid overtime) so that more patient treatment can be booked through.

Bring more awareness to the profession. Recognise the need for training in advanced techniques and provision of more staff. Bring back NHS bursary to bring more people to profession

Help our diagnostic colleagues with reporting scans! Secondment opportunities for therapeutic radiographers to help our diagnostic colleagues? Until they can efficiently scan our patients and report the outcomes, we can't really do our jobs!!

Upgrades of linear accelerators, upskilling of therapeutic radiographer advanced practitioners to share the load from clinical oncologist e.g., planning, and prescribing radiotherapy in the form of rapid access palliative clinics

Artificial intelligence software

More staff. More departments.

Extend days with split shifts for more flexibility for staff and patients

Ensure departments have access to QA software such as 'per fraction' as this maximises access to the linacs for patients. Ensure software upgrades are supported to ensure systems such as Aria and Mosaic are efficient as possible. Review the use of RT in all cancer pathways to see if the timing of RT can be shortened or altered to support theatre capacity and chemo capacity.

Invest in staff, lower grade staff to do routine tasks free up the reducing number of available highly specialist staff (B7 and above)

More funding for staff and for training new staff along with equipment funding. Tempting staff to the NHS by paying them what they deserve. Staff in my area cannot afford to buy even a small flat on their salary so its hard to recruit and retain staff.

Improve retention, there is a significant increase of experienced radiographers leaving the career. We also need to increase training of radiographers

We need GPs to see and refer patients and they need support to be referring the correct ones. We still have a drop in radical referrals and are not sure where these patients are. Funding to implement auto-contouring (licences are expensive) so we can save precious clinical oncologist time in preparing a patient's plan, support for plan sign-off by delegation when plan conforms to protocol.

More radiographers

It's not innovation- proper investment in staff.

Fractionations have been reduced where possible so the main barriers are staffing and access to appointments. Unfortunately, there is not a quick fix to this if there are not trained staff available to employ. Support to manage employment from overseas during this time may be beneficial

Treat staff better and so they feel valued in their role. It's not just a financial issue but some kind of appreciation for the staff that have worked hard through a pandemic while trying to keep themselves

and their family safe. We need more media coverage on radiotherapy in general so more people are aware how important we are in cancer treatment.

Better use of resources. E.g. upgrading IT systems to allow staff isolating to continue working from home so as to reduce pressure on frontline staff. Capacity usage in terms of collaborating with private sector to take on NHS patients.

The main thing required is funding! 50% of patients with cancer have radiotherapy, so the fact that we are not a priority for funding is disgusting.

Use of private sector and PBT

Addressing scheduling and maybe working weekends but would need more staff for this!

In September 2021 it was announced there would be £4bn additional funding for tackling backlogs, including the cancer backlog, under current arrangements how much confidence do you have that radiotherapy will receive sufficient levels of funding deal with the backlog? Please comment

It is cheap to deliver radiotherapy but investments are seldom made.

Managers seem not to recognise that the reaction to the pandemic in radiotherapy to deliver more treatments as hypo fractional regimens actually increases workload. That there are fewer patients visits makes each visit more complex. All our execs see is fewer fractions so we need less investment.

Radiotherapy is FREQUENTLY side-lined, with funding given to diagnostics, surgery and chemotherapy

Funding is of no use if there is no workforce to recruit - we are highly specialised

None, the funding has been targeted at the first line diagnostic pathway and surgery with nothing left for RT

Based on past history a significant chunk will be spent on pointless managers and bureaucracy. I have received emails about LGBT cancer treatment. It's no different from any other kind of cancer treatment but thousands of pounds were wasted on this.

More funding won't help the current when the primary cause is a lack of staff. Staff take years to train. It will make an impact on future waiting time though."

Cancer did not feature in last spending review so a little sceptical

I have no confidence (options given are not phrased correctly)

Radiotherapy is the end point of the treatment pathway and if imaging services / surgery/ expensive chemo take the lions share we will be the cinderella cancer service as usual.

No means low confidence

The management involved in budget decisions have little understanding of what is actually involved, and look at solely at numbers i.e. number of fraction, which do not represent actual workload or complexity

The money just goes into the NHS money pit. We used to be efficient however the multiple layers of managers and bureaucracy swallow anything that gets injected - frontline staff are irrelevant to the government and the NHS executive.

Access to funding initiatives requires Directors of Strategy to understand the role radiotherapy can play and bid for funding. Funding must be spent in 2021/22 FY.

I think that a lot of the funding will go towards surgeries.

Westminster funded initiatives don't always translate into funding for the same in Wales.

in addition to that Dedicated radiotherapy MRI could help solve the issue.

Current yearly budget for cancer therapies Â£5b, Â£4bn is nice but won't make up for a decade of under funding

It depends where the funds are utilised

Radiotherapy is rarely used to its full potential, it often feels a forgotten treatment option

From past experience additional funding tends to be sucked up by Headline projects and basically personal 'vanity' projects with little if any funds actually going to the clinical front-line departments and staff

This gov has shown it does not consider radiotherapy (see comments by PM re no knowing difference between therapeutic and diagnostic rads) I imagine this money will be swallowed by chemotherapy and other treatments.

