

Written evidence submitted by The British Thoracic Oncology Group (ECS0019)

Dear Yohanna,

Thank you for the opportunity to contribute to Health and Social Care Committee's Expert Panel evaluation of the progress the Government has made against its commitments in cancer services in England.

Please find below the British Thoracic Oncology Group's submission. Contributors include Dr Ruth Caulkin (palliative medicine), Ms Karen Clayton (clinic nurse specialist), Dr David Gilligan (clinical oncology), Dr Neal Navani (respiratory medicine) and Dr Tom Newsom-Davis (medical oncology). It is submitted for and on behalf of the British Thoracic Oncology Group's (BTOG's) Steering Committee. BTOG's steering committee are clinical experts and advocates from across the multi-disciplinary team involved in lung cancer care, treatment, and research from across the UK.

BTOG's Submission:

1. The Cancer Workforce Plan committed to the expansion of capacity and skills by 2021

The commitment from the Cancer Workforce Plan is clear: by 2021 there would be, compared to 2016, a total of 1281 FTE more consultants working in cancer, including 668 FTE more clinical radiologists, 316 more gastroenterologists, 243 FTE more oncologists and 94 FTE additional histopathologists. In addition, a total of 2227 FTE more diagnostic radiographers and 1,560 FTE more therapeutic radiographers were stipulated. In contrast, however, the actual number of Clinical Nurse Specialists (CNSs) was not clear with only a commitment that "every patient has access to a CNS or other support worker by 2021".

There remain significant workforce shortages, including thoracic radiology, medical oncology, clinical oncology, palliative medicine and CNSs. For example, a 2021 report by the Royal College of Radiologists found that NHS needed at least another 189 clinical oncologists to meet demand, that 52% of UK cancer centre clinical directors said oncologist shortages are negatively impacting patient care, and that the 2021 newly trained consultants will only fill 55% of vacancies (<https://www.rcr.ac.uk/press-and-policy/policy-priorities/workforce/oncology-workforce-census>). Variations in workforce may explain some of the inequality of outcomes and that very few lung cancer teams meet the NHSE service specification ([10.1136/thoraxjnl-2018-212588](https://www.nhse.uk/10.1136/thoraxjnl-2018-212588)).

In specialist palliative care consultant numbers are also affected: a 2019 report by the Association of Palliative Medicine revealed 80 consultant vacancies across the UK, with only around 37 new consultants qualifying each year (<https://apmonline.org/wp-content/uploads/2019/08/palliative-medicine-workforce-report-2019-2.pdf>).

Regarding cancer CNS, a 2021 Macmillan Cancer report found that nursing shortages have left more than half a million people with cancer in the UK (21%; 630,000) “treated but not cared for”. Furthermore, 25% of people diagnosed with cancer in the UK in the past two year – including at least an estimated 75,000 people diagnosed since the start of the pandemic – have lacked specialist cancer nursing support during their diagnosis or treatment (https://www.macmillan.org.uk/_images/Forgotten-C-Nursing-Report_tcm9-360416.pdf).

The COVID-19 pandemic should not be seen as an explanation for failures to create new positions as set out in the Cancer Workforce Plan. However, in keeping with other areas of healthcare, both Brexit and the pandemic have contributed to members of the oncology workforce retiring early or moving away from the UK.

2. A faster diagnosis standard from 2020 to ensure most patients receive a definitive diagnosis or ruling out of cancer within 28 days of referral from GP or from screening

The Faster Diagnostic Standard (FDS) is clear in its definition and the timeline for its implementation. The FDS is now included in routine Cancer Wait Times (CWT) reports, although it remains a metric to ‘shadow’ as opposed to a formal target.

Faster diagnostic pathways improve outcomes and are the premise of the National Optimal Lung Cancer Pathway (NOLCP) which aims to reduce the time from referral to treatment to 49 days (<https://www.roycastle.org/app/uploads/2020/09/National-Optimal-Lung-Cancer-Pathway-3.0.pptx>).

Significant progress has been made implementing the NOLCP, although it remains a challenge and performance varies across geographical regions. Full implementation of the NOLCP will improve all Cancer Wait Times, including the FDS.

Data on the FDS was not included in last annual review of Cancer Wait Times (July 2021). Anecdotal reports from BTOG members suggest an improvement in meeting the FDS standard, but that this often remains below the current 75% target.

