Written evidence submitted by the UK Breast Cancer Group (ECS0014)

Thank you for asking the UK Breast Cancer Group (UKBCG) for comments to the Health and Social Care Committee's Expert Panel's evaluation of the progress the Government has made against its commitments in the area of cancer services in England. We represent the breast cancer oncology community with our membership made up of the majority of consultant clinical and medical oncologists treating breast cancer in the UK.

The pressures on oncology services, and breast cancer specifically, have increased exponentially over the past few years. Each new treatment introduced comes with the need for more appointments for the delivery and supervision of more and more complex therapies and it is true to say that all of our breast cancer oncologists are struggling with workload pressures. Demand has already overtaken capacity in most centres. Chemotherapy units are seeing a 10-12% increase in visits year on year – these data are consistent across the country as shown in Figures 1 and 2 with data from Royal United Hospital Bath and The Christie, Manchester. The Christie's data show that although there is a year on year 5% increase in new referrals, the number of patients within the system increases by 12% each year, reflecting the fact that as treatments become more effective patients stay in the system for longer.

Figure 1: Chemotherapy unit appointments in Royal United Hospital Bath increased by 55% between 2012 and 2016

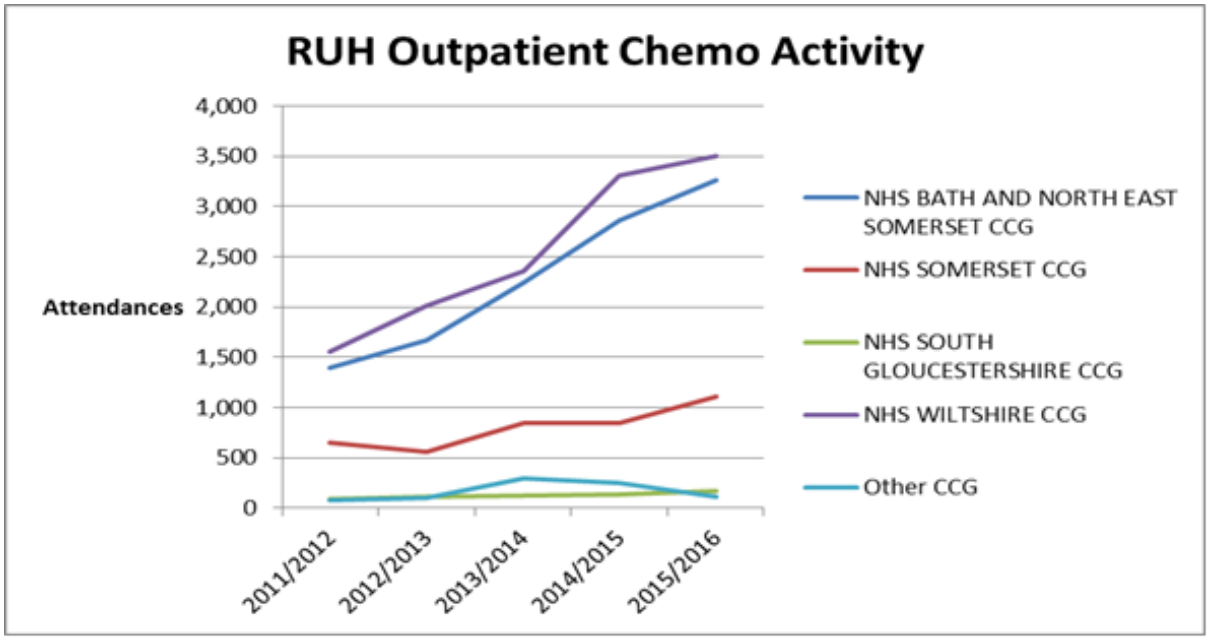

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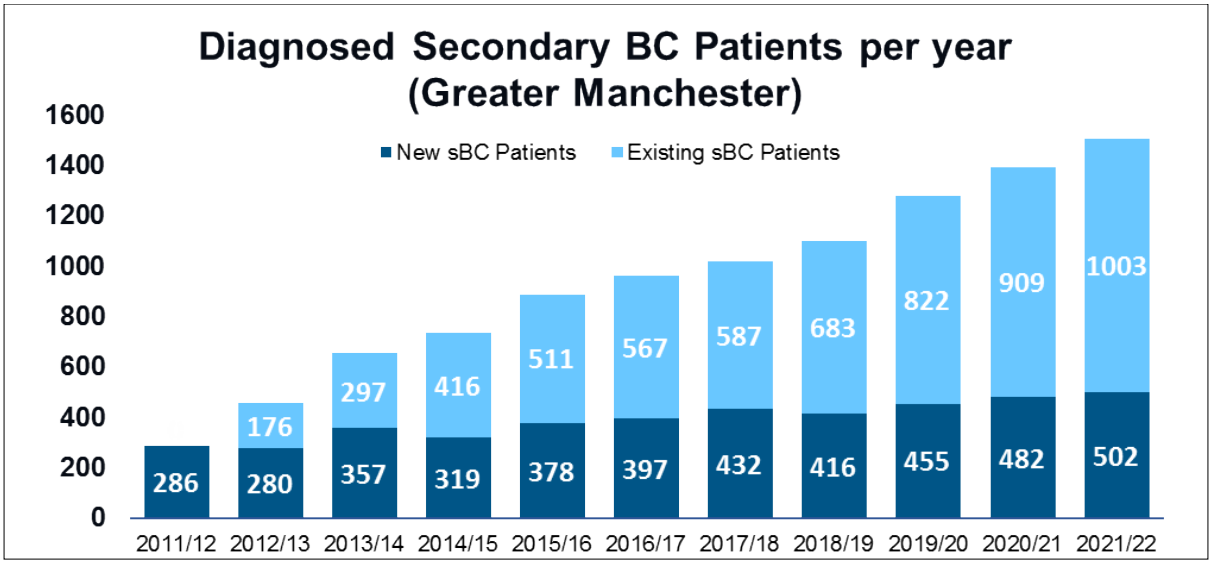
Figure 2: Data from The Christie (courtesy Prof Andrew Wardley). A 12% year on year increase of patients on treatment.