More funding is needed not only to train up staff through apprenticeships etc, the department also needs funding for more Radiotherapy machines and funding to have the new and most up to date treatments here in Sheffield.

Radiotherapy is not well known about and so may not get the funding it deserves

Radiotherapy departments are forgotten about in cancer treatments, costs £2 million+ to buy basic necessary equipment - £4bn across all NHS backlogs will equate to bare minimum per cancer departments/sites, let alone when split across immunotherapy, chemotherapy, radiotherapy, surgery, proton therapy etc

Bulk will be swallowed up on additional surgical capacity and admin projects with little effects.

Feel like people don't talk about radiotherapy much at all. Don't have faith that it has the recognition by the government it deserves

4Bn is not a lot when spread across every sector that has backlogs.

The prime minister said he doesn't care about cancer outcomes! Why would they care about helping us? Maybe someone should tell him that CRUK says people between 50-74 account for over half of new cancer diagnosis!! Matt Hancock thought diagnostic radiography is the same as therapeutic radiography!!

Never does come to us.

No staff!!!

Don't know enough about it.

Feel this will not be given to radiotherapy - radiotherapy seems to be the lesser valued treatment and in my trust has not seen significant investment or development. Our facilities - toilets, reception area have not been invested in since I started my training there in 2004.

Radiotherapy often is the last to get significant funding in cancer care with surgery and chemo receiving significantly more funding

Very outdated equipment still being used

Even if it goes to the NHS, the calibre of those entrusted to invest it will do more of the same and not deliver best bang for the buck

I've not heard where any of this funding will be used

There has been underfunding of the service for so long it will take a lot to catch up

Disadvantaged by working through 2020 - rules not transparent

Don't know how that's distributed and how Trust management choose to use it. Front line staff are just told there's no money.

I dont think there is enough understanding about the vital role radiotherapy plays in the treatment of cancer and this needs urgent attention so vital funds are received in this area.

Until we see how much of this money reaches the 'shop floor' and what restrictions are placed on its spending - this is tough to answer.

I think it will likely be spent on upgrading facilities and machines as these are essential, but whilst continuing to ask staff to work at above capacity.

RT is not well understood by hospital leaders and therefore the money generally does not come to radiotherapy

Not applicable to Wales

Radiotherapy is not seen as sufficient in the public's eyes, we have a real issue with our public image, it's all H&N skin reactions, patient overdosing errors and not enough WE'RE AS GOOD AS SURGERY FOR MANY CANCERS!

Nobody rates radiotherapy, including the general public. Funds will go to chemo, Macmillan, the areas that get press footage.

Radiotherapy has failed to secure significant funding before receiving a small percentage of the overall cancer budget. As a treatment that is non-toxic and does not require theatre or ITU capacity we should have had the flexibility to support cancer patients during the COVID pandemic but years of underfunding left us unable to flex our capacity to receive additional patients.

I'm not hopeful

Although we are cost effective most monies go to surgery and chemo (low benefit to high cost)

Money often gets consumed in the wrong areas within the NHS. Often filling in back logs from under funding.

I am convinced radiotherapy will be forgotten, the money will go mostly to surgery.

As before, it's not focused on key programs invest in staff not having access to HCS or MP training programs aimed at B7 and above.

Previous funding has been small and not of the required level.

How thinly is that Â£4bn going to be spread? I am extremely sceptical that radiotherapy will receive anything more than peanuts.

We need a longer-term plan to deal with workforce challenge.

More money goes towards the chemotherapy drug costs than Radiotherapy.

I think it takes a long time to get adequately trained staff and that is where the shortfall is, so it needs a long-term solution. pandemic burnout has led to a lot of staff retention issues

Â£4bn is not sufficient for whole of cancer treatment backlog. There needs a lot of planning in how this money will be spent and that will eventually increase a further bureaucracy.

I think most will be spent further up the chain before patients get to radiotherapy and probably chemo as there is more awareness around chemo

Unlikely for radiotherapy to receive an equitable proportion of this funding.

Workers on the ground will have no input or say in this.

We will have to wait and see. It will take time to resolve the current crisis happening in radiotherapy

Is that enough across the whole of NHS England?

I have VERY LITTLE confidence. It always goes to consultants and nurses. No one ever cares about us in radiotherapy - we aren't the 'sexy' department

There isn't the true understanding of how radiotherapy can be used and the general public sees it as a second-rate treatment option

No hints of radiotherapy having relevant weight

No oversight of how this will be allocated within our local Trust RT services

RT is traditionally underfunded; the capital funding system is broken. Managed at the individual trust level it doesn't work. There should a full, national scheme for all linac replacements. It's essential that TPSs are considered alongside linacs too.

The NHS is chronically underfunded so all departments are crying out for that money. Radiotherapy is often forgotten compared with the much more expensive, less effective but louder voices of chemotherapy and immunotherapy.

