

Executive Summary

- The **crisis facing the cancer workforce** is impacting the government's ability to deliver on its cancer commitments.
- It is vital that a **progress report** is made publicly available so that we can understand whether progress on the commitments has been made and **support future workforce modelling**.
- NHS staff are **working tirelessly**, but **increased demand** as services try to tackle the backlog threatens to **overwhelm a workforce** that was already under-resourced and over-stretched prior to the pandemic.
- A **fully funded, long-term strategic workforce plan** is vital to tackling the current crisis and ensuring the workforce is fully supported and resourced so that they can deliver the best care possible.
- While the government does meet its commitment to diagnose 75% of breast cancers at stage 1 and 2, there is still a **significant backlog of women** waiting to be screened.
- We are concerned that NHS England (NHSE) will not meet its aim to recover the breast screening programme by March 2022.
- We are particularly concerned that changes to the way women are invited to attend breast screening will result in a **decline in uptake**, especially amongst low uptake groups, which would then **widen health inequalities**.

To deliver on its cancer commitments, the government must urgently develop a fully funded, long-term workforce plan, and set out how it plans to recover the breast screening programme and ensure the NHS meets its target to make up the shortfall of breast cancer patients starting treatment.

About Breast Cancer Now

We're Breast Cancer Now, the charity that's steered by world-class research and powered by lifechanging care. We're here for anyone affected by breast cancer, the whole way through, providing support for today and hope for the future.

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

Q. Was the commitment met overall?

A lack of regular progress updates on the commitments made within the Cancer Workforce Plan Phase 1 (2017) and subsequent plans including the People Plan 20/21, makes it difficult to comment on the exact progress to date.

It is vital that a progress report is made publicly available so that we can understand whether progress on the commitments has been made and to also support future workforce modelling.

However, our own research found that despite the Cancer Workforce Plan (2017), and Long-Term Plan both stating that every patient should have access to a Cancer Nurse Specialist (CNS) or other

support worker by 2021, only 73% of respondents to our 2019 survey of secondary breast cancer patients were given the name of a CNS at diagnosis. In addition, 25% of respondents said they had not seen a CNS since diagnosis, less than a third (30%) said they had seen a CNS regularly and only 65% said that their CNS had enough time to spend with them¹.

Impact of Covid-19

NHS staff are working tirelessly to see as many women as possible at breast screening services and in breast clinics since screening restarted, but increased demand for imaging and diagnostic services threatens to overwhelm a workforce that was already under-resourced and over-stretched prior to the pandemic.

Access to a CNS has also been impacted during the pandemic, our 2020 survey of breast cancer found 41% of respondents felt they had less contact with their CNS during the coronavirus outbreak.²

The NHS People Plan, launched in July 2020 aimed to address workforce challenges, but this was only intended to be a short-term plan for 2020/21. To address the screening backlog, and fully recover breast services, the government needs to develop a fully funded, long-term strategic workforce plan, which includes ensuring the workforce is fully supported and resourced so that they can deliver the best care possible. Breast Cancer Now was pleased to hear the Secretary of State announce at the Health and Social Committee session of 25 January 2022 that he has asked the NHS to develop a long-term workforce strategy.³ We now need to see more detail on the scope of the strategy and timescales for publication.

Workforce burnout

Prior to the pandemic, the breast cancer imaging and diagnostic workforce was in crisis, with services overstretched and underfunded. The government needs to set out how it intends to deal with the challenges the cancer workforce is currently facing, taking into account the screening backlog and the impact of the pandemic on morale.

Our survey of specialist breast care nurses found that:

- Only 35% of breast nurse specialists say their current workload is manageable
- 44% said they experience work-related stress or burnout as a result of their current workload
- Less than half (45%) said they have a good work-life balance
- 39% said that their current workload is negatively affecting the quality of care they can give to patients.⁴

Increasing the number of CNSs supporting people with secondary breast cancer would reduce the workload for existing CNSs and increasing job satisfaction, therefore improving retention of the current workforce. The government must outline how it will address morale in the health workforce, which poses a serious risk to patient safety.

Long-standing workforce recruitment issues

While it is positive that the Cancer Workforce Plan (2017) committed to increasing numbers of clinical radiologists, it is unclear the impact this has had specifically for breast radiologists, which we know are in high demand. The Royal College of Radiologists' (RCR) most recent Clinical Radiology UK

¹ Breast Cancer Now (2019) Unsurvivors: Until Things Change, available at https://breastcancernow.org/sites/default/files/bcn_untilthingschange_final_30.09.20.pdf

² Breast Cancer Now (2020) Survey of Nurses

³ <https://www.parliamentlive.tv/Event/Index/de8fd5c1-619a-4569-ade1-ee6433d0dc3c>

⁴ Breast Cancer Now (2020) Survey of Nurses

Workforce Census found that for the third year in a row, breast clinical radiologists were one of the most in-demand specialists, with 41 vacancies in 2020. Yet there have been minimal increases in the numbers of breast clinical radiology consultants. Over a five-year period, the number of full-time clinical radiology consultants grew from 435 in 2015 to just 466 in 2020.⁵ It is evident that there are recruitment issues within the breast radiology workforce, these issues can only be addressed through the development of a long-term workforce strategy.

