

# The SACT capacity crisis in the NHS

Across the UK, the most pressing problem oncology departments are facing is capacity to deliver systemic anti-cancer therapies (SACT) to patients. The rise in demand for treatment coupled with the surge in available drugs on the NHS, means that overstretched oncology departments are struggling to keep pace or to make the case to local health systems for more investment.

The NHS and local health systems must take urgent action to ensure that departments are not forced to withdraw treatments and patients are not put at risk of delayed or ineffective care.

Due to the existence of separate health systems in each of the four UK nations, and the work of the National Institute for Health Care (NICE) in England, the challenges and recommendations presented in this briefing are England-focused. However, this issue is widespread across the UK and many of these solutions would be applicable to each national health system.

## The challenge:

**In recent years, demand for SACT has surged.**

From April 2021 – March 2022 there were nearly 3.5 million doses of SACT delivered in England.<sup>i</sup> This is thought to be increasing at 6-8% per annum.<sup>ii</sup>

Reasons for increased demand include:

1. Growing and ageing population
2. Higher cancer incidence due to lifestyle factors
3. New drugs increasingly approved for use (see below)
4. Increased tolerability of new drugs meaning patients with more comorbidities can have treatment but are more complex to treat
5. Each course of treatment lasts longer and often indefinitely with more modern drugs
6. Increased number of new adjuvant therapies
7. Increased duration of infusion times with more complex regimes
8. Increased survival rates due to more effective treatment mean patients are well enough for more lines of subsequent therapy when cancer returns or progresses
9. Reduced operational capacity due to COVID including staff and estate capacity.

**Advances in drug discovery have led to a rise in the number of cancer treatments available on the NHS.**

When NICE recommends a treatment for routine commissioning, the NHS must fund this and make it available to patients within 90 days of final guidance being published. Around 50% of all new drugs appraised by NICE are treatments for cancer.<sup>iii</sup>

Where treatments cannot yet fully demonstrate clinical and cost-effectiveness, they may be submitted to the Cancer Drugs Fund (CDF), a managed access scheme designed to enable earlier patient access to treatments. Since 2016, the CDF has provided funding for 234 new indications, treating 85,400 patients.<sup>iv</sup>

The rate of new cancer medicines entering the market remains high. In the next year, 56 different cancer treatments are scheduled in the NICE work programme.<sup>iv</sup> 92% of cancer drugs submitted in 2021/22 were approved, compared to 60% in 2011/12.<sup>v</sup>

### **Oncology departments are struggling to keep pace with the demand for SACT.**

These innovations are welcome, but the absence of both a publicised process to alert trusts when new drugs are likely to be approved, or a capacity planning tool for how to plan resources and put new systems into practice, has a major impact on oncology services' capacity. When treatments are approved, departments are not receiving an equivalent funding package for services to expand capacity accordingly.

Some departments are having to make difficult decisions over whether to withdraw access to CDF-approved treatments or prioritise which patients can receive treatment within an optimal timescale.

### **Impact of workforce shortages**

Workforce shortages are restricting oncology departments' ability to deliver treatment within the recommended time. Shortages in qualified staff – pharmacy, nursing and medical – and lack of physical space, alongside increasing demand, means that waiting lists are continuing to grow.

Workforce shortfalls are causing regular delays in patients starting SACT. 88% of cancer centre heads of service are concerned about workforce shortages delaying patients starting treatment.<sup>vi</sup>

### **To meet the increased demand for SACT treatments, oncology departments are having to compromise patient safety and increase pressure on overworked staff.**

If no additional money is provided to fund SACT capacity, departments have four options:

1. Add delays to most or every patient's treatment to fit new patients in – if everyone waits an extra few days to start treatment, more people can be accommodated. This causes potential harm to all patients and significant stress to staff who have to explain delays.
2. Explicitly ration treatment by not treating certain patients with certain drugs, prioritising treatments thought to be more effective. Deciding which drugs not to make available in a centre or nationally is very difficult methodologically and morally.
3. Find workarounds to create capacity, for instance sending patients to neighbouring trusts or using inpatient wards to treat patients. There is evidence of variation in how these decisions are made which may lead to inequalities in patient care.
4. Work harder – SACT departments will be kept open for longer with staff working additional hours. In turn, this increases burnout, further contributing to the staffing crisis.

