10 Year Workforce Plan call for evidence

Yorkshire Cancer Research response, November 2025

1. Section 1: the 3 shifts

1.1. Hospital to community

1.1.1. Yorkshire Cancer Research funds Active Together which provides a comprehensive prehabilitation and rehabilitation pathway for people with cancer. Active Together is a key example of how cancer treatment can be shifted into the community. Yorkshire Cancer Research is in the process of rolling out this service across the region, bringing multi-modal prehabilitation and rehabilitation into community venues, such as gyms and sports centres, across Yorkshire to bring the service as close to people as possible.

1.1.2. Each participant has a personalised care plan tailored to their goals, combining exercise, nutrition and wellbeing support before, during and after cancer treatment. Active Together maximises fitness and wellbeing before treatment, enhances readiness for and tolerance of treatment, supports recovery and quality of life, increases the chance of long-term survival and reduces the likelihood of recurrence.

1.1.3. Active Together is associated with an overall 10% improvement in survival for people with bowel, lung and upper gastrointestinal cancers.[1] Participants have shown clinically significant improvements in fitness, spent less time recovering in hospital after surgery and experienced fewer side effects. 97% of patients reported improved health and wellbeing, with many feeling more in control.

1.1.4. Additionally, Active Together was associated with a net saving of £366.36 per patient to the NHS, likely due to reduced time spent recovering in hospital.[1]

1.1.5. Active Together illustrates how investing in community-based teams can reduce the strain on hospitals. Once referred into the service, people are supported to build their strength and fitness ahead of treatment, to help increase tolerance of treatment and support recovery. This approach has proven successful. For example, Active Together participants undergoing upper gastrointestinal (GI) and colorectal surgery spend fewer days in critical care and experience shorter hospital stays than declined and historical patients. Yorkshire Cancer Research's modelling demonstrates that if cancer prehabilitation and rehabilitation is rolled out across the country, it could free up thousands of bed days annually.

1.1.6. To deliver these results, it is important that the service is delivered by a diverse, qualified specialist team, including nutritional, wellbeing and exercise specialists. Each specialism complements the other to ensure healthy behaviours developed in

the programme are long-term and sustainable. Multi-modal prehabilitation and rehabilitation provides tailored behaviour change techniques across all three components, each reinforcing the efficacy of the other.

1.1.7. Active Together is delivered by a team of highly skilled allied health professionals, supported by fitness professionals. Fitness professionals can deliver interventions for participants with lower levels of need and complexity. Therefore, rather than recruiting entirely new staff, the existing workforce can be upskilled to deliver the programme effectively. This includes the wider health and wellbeing workforce such as personal trainers and fitness instructors. For instance, when implementing Active Together in leisure centres and gyms, current staff can be trained in key areas such as behaviour change, exercise referral and cancer rehabilitation. There is also potential to host placement students, under the supervision of clinical leads, to strengthen the future workforce. Delivering the programme within community venues using existing staff from these venues can also help develop long-lasting behaviour change. After discharge from the service, participants are likely to be more comfortable continuing to attend settings such as gyms if they are already familiar with the environment, staff and routine. It is important to explore how to ensure that people who cannot afford continued gym access can be supported to develop and sustain these long-term behaviours.

1.1.8. To support the shift from hospital to community, the NHS must be enabled to commit to multi-year funding to innovative programmes such as Active Together. Currently, despite there being appropriate staff within the existing workforce to up-skill, one-year contracts make staff retention difficult. Multi-year contracts are required for programmes such as Active Together to offer the job security required to attract and retain high quality staff who look for secure employment and potential professional development and progression.

1.2. Analogue to digital

1.2.1. Active Together utilises digital technologies and initiatives to support behaviour change, intervention delivery and patient engagement. Technology is used to support the delivery of remote services for those who have issues traveling and can enable the provision of life-long support after discharge from the service to ensure long term, sustainable behaviour change. Whilst digital initiatives could enable broader impact of prehabilitation and rehabilitation, non-digital alternatives to all assets should remain available. It is important that consideration is given to how any use of technology can overcome barriers including digital literacy, language and cultural appropriateness.