Worryingly, a high proportion of consultant breast radiologists are expected to retire within the next five years - 23% in England compared to the clinical radiologist consultant average of 19%.⁶ Breast consultant shortages could increase over the same period unless urgent mitigating action is taken.

Workforce forecasting

Last summer, the Government instructed Health Education England to review, renew and update the existing long-term strategic framework (called Framework 15), which, among other things, looks at key drivers of workforce demand and supply over the longer term. It will set out how these factors impact on the required shape and numbers of the future workforce to help identify those main strategic choices. We are expecting this to be published in spring 2022. However, the current Framework 15 was first published in 2014, last updated in 2017, and yet there are no agreed, publicly available assessment of workforce numbers now nor into the future.

For this reason, Breast Cancer Now, along with over 90 health organisations has supported an amendment to the Health and Care Bill currently going through parliament. The amendment to Clause 35 would require the Government to publish independently verified projections of the future supply of the healthcare workforce for England. This would enable the Government to take an evidence-based approach to workforce planning that responds to patients' needs now and into the future. It is vital that the Bill is strengthened to increase transparency and accountability on whether we are training enough people now to meet demand in future.

Was the commitment effectively funded (or resourced)?

A fully funded and resourced cancer workforce is integral to meeting the needs of people with breast cancer. However, despite the urgent need to invest and support the NHS cancer workforce, the Comprehensive Spending Review (2021) did not immediately specify how much funding would be provided to Health Education England (HEE).

The new financial year is due to start in a matter of weeks and yet, HEE's budget is still to be finalised.⁷ Funding and resourcing the cancer workforce remains one of the greatest challenges facing the NHS, therefore, an update on how much funding HEE will receive in the coming year is urgently needed. With the integration of NHS England and HEE it is vital that there is transparency on how decisions about future funding are made and allocated.

Q. Did the commitment achieve a positive impact for patients?

The commitment to access a CNS, including for all secondary cancers, is hugely positive for patients, therefore it is concerning that our findings show not everyone had access to a CNS. Breast cancer CNSs play a crucial role in coordinating care and providing the information and support people need to manage their breast cancer diagnosis and treatment. Their role is vital for patients with incurable secondary breast cancer, who will be on lifelong treatment and often have very complex emotional

⁵ The Royal College of Radiologists (2021). Clinical radiology: UK workforce census 2020 report. Available from: https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-2020-report.pdf

⁶ Ibid

⁷ <https://www.parliamentlive.tv/Event/Index/de8fd5c1-619a-4569-ade1-ee6433d0dc3c>

and supportive care needs. CNSs are the single most important contributing factor to people's positive experience of care, with our survey finding⁸:

However, we know that access to a CNS can vary between different cancer patients. For example, the 2019 national Cancer Patient Experience Survey for England found that 89% of all respondents said that they were given the name of a CNS who would support them through their treatment⁹, however, 25% of respondents to our secondary breast cancer survey in 2019 said they had not seen a CNS since diagnosis.¹⁰ This inequality of access demonstrates that in future a commitment needs to be developed for each type of cancer to ensure all cancer patients have equal access to a CNS

Q. Was it an appropriate commitment?

Any long-term workforce plan must learn from and consider initiatives already in place to meet cancer workforce challenges. The National Breast Imaging Academy (NBIA) programme is a collaborative, multidisciplinary initiative which aims to provide a range of solutions to address the severe workforce issues faced in the delivery of breast imaging services across the country. It is clinician led and supported by a number of bodies and organisations including Breast Cancer Now, Health Education England, the Royal College of Radiologists and the Association of Breast Clinicians.

Key proposals include the establishment of a national centre of excellence for training, the development of high-quality training programmes for all staff and an online, technology-enhanced learning hub. The NBIA is an important innovative programme which has already made positive strides in addressing workforce challenges facing the breast cancer workforce through the introduction of new roles. However, to ensure the continued expansion and success of the NBIA and to sustain the new roles, long term support and investment are needed.

In terms of geographical variation there are currently no specific CNS posts supporting secondary breast cancer patients in East Anglia and the north of England, according to our Secondary Breast Cancer Nursing Group. Any future commitments need to address the cause and tackle these geographical variations.