Money doesn't make more staff

Radiotherapy has been historically underfunded

Always goes to other services. Radiotherapy do whatever is necessary to ensure that patients don't wait and consequently people believe that funding is not required

We never seem to see any additional funding from central government it always seems to need to come from the individual hospital management luckily, we are generally well supported

There is a long-term funding issue that was there before COVID

I think radiotherapy will not receive sufficient funding as its ability to contribute to clearing the backlog is underappreciated

We won't receive enough of it although linacs are fundamental for cancer treatment. Or the money will go in linacs rather than additional staff. So our workforce will be spread out and more susceptible to burnout.

RT is forgotten by the government

The backlog can't be fixed just by throwing money at it as there is a finite resource in place in terms of staff, consultants for example can't suddenly work for double the hours to prescribe and plan treatments and you can't just train more in short order, there needs to be long term planning in place to ensure the service has a level of redundancy built in to cope with these issues

Statement says that but until noticeable differences are shown do not have much confidence

Not sure how much of that will filter down to educational establishments or be used towards training.

Radiotherapy is severely underfunded

It takes time to source equipment, install & then commission it. Also, staff need training prior to its use.

No clarification on how this will be distributed per centre or how it will be spent.

Is this an actual survey or is it merely supposed to give the illusion of being asked our opinions?

Question: "how much confidence..." Answer: yes/no...? Also, which govt? There's a few. Governments seem to be performative only in the UK. Maybe they only listen to the wrong people.

Money should be invested in service support. In supporting managers to manage more effectively. We need to reduce waste in the system. There is far too much toxicity and obstructive behaviour which has worsened

during the pandemic.

Unfortunately, RT is not always recognised highly in the cancer pathway

Chemotherapy & Surgery are massive sink holes for money.

We don't all need new Linacs its investment in staff so we keep the experienced workforce to train the next generation of radiographers.

Unaware if any of this funding is coming to Radiotherapy in Northern Ireland

RT has always been underfunded

Lack of trained staff

Chemotherapy will probably consume most of that money.

This will be focussed on diagnosis

The biggest backlog is in diagnosis and access to cancer diagnostics for our patients which means they come to treatment with a later stage disease. This needs to be tackled urgently so we can deliver more radical treatments and not see the continuing rise in palliation

RT is still painfully misunderstood by Health ministers. Don't seem to realise how cost effective it is!

Money can't provide more staff when there is a national shortage of staff. There is a danger that the money goes on managers, bureaucracy and hospital debt because that is an easier spend. Clinical staff lack basic IT to do zoom meetings when managers and short-term project leaders get iPads and laptops?

Historically we have been underfunded, so I don't see why it would change now. there was even a government petition but this was fobbed off.

It takes 3 years to train a therapeutic radiographer so this should have been considered a while ago - perhaps apprentice-type training, paid whilst training would be better

Funding to buy new machines, employ more staff

They don't really know about us!

Radiotherapy is rarely seen as a significant part of a patient's cancer treatment and therefore is generally unseen and underfunded.

Post pandemic, NHS workers saw a pay increase of 1% despite sacrificing a year of their and their family's wellbeing and health during the actual pandemic. While most of the country didn't leave their homes. And the financial sector got their bonuses and pay increase doing what?

Actions speak louder than words. Saying there will be an investment doesn't equate to its actuality and reality

Significant cutbacks throughout all departments means just that.

I believe there will be money, just where and what is being spent on is the question

5% of cancer funding goes to radiotherapy (not enough!) this will be the same again

It gets lost between government and the clinical provision

The effect from past funding increases has been difficult to see from the ground level, and my worry is that the funding will be used to fill existing issues due to funding shortfalls in the past decade rather than the backlog.

I believe workforce will be a bigger barrier.

Please add any further comments about the sustainability of the workforce

Need investment in students, staff training as this impacts on retention etc. Look at RePAIR recommendations and implement! The lack of oncologists is visible and TRads are doing more but with lack of staff development and training.

Staff are exhausted across the professions. Please can we have more of them to share the burden and we won't have as many leaving to be ultra-sonographers or mammographers or teaching assistants or whatever.

Staff are suffering anxiety and burnout, saying we can operate at 110% is probably unachievable - more people looking to other sectors for different roles to provide more work/life balance

Workforce is feeling stressed.

Current working patterns are not sustainable.

It is not sustainable we are heading for a crash

Investment in future staff is essential. Better pay is essential. Politicians need to understand there are more than just doctors and nurses in the NHS.

We have excellent data about the growing gap between demand and supply of workforce yet there is no clear plan to address this.

Pre-covid our service capacity could not meet the demands upon it. Staff are absolutely wrung out, tired, emotionally drained and feel utterly ignored.

Not sustainable at the mo. burnout. too many people leaving, not enough joining (new recruits being trained) ageing and stressed workforce who may well leave

All less resilient and likely to burn out. No access to supervision and little understanding from managers who appear more interested in retiring

The situation on the ground here is not sustainable. there should be a salary cap for the lead NHS and Trust executives when compared to what a Band 5 health care professional earns. IE maybe 5 times the amount?

As the need for staff increases the available pool of candidates decreases as there is insufficient investment across the sector and HEIs

Radiotherapy it's a specialist job and has to be looked at it in the same way. it takes efforts of different staff group together to treat one patient and hence this group of people should be provided with adequate resources and manpower to run the service smoothly.