The COVID-19 pandemic has compromised all aspects of the patient pathway, impacting on the ability of services to meet the FDS. The issues include, but are not limited to:

- Reduction of presentation to primary care and urgent suspected cancer referrals.
- Restricted access to timely imaging, especially CT, MRI and PET/CT modalities.
- Reduction in diagnostic capacity in secondary care, especially endobronchial ultrasound.
- Reduced capacity in treatment pathways including surgery, radiotherapy and chemotherapy.

Further detail on the impact of COVID on lung cancer is summarised here: <https://www.nature.com/articles/s41416-021-01361-6.pdf>

The National Lung Cancer Audit (NLCA) has driven quality improvement in this area since 2005, and has recently improved its methodology in order to provide more real time data to monitor whether all patients receive the best evidence based treatments in a timely manner. Trusts should be supported to regularly supply and validate these data and improve pathway timelines and patient outcomes.

3. By 2028 the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% now to 75% of cancer patients

The timelines stipulated are clear, although the details around proposed rates (50% for both stages 1 and 2) are broad. It is unclear what the target is for lung cancer patients: Currently 27% of patients with lung cancer were diagnosed with stage 1 and 2 disease, which has not improved from previous years (28% in 2019).

Fig 1b. Distribution of stage of patients with lung cancer in England in 2019 and 2020



Diagnosing lung cancer at an earlier stage will improve outcomes by more than any other intervention. This is also consistent with the NHS Long Term Plan (<https://www.england.nhs.uk/long-term-plan/>). Earlier stage diagnosis can be achieved by (i) Running further public awareness campaigns such as “Help us help you – lung cancer” (ii) Implementing lung cancer screening with low dose CT nationally (iii) Continuing and funding new research into early diagnosis (iv) addressing resource issues, for example, the UK has amongst the lowest numbers of CTs scanner per capita.

These policies have been proven to promote earlier stage lung cancer diagnosis in real world settings.

- An early diagnosis campaign for lung cancer in Leeds in 2011 included a self-request CXR service for patients aged ≥ 50 with respiratory symptoms lasting ≥ 3 weeks. This resulted in a significant increase in chest X-ray requests and a 9.3% reduction in the number of patients diagnosed with stage III/IV disease ([10.1136/thoraxjnl-2018-211842](https://doi.org/10.1136/thoraxjnl-2018-211842))
- GP direct access to CT pathway in Nottingham, if the CXR was considered normal. This led to a 2.4% lung cancer pick up rate with positive patient and GP satisfaction scores.
- The major cause of lung cancer is tobacco, yet most patients do not have access to timely, specialised smoking cessation treatment in hospital out-patients or Primary Care. A policy of providing, and funding, comprehensive stop smoking services to the population should be prioritised. Focus on health-inequalities, as highlighted in the Marmot Review ([Fair Society Healthy Lives full report \(parliament.uk\)](https://www.parliament.uk)), is an essential part of this lung cancer prevention.
- Lung cancer in never smokers is responsible for about 15% of cases in the UK and research into causes and risk factors for this is urgently required.

The Accelerate, Co-ordinate, Evaluate (ACE) programme took place between 2014 and 2017 and resulted in several projects with the aim of reducing late stage diagnoses: (https://www.cancerresearchuk.org/sites/default/files/ace_proactive_lung_report_with_economic_evaluation_final_version_1.1a_0.pdf)

Lung cancer awareness in primary care should also be improved.

- Increase access to diagnostics e.g. self-referral and open access for CXR. CT resource prior to the pandemic was poor compared to similar spending nations.
- Direct self-referrals from patients to secondary care e.g. via Rapid Diagnostic Centres

4. By 2021 where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support

Although the timeline is specific ('by 2021') the definitions of what is required remain broad and open to individual interpretation. This risks significant variation in quality of patient care from area to area.

Significant advances have been made in this area over the past 5 years. This reflects a cultural shift within healthcare of the importance of early referral for supportive care, including symptom control and psychological support. Stronger, collaborative engagement between oncology and palliative care underlies these improvements, and current performance indicators include, for example, proportion of patients being offered a Holistic Needs Assessment at various stages through their cancer diagnosis and treatment.