1.2.2. Yorkshire Cancer Research funds research which is advancing the application of digital technologies to support people living with cancer, outside of the Active Together programme. The Charity funds the APPROACH trial, which tests if a physical activity mobile app alongside behavioural support can support people with breast, prostate or bowel cancer to increase their physical activity levels.[2] A pilot study demonstrated that the approach was both feasible and acceptable to

participants.[3] A larger Randomised Controlled Trial will investigate the intervention's efficacy and cost effectiveness.[2]

1.3. *Sickness to prevention*

1.3.1. Yorkshire Cancer Research has funded and delivered preventative care services. For example, Yorkshire Cancer Research has funded and delivered preventative care services. For example, the Charity funded the Inpatient Stop Smoking Service at Leeds Teaching Hospital NHS Trust (LTHT) with the aim of reducing smoking-related health inequalities across Leeds and the wider Yorkshire region. During the funding period, the service delivered significant outcomes. A total of 7,553 patients received Very Brief Advice, whilst 6,055 patients received tailored behavioural support and Nicotine Replacement Therapy (NRT). The service supported 1,369 patients to successfully quit smoking. The funding enabled the establishment of a dedicated, in-house stop smoking service for hospital inpatients identified as people who smoke. Patients were automatically referred into the service, with clear pathways to ensure timely follow-up in the community for those discharged or who declined support. Pharmacotherapy was provided directly by the service. This initiative not only improved patient care but also strengthened the partnership between LTHT and Yorkshire Cancer Research, reinforcing the Charity's commitment to reducing cancer prevalence and demonstrating the value of smoking cessation within secondary care settings.

1.3.2. The Charity also funded the Yorkshire Lung Screening Trial (YLST), which provided lung health checks to people aged between 55 and 80 who smoke or used to smoke, in community locations across Leeds.[4] Of the lung cancers detected by the programme, 80% were found at an early stage. This increased to 88% in the second round of the screening programme. Evidence from the programme contributed to the National Screening Committee's recommendation in favour of an NHS lung cancer screening programme.[5]

1.3.3. The Yorkshire Enhanced Stop Smoking Study (YESS) was funded by Yorkshire Cancer Research and was delivered alongside YLST.[6] The trial provided an opt-out, co-located smoking cessation service, delivered within the same appointment as lung screening. Every lung screening participant who did not opt out received ongoing behavioural support and pharmacotherapy for a maximum of 12 weeks.[7]

1.3.4. The trial found that this co-located provision of personalised smoking cessation support resulted in 15.0% of all eligible participants self-reported stopping smoking at 4 weeks. This co-located approach was more effective than comparable screening programmes without a co-located service. The UK Lung Screening Pilot provided signposted participants to other services and had a 4-week self-reported quit rate of 9.9%.[7]

1.3.5. The co-location of specialist stop smoking advisors with lung screening is central to the increased smoking cessation rates delivered by the YESS trial.[8] An embedded process evaluation concluded that the full benefits of lung screening can only be

realised through investment in appropriately trained stop smoking advisors who deliver person-centred smoking cessation support.[9] Stop smoking advisors described how they personalised discussions on the basis of an individual's quit motivation and emotional state.[9] They also utilised the context of lung screening to emphasise the benefits of quitting.

1.3.6. Participants described how they had built a trusting relationship with stop smoking advisors, which was informed by a non-judgemental and compassionate approach to support.[9] Flexible appointments were available to fit around participants work, further increasing the accessibility of support. Home visits for carbon monoxide quit validation breath tests were standard practice on the YESS trial.

1.3.7. A key barrier to the delivery of co-located smoking cessation services is the recruitment and retention of specialist, experienced stop smoking advisors. The decline in public health budgets has reduced the availability of specialist stop smoking advisors for delivering interventions.[10] [8]

1.3.8. An important consideration is that screening sites have the appropriate facilities to co-locate specialist stop smoking advisors with lung screening. Yorkshire Cancer Research estimates that co-locating smoking cessation support across the whole of the national Lung Cancer Screening Programme could support 15,400 people who are newly eligible for lung cancer screening each year to quit smoking.[11] However, variation in the size and design of mobile screening units nationally may act as a physical barrier to delivery, with many units lacking the dedicated space to deliver this intervention.

1.3.9. Nationally, the variation in the delivery setting of the Lung Cancer Screening Programme can act as a barrier to the delivery of smoking cessation support. For example, disjointed IT systems between different primary and secondary care settings can negatively impact service delivery.