Shortage of clinicians, specialised radiographers being upskilled to fill roles which is great but they are not being backfilled so depleted pool of radiographers to perform day to day treatments. Specialised rads not always recognised financially for the additional roles and responsibilities they have taken on.

Staff are worn out from the pandemic they have been giving 150% to get through the COVID period and have little if any left in the push to tackle the backlog

We need more staff IE treatment Rads, this is difficult to increase very quickly as we are small specialisation. I think it will be difficult to increase capacity without exceeding 37.5 hrs a week work.

More funding is required so we can have enough staff.

We were understaffed prior to Covid following expansion of our service to include satellite centre with no associated staff increase. During pandemic we have seen a higher proportion of staff going on mat leave and retiring early than I've experienced for many years. This was a direct response to getting away from the highly pressured environment but which of course makes things more pressured for those remaining. We are short of staff in all professions

The government has no idea what radiotherapy is, a press visit every 5 years does not help funding or staff morale

Not sustainable at current commissioning levels

There has been underinvestment and poor workforce planning for years and the effects of this are now coming home to roost

The problem will only get worse as staff shortages will cause more people to leave due to stress

No recognition of the additional workforce needed to deal with the increasing complexity of workload. It's not just about the number of treatments but the additional time and complexity these take to plan and treat

Newly qualified and inexperienced staff are leaving the profession at high rates, senior staff are moving to different roles in order to reduce stress. Burn out within the profession is high.

Decreased recruitment and retention

They've fudged the numbers to make it look like we're back working at pre-covid levels but forgot to mention how many more patients are palliative, also that actually having less patients is because not as many are being diagnosed. Wasn't it something like 56,000 cancer diagnosis' are going to be missed? Add those numbers in and then every department is working >100% capacity!

A very real trickle of people leaving could become a flood.

We have lost many staff to other roles due to long working hours, these have not been replaced.

Poor - staff morale is at an all-time low. We are being asked to work more and more shift patterns and longer hours - we are not provided with adequate facilities to have time out. There is no support services in terms of parking nearby to the workplace; pay is low for the level of responsibility - in my

trust we are paid band 6 and 7 wages to prescribe medications and to complete consultant's work. The level of stress and volume of work completed outside of work hours is not sustainable.

Radiographers are one of the many forgotten workforces within the NHS, there are more to the NHS than nurses and doctors

There has been a known shortage of all staff groups in RT even before covid. Removing funding and threatening grant repayments at lower salaries is not going to help.

We are not training enough of the key radiotherapy workforce. We have know this for years but are starting to feel the impact now. For radiographers providing backfill for apprentice posts would be a great help. It takes times to train specialist staff

Working nonstop through pandemic, exhausted, disillusioned.

Older consultants are critical for training and mentorship and are very likely to choose early retirement at current workforce levels. Trainees are now appropriately protected against working overtime, but this leaves evermore for 'the boss' to do. Funding acting down remuneration would be one means to value this role, but we need more trainees to fill the posts unfilled, and nurse consultants and specialist radiographers to support planning and PT care more so it all doesn't fall on medical staff.

Insufficient workforce before COVID. Assuming all centres will need more staff I do not believe there are sufficient oncologists, radiographers, physicists, dosimetrists or engineers to go around.

Focus is ALWAYS on the doctors and nurses from the government and public within the NHS. The lack of understanding of the role cancer specialists play in the whole cancer pathway needs recognition to understand the impact our role has.

See previous answers. Freezes on recruitment when trying to increase capacity led to more staff leaving - increasing pressure on those that stay: more leave. Small patches don't fix the problem. Need a big injection of staff

I think the government still seeing anyone other than doctors and nurses as supernumerary, forgetting that a radiotherapy department, involved in the majority of cancer treatments, is mainly made up of AHPs and healthcare scientists.

The treatment of staff has been very disappointing and throughout the covid pandemic staff have not been supported well with wellbeing not a job to recommended to youngsters

Wales approach separate, some agreement from WG to follow NHE/ Westminster funding would be very beneficial

We're burnt out. We'll seek roles in supporting services rather than continue to utilise our skills as radiographers.

Unless we train more people (give them bursaries and funding) then there will be no workforce in 5 + years

There are huge gaps in all professions and (other than Doctors) all posts are not remunerated well enough

Not enough physicists being trained, not enough resources (time & money) to train more, recruitment problems, now harder to recruit from overseas

For years the RCR and the SCoR have tried to explain the need to ensure the cancer workforce was resilient but recommendations such as increasing the number of training places was ignored. We are now seeing the effects of that with having to look overseas to recruit to all 3 disciplines.

Clapping does not enable an exhausted and demoralised workforce to carry on indefinitely with no effective increase in salary for the last 20 years. The last NI hike removes any benefit from the 3% rise

I think the government would welcome more patients being treated in a private setting. There is a wider argument about the government and how they treat the NHS workforce in general.

Staff under a lot of staff leaving/reducing hours. Also, staff isolating.