Despite this progress, problems persist. The quality of personalised care is too variable not only geographically, but also between tumour types, with some cancer patient populations having much better access to services than others. Psychological services, financial support, provision of community services and social care are

areas which are particularly poorly provided. Variations in provision of personalised care will persist until services are fully commissioned with complete equity of access.

National Lung Cancer Audit (NLCA) data presented at the BTOG Annual Meeting (2022) noted a reduction to 75% in the proportion of lung cancer patients seen by a lung cancer CNS at diagnosis, meaning that a quarter of lung cancer patients would probably not even have a contact number for their keyworker.

Other factors which have impeded the commitment being made are diverse and include, but are not limited to, an ageing CNS workforce with corresponding high rates of retirement. There are additional difficulties in workforce planning due to the demographic and flexible employment requirements of the specialist palliative care workforce who are the majority providers of personalised care.

COVID-19 has affected provision of personalised care in the short-term, with re-deployment of healthcare professionals during the peak of the pandemic, although these re-deployments are now largely finished. In a recent survey of lung cancer and mesothelioma nurses during the COVID-19 pandemic, respondents expressed concern that stretched services, increased caseloads of late-stage patients, and new methods of virtual working have negatively impacted on the care and support given to patients and their families. Nurses report working long hours to try and prevent this.

A longer-term, and indeed more troubling, consequence of COVID-19 has been the huge fall in income for hospices from their charity and other fund-raising activities. With government funding only accounting for 30% of adult hospice income, reductions in charitable income are having a marked detrimental impact on community palliative care services.

5. Safer and more precise treatments including advanced radiotherapy techniques and immunotherapies will continue to support improvements in survival rates

No specific timelines are mentioned in the top-line commitment to introduce novel radiotherapy and immunotherapy treatments.

Project Orbis has been a notable success in expediting MHRA approval and introduction of new cancer treatments, with Sotorasib, adjuvant Osimertinib and adjuvant Atezolizumab all approved through this route.

Most biological agents require identification of a tumour biomarker. Timely, accurate and comprehensive identification of these is the focus of National Genomics Programme, which has been a great advance and is to be commended. However, the quality of service is too variable from region to region. Furthermore, there remain anti-cancer drugs which are available through access programs, but for which the relevant genomic target has yet to be included in the National Test Directory.

In June 2020 the Royal College of Radiologists (RCR) produced a consensus statement on radiotherapy for lung cancer (https://www.rcr.ac.uk/system/files/publication/field_publication_files/radiotherapy-for-lung-cancer-rcr-consensus-statements.pdf). This included many recommendations for the delivery of optimal treatments

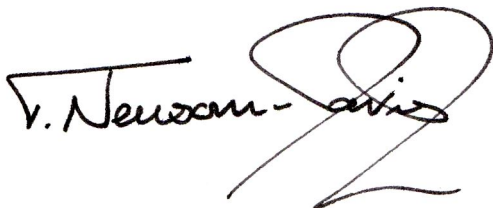
and technologies including the use of stereotactic radiotherapy (SABR) and use of IMRT/VMAT techniques as well as the optimisation of combined modality treatments. A recent audit of these guidelines has shown that significant changes have been implemented but several areas especially around chemoradiotherapy require renewed efforts. NHS England have, subject to Commissioning rules and local implementation plans, approved SABR for early-stage non-small cell lung cancer and SABR to oligo-metastatic disease in all centres.

As new treatments continue to improve survival and are now often long-term therapies, the number of patients attending chemotherapy units grows every year putting unprecedentedly pressure on these services. Novel approaches, such as support for widespread adoption of nurse- and pharmacist-led clinics are required.

The COVID-19 pandemic has not reduced the approval of novel anti-cancer therapies or radiotherapy technologies. Instead, a number of targeted anti-cancer treatments were made available at the beginning of the pandemic (for example, trametinib and dabrafenib for BRAF V600E lung cancer) to minimise the need for chemotherapy-based treatments. Some such approvals have subsequently been withdrawn, although the most clinically relevant ones remain in place.

Changes in anti-cancer therapy are demonstrated in the SACT dataset which is published annually, although the data is not at sufficient detail yet to allow year-on-year assessment of trends in use of new therapies.

Yours sincerely

A handwritten signature in black ink, appearing to read 'V. Newsom-Davis', with a large, stylized flourish extending from the end of the name.

Dr Tom Newsom-Davis

BTOG Steering Committee Vice-Chair

Jan 2022