### **The SACT dataset needs investment to improve the data quality.**

The cancer waiting times target measuring SACT delivery is 31 days from referral to starting treatment. This target is more likely to be met than most others, meaning alliances and trusts are focusing on diagnostic waits and surgical delays where there are waiting times breaches.

For many oncologists and patients, 31 days feels too long to wait for SACT. For every four-week delay before patients start treatment, the risk of death increases by around 10%.<sup>vii</sup> These delays are particularly concerning given that many patients will have already been waiting a long time due to pressures in the diagnostic pathway – the 62-day cancer waiting times target has been consistently missed since 2014.

SACT waiting time data therefore needs more investment and consideration. The 31-day target has a weekly breakdown for those who miss the target (32 - 38 days, 39 – 38 days). This could be extended to include a weekly breakdown for those that fall within the 31-day target (0-6 days, 7-13 days etc), to understand when patients are receiving treatment. The data should be more granular, for instance, breaking down curative and palliative

treatment, and reporting time from surgery to SACT for adjuvant therapy. Insights from this additional data would help to inform SACT capacity planning, benchmarking and sharing of good practice.

### **Concerns around NHS funding arrangements**

Oncology departments need to be able to highlight capacity concerns to local health system leaders and make the business case for increased capacity/funding if we're to recover services and keep up with the rising demand for treatments.

However, NHS England's funding arrangements do not support this. During the COVID pandemic, NHS England moved to a block contract style funding arrangement to encourage a whole systems approach to the pandemic and elective recovery. The amount of the block contract was felt to be on the generous side, so that if SACT treatments later increased (as they have done, with more drugs being approved) there should be sufficient funding to cover this.

However, this is not the case on the ground. Once allocated to health systems, there is no way to track the money and there is a perception that oncology services aren't sufficiently funded to cope with rapidly increasing demands.

From 2023/24, NHS England is reverting to pre-COVID funding arrangements whereby funding is based on the volume of treatment delivered. A chemotherapy delivery tariff factors in the number of drugs that trusts are administering to patients. Specialised Commissioning will annually review these rates and adjust the tariff according to activity. Through this model, it is expected that any increase in activity should therefore attract additional funding.

However, if capacity issues and workforce shortages are preventing treatments from being delivered, this may result in a reduction in annual funding. By setting the departmental budget based on past activity, future budgets will not account for the increasing rate of SACT delivery, currently rising by 6-8% per annum. From 2024, Integrated Care Boards (ICBs) will take responsibility for funding specialised commissioning. There is currently a lack of clarity on how oncology departments will receive their funding.

## **Case study:**

“Over the last two years our breast consultant oncology workforce has dropped from 13 consultants (10 WTE) to eight consultants and shortly to five consultants (3.7 WTE).

The reduction in consultant numbers has resulted in an unsustainable workload of 470 new patients for each consultant in a year. RCR guidance recommends taking on no more than 150-200 patients per annum. Staff are under enormous pressure which is impacting their health.

Our workforce issues resulted in us [delaying] the implementation of NICE approved treatments...and we are now having to explore options for external support which may include some patients having to travel further for treatment. This is heart breaking for both the patients affected and the staff involved in the service.”