11% vacancy rate for clinical scientist, 10% vacancy rate for radiographers, not enough oncologists, lack of GP face to face referrals

Invest in lower staff groups to develop them for the future.

We've lost staff to Brexit. Not enough new radiographers coming through

We need to train more staff but the best people to do this are also managing the recovery of services.

They ought to as this could be a vote winner and that seems to be all that matters to them at times.

The removal of bursaries for radiography students reduced the numbers entering the profession and there is a severe shortfall

Current radiotherapy physics training schemes are not fit for purpose, the scheme is highly competitive with many more applicants than places but we have insufficient numbers of physics staff being trained, we are having to recruit from overseas and think about alternative options e.g. equivalence and route 2

There are a lot more specialists who work in radiotherapy than doctors and nurses.

Adequate training to create more qualified staff and equipment. Also, a push to move onto more up-to-date techniques

Stress, poor staffing and finances need to be fixed for any other investment to have any impact.

Oncology is a struggling field due to increased pressures in the working environment, more staff leaving the career. This is not limited to radiotherapy but extends to all areas of oncology from doctors and secretaries, nurses and pharmacists

We have lost so many radiographers due to the additional workloads and increased stress, we have actually stopped running Linacs due to a lack of staff to run them

Staff are very strained due to low staffing numbers and lack of appropriate technology. We have been losing staff we cannot replace.

There is no sustainability - the standard of students we are producing is now significantly lower and we are lucky to even get students with no bursary. I don't want to be working in radiotherapy in the next 5 years and I like my job more than some

The workforce in general across the NHS is going to be retiring around the same time and there is going to be a crisis of all staff

It was already an issue pre covid, so unlikely that extra pressure now will be the answer. RCR remains happy to deny that the current clinical oncology arrangement stops clinicians from being involved in Radiotherapy developments

Clearing the backlog will require people to work longer hours as we don't have more staff. We can't ask others to be redeployed into our jobs. The pay increase was too low to make staff feel valued by government although our Trust has worked hard to support us, including 2 extra days leave.

The workforce is currently unsustainable

I am fed up with working > 60 hours a week as a Consultant Clinical Oncologist with no end in sight. More staffing is needed. This is not due to COVID, it would be the case without COVID too

The workforce is tired, there is no additional give in the system in terms of resources the implication is we will just need to work harder and longer with the resources we already have

Improved funding to encourage students into the radiotherapy workforce and make roles more attractive, improved flexibility of roles

We focus on therapy staff as being the solution, however, support staff are stretched to the limit, and rarely if ever considered

The workforce is a majority of working mothers. They will work and work because they have no choice, they have families to support. They may be asked to strike by their respective unions, but most will not as they have vocational jobs which means they care about their patients as much as they care about pay and conditions. They are concerned about both equally but they are employed to provide a service to patients and feel strongly that striking affects the patient. The government should be aware that just because they don't strike isn't because they don't want to.

Pay rates in health care are low up to and including Band 6, people in our local area can earn more working in call centres (I took a pay cut myself to move to the NHS from a call centre), with the added pressure of Covid, the availability of higher paid less responsible / stressful jobs, sustainability is going to become more of an issue.

The shorter staffed the department is, the less able they are to manage students, so the student receives less support and attrition rates go up. And so the vicious circle begins. It's not rocket science.

Staff are stressed and over-stretched. People are leaving the profession.

Need better access to training for radiographers/physics, reintroduce bursaries, support role extension

We need to look properly at what will keep staff in the profession, not just recruitment.

We are short of consultants - have had to employ locums at massive costs (locum salary vs standard NHS salary). So difficult to recruit new staff in all areas.

Currently, we are upskilling our radiographer colleagues to cover doctor gaps but then we are short of treatment radiographers. there is only a finite number of correctly trained staff and it is not actually going up with time

The NHS runs on goodwill. The lack of adequate response from any govt has steadily eroded this goodwill. The ministers and trust directors have steadfastly refused to recognise any other problem in the NHS, why would they start paying attention now? I see a lot of NHS staff who only show up to work because they need the money and can't quit. The arrogance and incompetence of management isn't helping to create any positive working environment.

More investment into training undergraduates is required for long term sustainability

If they did they would offer a more realistic pay rise to the nhs.

Urgent need to fund training places on STP and HSSTP in Northern Ireland to ensure there is a pool of qualified staff to fill vacancies and replace staff who leave or retire.

All cancer services are under staffed and are not sustainable

Radiotherapy can't be used as a quick fix, it takes over 12months to install and commission a linac and 3 years to train more radiographers.

Working on minimal staffing levels is not sustainable and the team are showing lots of signs of burnout. I think the situation will get worse in the coming year as staff are actively seeking less stressful roles and will leave the workforce

Decisive action is needed to encourage students training. It is a tough physics and technology-based degree with placements working with acutely sick patients. A tough course.

Staff morale is at an all-time low, covid restrictions are still very strict for staff at work even though we can live a normal life outside of work. this will undoubtedly affect staffing levels if this continues.

Diagnostics are going to be the biggest problem - not enough staff or equipment.