1.3.10. If there is not the physical space to co-locate smoking cessation support, a same-day telephone appointment is the next best option, as smoking cessation remains an integrated, opt-out element of screening appointments.[8] Staff who deliver telephone appointments should receive specialist training which is tailored to the more complex needs of the population attending screening. Lung screening participants may have a longer smoking history and multiple failed quit attempts. Furthermore, lung cancer rates are higher among people from more deprived areas.[23] As a minimum, training in delivering Very Brief Advice on Smoking should be provided to all staff involved in the delivery of the Programme.

1.3.11. Research has demonstrated that co-located smoking cessation is cost effective compared to the standard treatment approach of onward referral to other services. For the YESS study, the staff cost was calculated at £42.60 per participant. This investment resulted in significant cost benefits. After accounting for staff costs, the

net monetary benefit of providing smoking cessation support was £2,150 per person at a willingness to pay threshold of £20,000 per QALY.[12]

1.3.12. Yorkshire Cancer Research also directly delivers smoking cessation services. In 2026, the Charity will open a new Active Together centre in Hull, in partnership with NHS Humber Health Partnership. The Centre will feature a co-located service which will provide specialist smoking cessation support to people who smoke in a non-clinical and welcoming environment. People who smoke from across Hull and beyond will be able to self-refer to this smoking cessation service. The new Centre in Hull is accessible via public transport. In 2023, 17.6% of adults in Hull smoked, significantly higher than the regional average of 12.4% and the national average of 11.6%.[13] The Charity is also planning to deliver smoking cessation brief intervention training to retail staff in 2026. This will equip staff with the skills to deliver quick, effective interventions that encourage customers to consider quitting and connects them to further support.

1.3.13. The principle of co-located smoking cessation support can be applied to a wide range of healthcare settings, including Accident and Emergency, mental health appointments and whilst awaiting or undergoing cancer treatment. Yorkshire Cancer Research advocates for automatic enrolment into smoking cessation support in as many NHS touchpoints as possible, so that whenever someone who smokes interacts with the NHS they are offered the high-quality stop smoking support they need to quit.

2. Section 2: modelling assumptions

N/A

3. Section 3: productivity gains from wider 10 Year Health Plan implementation

N/A

4. Section 4: culture and values

4.1 Clinical research capacity

4.1.1 Increasing the capacity for clinical research within the NHS can improve both workforce and patient outcomes.

4.1.2 There is evidence to support that increasing research opportunities for clinicians could help to improve retention of the workforce.[14] The Royal College of Physicians census of consultant physicians found that over a third of those surveyed would like to participate in research, but that a lack of ringfenced time acted as a barrier to

participation.[15] Furthermore, a quarter of respondents would prioritise research activity ahead of all other Supporting Professional Activities.[15] Respondents who did participate in clinical research reported that it increased their job satisfaction.

4.1.3 Research shows that increased clinical research activity is linked with an improved quality of care. A 2017 study which evaluated the relationship between 129 NHS Trusts and research activity found that the Trusts with the higher numbers of participants relative to their size were associated with improved Care Quality Commission (CQC) ratings.[16] A separate study found that patients admitted to more research active hospitals had more confidence in the doctors treating them and were more informed about their condition.[17]

4.1.4 Healthcare settings with increased levels of clinical research activity are associated with improved survival outcomes, including for specific types of cancer.[18, 19] For example, research has evaluated the relationship between research activity and survival outcomes for acute admissions to NHS Trusts. A study used levels of NIHR Clinical Research Network (now Research Delivery Network) funding and the number of patients recruited into NIHR portfolio studies as indicators of clinical research activity.[18] This study found that NHS Trusts with highest levels of clinical research activity had improved survival outcomes compared to less research active Trusts.[18, 19]

4.1.5 Research has also demonstrated the relationship between increased research activity and improved survival outcomes for specific cancer types. A 2017 study tested if high participation in interventional clinical trials in an NHS Trust improved survival outcomes for all patients with colorectal cancer treated at the Trust.[19] Analysis of the health data of 209,968 people with colorectal cancer showed that being treated in an NHS Trust with high clinical research participation (>16% of patients participating in interventional clinical trials) was associated with an improvement in 5-year survival outcomes.[19]