Even for managers and commissioners working closely with cancer services, the sheer magnitude of this growth is rarely appreciated. To illustrate this the committee may find it useful to look at a typical breast cancer patient journey. If we look at a woman presenting with oestrogen receptor positive metastatic breast cancer as an example, a decade ago patients would be treated with hormone tablets alone. They would have had 3-monthly follow-up clinic appointments and 3-6 monthly scans. The tablets would be provided on repeat prescription from the GP. There might be 6-8 hospital visits in total over a year and this first line therapy might be expected to work for 12-14 months on average. Over the course of this line of treatment the average patient might therefore expect 8-9 hospital interactions.

Now patients receive a new class of drugs (cdk 4/6 inhibitors) which require monthly oncology appointments, 2-weekly then monthly blood tests and more regular scanning. The drugs are expensive so need to be monitored more closely and are only dispensed from hospital pharmacy. They also have more potential side-effects such as low blood counts. Patients are also likely to receive a drug called denosumab to help control breast cancer in the bones- this requires 4-weekly visits to the oncology day unit to receive an injection. If the clinic (12), pharmacy (12), day unit (12), radiology (4) and phlebotomy (14) appointments are added, this means potentially 54 hospital interactions in a year. These drugs effectively double the length of disease control compared with the hormone therapy alone to around 28 months. So, for the first line of therapy this same patient, who a decade ago would have had 8-9 interactions with the hospital, now might have over 100.

It doesn't stop there – we have more 2nd, 3rd, 4th line and beyond options, all with more complexity and requirements. Nor is it confined to ER positive metastatic breast cancer – there are new drugs in HER2 positive and triple negative disease both in the early, localised and advanced, metastatic settings – and of course similar developments have been made in other tumour sites such as melanoma, lung, prostate, etc. This impact is felt most acutely in the oncology service but also impacts on other departments, notably pharmacy and radiology where workforce issues are also a problem.

To cope with this increase in demand we have introduced a number of new ways of working, including non-medical prescriber (NMP) clinics with pharmacists and specialist nurses or outsourcing some treatments to homecare or the community. Nevertheless, the breast oncology medical workforce feels stretched further than ever before. The quicker and easier consultations have been

moved to NMP clinics, leaving the oncologist clinics full of complex or progressing patients, with no increase in time allocation for a consultation. The administration in terms of electronic prescriptions, consent forms, funding applications, scan requests and such can easily use up more than half of the allocated 20 minutes appointment time.

Cancer targets and incentives for Trusts are very much front-loaded towards early diagnosis and first cancer treatment, largely ignoring metastatic and advanced cancer patients and those on longer term treatments which is the group that dominates mush of the time and resource of oncology departments.

In response to some of the questions raised in the planning grid:

Was the commitment met overall?

With regard to the specific questions raised by the panel, the UKBCG feels the commitment to workforce planning is not sufficient. Many Trusts have unfilled posts and we feel training posts in oncology urgently need to be expanded. Even if these posts were filled, in many cases more would be required. The NHS COVID response has added extra complexity and workload to oncology services, but not significantly affected recruitment, and the outstretched capacity had been building irrespective of COVID. The wellbeing of oncology staff is a major issue and certainly has not improved.

Was the commitment effectively funded?

There is a clear need for more funding for oncology services. A particular issue over recent years has been the adoption of new treatments without a parallel increase in workforce. Drugs and technologies are assessed by NICE and approved based on cost and clinical value, but despite extensive economic modelling during appraisal, there is no routine modelling of the required capacity uplift. We have recently undertaken, as yet unpublished, modelling of the impact of introducing abemaciclib in adjuvant breast cancer. This is an indication currently under appraisal by NICE. Although just one drug in a relatively small cohort of patients, our modelling suggests it would require about a 4% increase in breast oncology capacity which in a moderate sized cancer centre would equate to 1 or 2 additional clinics per week. If this kind of work was included for each drug or indication approved, very soon we would see enough to justify an additional oncologist and nurse. Other specialities are much better at insisting on additional resource to run extra services. It would be unthinkable for a surgical speciality to take on 2 extra operating lists per week without additional investment.

Did the commitment achieve a positive impact for patients?

The availability of new drugs and innovations has clear benefit for patients, significantly improving cancer outcomes. Measurable outcomes continue to improve. Recently for the first time ever a study in metastatic breast cancer has reported median overall survival figures of more than 5 years. However, the patient experience as a whole is in danger of deteriorating due to overstretched services. The complexity of consultations is ever increasing, but patients are having less time available for detailed discussions and waiting times for appointments are becoming longer.

In terms of equity for groups, one group of patients who are often not well served by clinical nurse specialist input is those with metastatic disease, particularly if they are well and not requiring

palliative care or hospice input. This does vary geographically and ensuring a named key worker for all patients across the UK should be a priority.

Thank you for taking the time to consider our comments. We would be very happy to contribute further to the process if the panel thought that might be helpful.

February 2022