We are used to working flexibly in radiotherapy - increasing our working hours to cover constantly changing workload. This relies on a lot of goodwill, but the worry is that staff are feeling burnt out and taken for granted, particularly after the pandemic and will leave the profession.

It isn't sustainable. We are tired. Our work is getting more complicated with more - tighter targets to meet. It's unsafe and unfair on patients and staff

There aren't enough radiotherapy physicists being trained. This can't be solved in the short term given how much input is required from trained physicists whilst trying to get the clinical job done.

Having worked in the NHS and the private sector, the healthcare workforce is almost invariably near burnout, and many healthcare workers have been leaving. Without the ease of movement provided by being in the EU or bursary funded training, I can't see new staff intake meeting number requirements.

Limited number of radiographers currently, radiographers leaving the career as extremely stressful

Is there anything else you would like to tell us?

Good luck with your attempts to help us.

Government need to realise radiotherapy is the most cost effective treatment available for cancer and better funding for radiotherapy is needed, more staffing and better equipment

Yes, I have applied for a job outside radiotherapy due to stress

Take serious action on the causes of cancer in general. Obesity should be treated seriously. Fat children should be taken away from parents, and the parents should be charged with child abuse. This will reduce the number of future cancer cases. People of healthy weights should be used in promotional material. Exercise should be properly encouraged. Teach people to aim for a good body. This would also reduce food and packaging waste which is good for the environment.

The irony is that expanding the oncology and RT workforce would open up opportunities for NHS to innovate and engage in clinical trials and generate new revenue for benefit of whole system and patients

I have worked in radiotherapy for 30 years. Apart from the period when NOF money was made available, we have been ignored as a service and as key professionals within the cancer workforce. Fiddling while Rome burns has been the philosophy for too long, particularly with respect to the workforce challenge which is no longer looming - it has arrived.

I am doing a fellowship with HEE to try and increase training for scientists. this kind of thing helps long term but more funds are needed for staff for short term - not so much for kit

Better investment in counselling and support services as I have supported patients who have declined treatment out of fear and have successfully completed radiotherapy now.

I work in Proton Therapy that does not treat palliative patients. i assume failures to refer here for Radical treatment because of COVID will result in an increase in Palliative treatments at other centres but I will not be able to see this firsthand.

No, nothing will change. The government have created a top heavy, bureaucratic monster that desperately needs real reform. Its been like that for at least 15 years but they won't change it except to privatise by stealth

People will leave the NHS if it carries on like this

Resources and manpower are the vital factors. Often managers tend to save money to get pat on their back from higher finance directors. As a result of this, the service suffers and so the staff to even greater extent.

New ways of training up current staff are needed in cancer care as well as funding for the latest treatments.

I did leave and come back.

Many people have left our workforce this year as a result of burn out

Maybe less focus on super fancy novel machines like MRLinacs and more focus on conventional linacs which have a far higher patient throughput. This could help with the backlog.

Only receiving a 3% pay rise for all the additional work during covid is not only offensive but disheartening and deeply worrying for future retention of staff.

Bullying is very common and nothing is done about it when you speak up

Not currently clinical so unable to answer many of the questions

I don't believe that the increase in complexity of radiotherapy treatment has been recognised. This is going to have an impact on capacity, although hypofractionation is helping.

Concerns that maintaining high levels of activity will have mental health impacts on staff. Also concerns that there will be substantial impact on ongoing service development.

Thank you for being our voice!

Pressure and the need for PPE have been additional stress on the workforce and therefore many are considering leaving or retraining

TRAIN MORE STAFF!!!!!!!!!!!!

If the government does not act now to support the cancer workforce and infrastructure there will be serious implications for cancer patients in the not too distant future.

There is tremendous pressure throughout the NHS, staff are trying but it is difficult when there are so many factors beyond their control.

Failure to adequately fund this service will result in higher mortality rates.

Our radiotherapy department kept working well during the pandemic so we have quite a healthy position but the late referrals and later stages of cancer presenting are causing issues

Limited funding and having run on a minimum/below minimum workforce for years makes it difficult to suddenly try and cope with a backlog. I think you'll see this across the entire NHS. Will probably have to do the best we can but any additional help will be appreciated and most useful. I think there also needs to be more push towards funding in upgrading outdated IT systems and a huge push in AI/automation to help cope with the backlog especially if we can't get more staff in due to limited funding (whether this can be implemented quick enough is another story).

The stress has been significant and also unappreciated. I was constantly told 'you don't treat COVID patients in radiotherapy' so we were not getting prioritised for resources no matter how many times I told them we were. Staff have been off sick and others have had to work themselves to the bone to pick up the slack. PLEASE AT LEAST PAY US MORE!