4.1.6 The study also showed the importance of embedding research opportunities within the NHS over a sustained period of time. There was an estimated 3.8% improvement in survival for patients with colorectal cancer treated in an NHS Trust with high research participation sustained for four years or more.[19]

4.1.7 Alongside increased research capacity, a more diverse workforce could positively impact the research agenda, so that it more effectively addresses the health inequalities experienced by groups which are typically under-represented in research. The Medical Schools Council's Clinical Academic Survey found that nationally, 74.4% of Professors and 60.8% of Senior Lecturers are men.[20] Whilst this represents an improvement on historical data, the evidence demonstrates the continued need to support women into the most senior clinical academic positions.

4.1.8 Whilst research shows that clinical research activity can improve both workforce and patient outcomes, the Medical Research Council's report *Clinical researchers in the UK: reversing the decline* highlighted that there has been a 6% decline in

medical research staff between 2012 and 2022.[21] The Government has committed to publishing a research delivery workforce strategy in Autumn 2025.[22] It is critical that this strategy ensures the long-term sustainability of the clinical research workforce, increasing flexibility, promoting diversity and providing a clear pathway to clinical academics. It should also align with the wider 10 Year Workforce Plan, to ensure that clinicians are able to effectively split their time between clinical and research responsibilities.

4.2 Cancer Alliance capacity

4.2.1 Cancer Alliances provide a critical delivery mechanism, bringing multiple partners together to implement innovative interventions and to deliver agreed regional plans. Having dedicated staff capacity has enabled the successful delivery of cancer programmes and effective partnership working. For example, Yorkshire Cancer Research have worked with Cancer Alliances across the region to embed the QUIT programme, Active Together and clinical trials. In turn this has brought improved quality of care to patients.

4.2.2 However, Cancer Alliance capacity could be significantly reduced in some areas as a part of the requirement for ICBs to reduce headcount by 50% which would leave these areas with limited dedicated capacity to deliver. Concerningly, this would not impact all areas equally due to varying hosting arrangements. Cancer Alliances hosted by ICBs are included within this headcount reduction whereas those hosted by NHS Trusts remain unaffected. This decision could widen existing health inequalities and potentially create a postcode lottery for cancer outcomes depending on whether the Cancer Alliance was originally hosted in the ICB or not.

4.2.3 The Charity has received assurances that Cancer Alliance funding continues to be allocated according to need and that Cancer Alliances remain central to the delivery of NHS cancer priorities. However, it is unclear how Alliances are expected to deliver on these priorities with significantly reduced capacity. The ability to translate funding into transformation depends on having sufficient and skilled capacity in place. Some areas, including areas in Yorkshire and the North where cancer outcomes are already poor, have been left with limited numbers of staff to deliver cancer programmes. The lack of consistent approach risks exacerbating health inequalities.

5. Section 5: any additional comments

5.1 It is vital that the 10 Year Workforce Plan addresses regional variation in workforce levels.

5.2 Yorkshire and the Humber has the lowest rate of clinical and medical oncology consultants in the country at 5.1 per 100,000 people aged 50 and over, in stark contrast to London's 11.3 and below the national average of 6.6.[23] The region also faces an 18% shortfall in clinical oncologists, higher than the national average. Nationally, 76% of cancer centre

heads express concern about patient safety due to oncologist shortages, underscoring the urgency of addressing regional disparities in workforce planning and resource allocation.

5.3 Nationally, there are 3,962 full-time equivalent (FTE) consultant clinical radiologists, equating to 10.1 per 100,000 people.[23] Yorkshire and the Humber marginally exceeds this rate at 10.4 per 100,000. However, this figure masks significant challenges in the region. In Yorkshire and the Humber the clinical radiologist vacancy rate is 12%, one of the highest in the country. Notably, Yorkshire and the Humber has the joint highest proportion of clinical radiologist consultants expected to retire over the next 5 years (22%, 20% in England), and a lower-than-average forecasted growth in this role.

5.4 GPs are also an important element of the cancer workforce as they are often the first point of contact for people with cancer symptoms. Yet, there is significant variation in GP availability across the country.[24] For example, in Kingston Upon Hull East, each GP serves 3,664 patients, more than double the number in Sheffield South East (1,428).[25]

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