# Recommendations:

**We would like to meet with NHS England to discuss our recommendations for how we can work together to ensure that patients continue to receive access to life-saving cancer treatments.**

## 1. NHS England must publicly take responsibility for addressing the SACT capacity crisis.

- Cancer Alliances are focused on diagnostics, trusts are distracted by emergency department constraints and reaching cancer targets, commissioners are not being involved in the issue, and NHS England maintain that day-to-day capacity is not their responsibility.
- The lack of assigned responsibility means that there is no accountability for improving outcomes.
- NHS England should make a public statement on the SACT capacity crisis, announce the establishment of the Task and Finish group, and reiterate the importance of SACT delivery to commissioners.
- Alliances, trusts and commissioners should urgently review SACT capacity in their local health system, and develop plans to resolve the issue, taking into account the likely 6-8% increase required annually.

## 2. NHS England should better support oncology departments to implement new treatments and deliver chemotherapy services.

- NHS England, in collaboration with NICE, should develop a clear horizon-scanning style process for Cancer Alliances and trusts for short (<1 year) and long (5 years) horizons.
- NHS England should develop a capacity planning tool, to be produced and made available for each new cancer drug before or when it is approved. This should include an overview of what medical, pharmacy, nursing and physical capacity is required to roll out new treatments within a system and consider the potential impact on other departments such as Acute Oncology services.
- NHS England should fund protocols for each new approved SACT regimen, covering drug administration and management of side effects, to ensure standardisation of delivery among individual trusts.

## 3. NHS England should invest in the SACT dataset, to improve the data quality.

- The SACT dataset is a potentially rich resource of information, which can be used to improve practice.
- However, there are concerns that the merger of NHS Digital, which incorporates the National Cancer Registration and Analysis Service (NCRAS), with NHS England may result in less investment in the future.
- We need to look at the trend towards patients being treated closer to the 31-day target. This was always intended to be the limit, but increasingly patients are being treated just within this period or even after.

## 4. NHS England should consider how to reduce unwarranted variation in the delivery of SACT, between trusts, health boards and oncology departments.

- Common areas of variation include capacity planning, prioritisation in the case of no capacity, and the delivery of some agents for example, hydration regimens and dose banding.
- It is important to consider how best practice can be shared among Cancer Alliances and oncology departments most effectively.
- The Task and Finish Group established by NHS England is likely to consider this, and we encourage NHS England to be ambitious with the group's scope and urgency.

## 5. NHS England should clarify how they will ensure that oncology departments are receiving sufficient funding for national initiatives under the move of specialised commissioning to Integrated Care Boards (ICBs).

- When national-level initiatives are introduced, such as a new treatment approval, there is a lack of ability at departmental level to respond since the money is not seen on the ground.
- There is a perception from oncology departments that funding that has been assigned to implement and deliver new treatments is not reaching the department.
- Measures to ensure transparency from trusts and ICBs would guarantee accountability and foster improved whole system working.

## 6. NHS England should explore the potential of IT and artificial intelligence (AI) in increasing patient involvement to reduce demand on oncology departments.

- Patients should be empowered to become more involved in their treatment through new IT systems.
- For example, patient-reported outcome measures (PROMs) are questionnaires patients complete on their health and quality of life.
- If patients receiving SACT were required to complete PROMs following treatment, departments could only require patients who are reporting side effects to re-enter oncology departments for a review, freeing up staff capacity to deliver care elsewhere.
- Similarly, expanding the use of remote monitoring technology can assess patients' health and care while they are being cared for at home, reducing the need for follow-up appointments.

## 7. The oncology workforce needs long-term investment and support.

- Commitments in the NHS long-term workforce plan should be fully funded with new income sources.
- Training places across the pathway – from medical school to speciality training – need to be expanded and targeted in areas with worse staff shortfalls. The cancer nursing and pharmacy workforce similarly requires ongoing investment.

## 8. Oncology departments should take steps locally to improve outcomes for their system and to raise the profile of the challenge within local health systems.

- Oncology leads should approach their local health system board, Cancer Alliance, and ICB to ensure the profile of the issue is being raised.
- Oncology leads should ask that the SACT capacity issue is added to the trust's Organisational Risk Register
- Responsibility should be assigned within the department for exploring existing and published ways to reduce variation.

## References

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