The covid situation has added to the pressures that departments and staff had before it arrived and has highlighted a lack of understanding of managers of what the workforce is capable of

Without clinicians pushing for change everything will be more difficult

Dire situation for all of the NHS workforces. We cannot keep asking staff to work under these pressures any longer. Retention is at an all-time low. Job satisfaction also. The ability to provide adequate, never mind exceptional patient care is greatly impeded

Staffing needs addressing. Consultants are never surveyed on hours worked because no one wants to hear how bad it is. As more and more can be done for patients, and the population ages, there has not been a commensurate increase in staffing. The NHS pension problem also still needs addressing, I am not highly paid, not affected by the taper, and yet paying high pension tax due to long service in the 1995 scheme. I am 54 but think I will be forced to reduce my hours before I reach 60. The frozen lifetime allowance also does not help but is not as toxic as the arbitrary annual allowance taxation.

Very low morale of staff post-COVID, huge levels of stress and burn out. Staff leaving departments for a fresh start. Most RT depts I know are struggling to safely staff departments at present

*This survey is *really* biased. It's very clear what the answers will be from the ways the questions are asked.*

The heart break of a relative with cancer during Covid will only ever become clear to politicians if they find themselves or their relatives at the back of a very long queue for treatment or mourning the loss of a loved one who wasn't treated in time. These politicians need to hear some real-life experiences and be invited to come to our departments and see the challenges we are facing for themselves.

Not enough support for staff, the government don't care about us unless it's for a headline in the newspaper

Radiotherapy has evolved over the last 20 years & has now become quite complicated. It takes longer to treat patients than it used to which impacts the number of patients we can treat in one day. Is it morally right to spend 1.5 hours treating a palliative brain metastasis, as we need to meet targets, than treat 4-6 other radical patients who would hopefully achieve a cure?

The fact that i have to use a personal device to complete this survey is fitting, as so much in the NHS relies on using personal devices for job-related tasks. Your questions illustrate an England centric mentality and a lack of attention to detail. Regarding the NHS in Scotland, there is a widespread mentality of not questioning or thinking critically about info passed on from senior staff. It is expected we just blindly follow. This attitude is not only weird, it is unhealthy for staff and downright dangerous when it comes to patient safety. Just because someone has been in post for years doesn't mean they know everything, are always right, beyond questioning. Furthermore, respect should be earned, not simply demanded by anyone with any seniority or authority. This is a widespread attitude and needs to be handled in a systemic fashion. Even if this is "only a Scottish issue," IPEM needs to be putting together an action plan for relegating this attitude to history.

Improvement is stagnating due to underfunding for the last 10years made worse by covid

I feel immense pressure if I have to be off work. For example, now I am at home with my 12-year-old son who is positive for COVID and therefore as trust policy, I am unable to work due to being exposed to immunosuppressed patients. But I feel extremely guilty that we are so short-staffed that I am letting the team down but I cannot work due to the trust. I shouldn't feel this guilt as it is out of my control but I do, not good on my mental health. Line managers should not make staff feel guilty for taking time if you need it.

Feels like an odd survey from my perspective but appreciate things must be worse in certain areas of the country - uncertain how we can speed up primary care (always been poor) surgery, diagnostics, imaging etc as these are out of our control

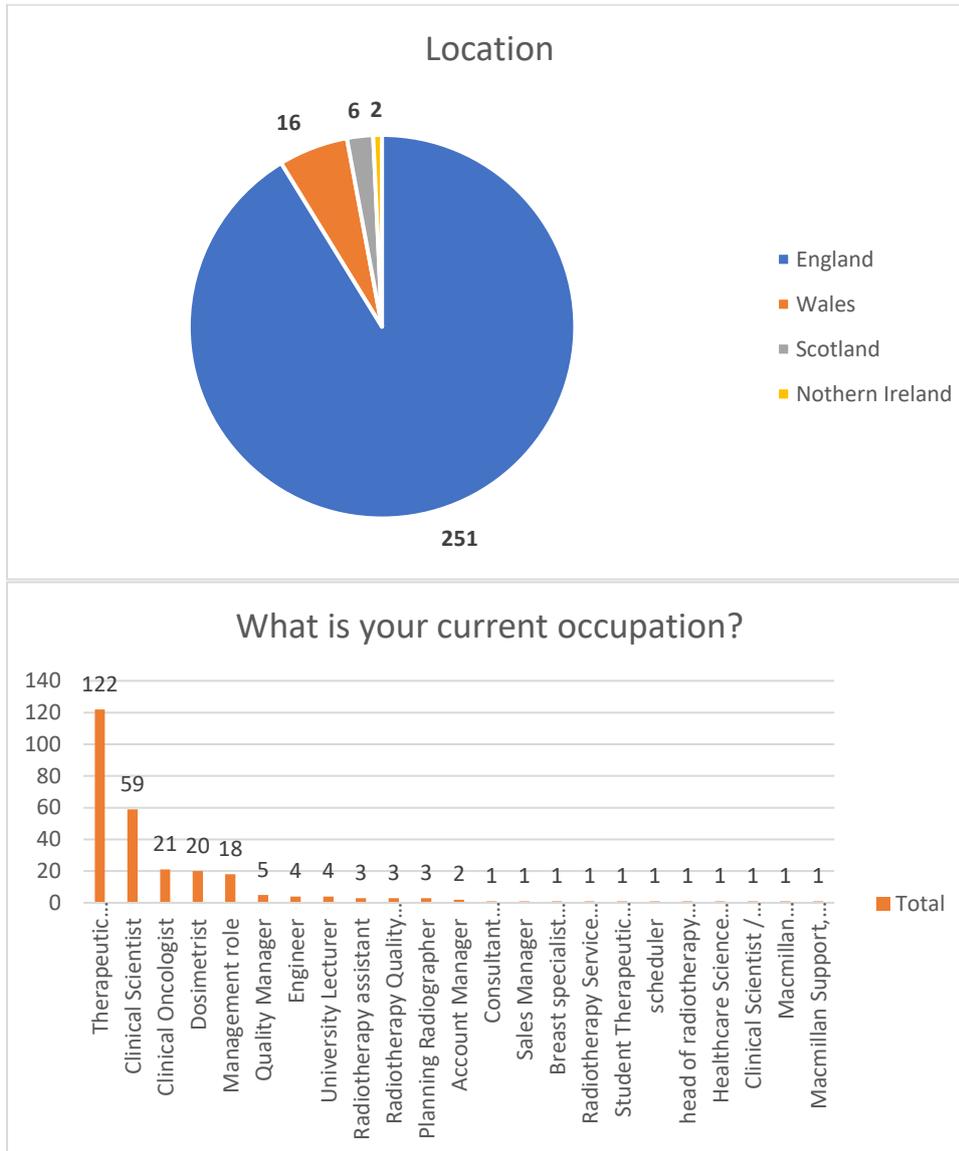
I plan to retire in March 2022- I am exhausted

Easing of the covid-19 backlog will be helped by improved collaboration between the NHS and well-resourced independent cancer providers. Independent cancer providers are able to provide more of innovative treatment solutions and this, in turn, saves the NHS money longer term by reducing the costs of expensive systemic treatments

I'm worried how much lower this government can push us before we all crumble

A long-term plan is required. investment in linacs just occurred for some departments - however it is short notice, and the machines have to be installed in a very short timeframe. this unplanned activity puts strain on industry in terms of installation resources and unplanned product capacity. Also, the funding for room turnkey / refurbishment is not considered or provided. the time to do the room refurbishment is not planned and again resources are limited to do this work.

Appendix 2: Survey Respondents



Appendix 3: Survey Questions

Do you work within Radiotherapy?

Where are you located?

What is your current occupation?

How serious a problem do you think the COVID induced cancer backlog is?

Have you seen an increase in the number of palliative patients treated with radiotherapy at your centre in the last 6 months?

Have you seen a shift to later stages of diagnosis in the patients treated with radiotherapy at your centre in the last 6 months?

Does it feel like you are you currently seeing an increase of activity compared to a normal non-COVID year?

The Government have underlined the ambition of getting cancer services to run at 110% pre-COVID capacity to tackle the backlog. With current levels of funding, can radiotherapy reach 110% pre-COVID capacity?

Can the department you work at reach 110% pre-COVID capacity with current levels of resources?

If, not, what needs to happen to get to 110% capacity?

In light of the Government ambition of reaching 110%, please estimate what level of pre-COVID activity levels you feel your service is able to sustain with current resources?

Does your radiotherapy department currently have a backlog of referrals / waiting list?

If Yes, please indicate approximately how long the waiting list is?

What categories of patients are on the waiting list? e.g. low risk breast cancer patients / hormone treated prostate cancer patients

Consider the statement "the current radiotherapy service is equipped to tackle the cancer patient backlog in radiotherapy"

How strongly do you agree/disagree with the following statement: "With a modest investment in new and additional equipment radiotherapy could have a significant impact on the cancer backlog?"

To what extent do you agree that bureaucracy impedes your centres ability to tackle the COVID induced cancer backlog? e.g. Purchasing rules, tariffs

Are there any barriers that prevent you delivering the best patient care that could be defined as bureaucratic?

Is your centre using SABR for any of the following?

If your department has not been delivering this please say why?

Do you feel current purchasing rules and funding mechanisms prevent your centre from upgrading to the most COVID safe advanced radiotherapy machines?

Do you have sufficient levels of:

- Up to date treatment equipment
- Up to date planning equipment
- Funding for staff training
- Investment in IT systems
- Workforce

How significant a role should radiotherapy treatments play in bringing down cancer backlog waiting lists caused by the pandemic?

How strongly do you agree/disagree with this statement: “The Government and NHS leaders do not sufficiently recognise the key role radiotherapy has to play in tackling the cancer backlog?”

In your opinion, what immediate or innovative solutions can be implemented in radiotherapy to tackle the covid-induced cancer backlog?

In September 2021 it was announced there would be £4bn additional funding for tackling backlogs, including the cancer backlog, under current arrangements how much confidence do you have that radiotherapy will receive sufficient levels of funding deal with the backlog?

Do you feel the Government understand the role of the specialist cancer workforce?

Do you feel the Government understand the impact workforce challenges have on efforts to tackle the COVID induced cancer backlog?

Has the COVID and the COVID induced cancer backlog related pressure had a negative impact on your mental health?

Have you, or someone you know, considered leaving the workforce in the last 12 months as a result of the additional pressure?

Is there anything else you would like to tell us?