The Cancer Workforce Plan's commitment for every cancer patient, to have access to a CNS by 2021 was not specific enough. Future commitments on access to CNSs need to focus on the type and stage of the cancer, building on the current commitment's focus on the specific need for secondary cancer patients to access CNSs. Future commitments need to develop an assessment of how many FTE CNSs post would be needed for each stage and type of cancer. Secondly, any associated resources to deliver such commitments should be developed for each cancer and stage and be informed by existing resources such as Breast Cancer Now secondary breast cancer toolkit which provides guidance on developing and maintaining core competencies and an overview of opportunities for CNSs to develop skills and knowledge.¹¹

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

Q. Has the commitment been met/is it on track to be met equally across England or are there regional variations?

⁸ https://breastcancernow.org/sites/default/files/bcn_untilthingschange_final_30.09.20.pdf

⁹ https://www.ncpes.co.uk/wp-content/uploads/2020/06/CPES-2019-National-Report_V1.pdf

¹⁰ https://breastcancernow.org/sites/default/files/bcn_untilthingschange_final_30.09.20.pdf

¹¹ <https://breastcancernow.org/information-support/healthcare-professionals/secondary-breast-cancer-nursing-toolkit>

As of 2019, 85.7% of breast cancers in England are diagnosed at stage 1 or 2, meeting the government's 75% early diagnosis target.¹² The proportion of breast cancers diagnosed at stage 1/2 has remained static with relatively little change in the proportions of cancers diagnosed at each stage over the last decade.¹³ A further 7,000 people are diagnosed with DCIS (ductal carcinoma in situ), an early form of breast cancer, in the UK every year.

Breast screening services were paused in England during the first peak of the pandemic and restarted in the summer of 2020, albeit at a reduced capacity due to infection prevention measures.

Despite the hard work of NHS staff, there is still a significant backlog of women waiting to be screened. We are concerned that NHS England (NHSE) will not meet its aim to recover the breast screening programme by March 2022, which has been defined as restoring the three-year invitation cycle for all women, or reduce the shortfall in the number of women that have had screening.

This in turn will make it difficult for NHSE to meet its target to make up the shortfall of patients starting cancer treatment by the same deadline, as a many of the missing breast cancer diagnoses will be in this group of women who have not had breast screening.

We are particularly concerned that recent changes made to the way women are invited to attend breast screening in response to COVID could result in a decline in uptake and widen health inequalities.

Q. To what extent has the NHS's Covid-19 response affected progress on targets?

Falling performance for breast cancer

At the moment, record numbers of women with possible breast cancer symptoms are currently experiencing longer waiting times to see a specialist, with only half being seen within two weeks of urgent referral. This was the picture before the impact of the Omicron variant, meaning the situation may get worse before it gets better.

The drastic drop in performance for breast cancer referrals against the two-week wait, which is five times higher than the decline across all cancers, illustrates the extreme pressure the system is under.

The latest [Cancer Waiting Times data](#) (November 2021) revealed:

- The target is 93% but in practice just over half of women with suspected breast cancer were seeing a specialist within two weeks (51.8%), a staggering 35.7%-point drop in only two months.
- This decline in performance is five times higher than that of the average performance across all cancers, which dropped by 6.7%-points. It is likely that the combined impact of long-term workforce shortages and pandemic burnout, and an increase in referrals, has created a 'perfect storm' of service pressures.
- Longer waits can cause many women unimaginable distress and anxiety.

This fall in performance has real-world implications for those diagnosed, as rapid confirmation of breast cancer, including information such as the type of breast cancer a patient has, is key to

¹² NHS Digital (2021). Case-mix adjusted percentage of cancers diagnosed at stages 1 and 2 by CCG in England, 2019. Accessed 1st February 2022. <https://digital.nhs.uk/data-and-information/publications/statistical/case-mix-adjusted-percentage-cancers-diagnosed-at-stages-1-and-2-by-ccg-in-england/2019/unadjusted-percentage-of-cancers-diagnosed-at-stages-1-and-2-by-cancer-site-group-and-deprivation-2019#cancer-site-group>

¹³ Cancer Research UK (2021). Incidence by Stage Over Time. Accessed 1st February 2022. <https://crukancerintelligence.shinyapps.io/EarlyDiagnosis/>

ensuring people with breast cancer are started on treatment which is optimal for their tumour type as quickly as possible.

Breast cancer screening backlog and recovery

Breast screening services were effectively paused in England during the first peak of the pandemic and restarted in the summer of 2020. Despite the hard work of NHS staff, there is still today a significant backlog of women waiting to be screened.

- [We estimated](#) that around 1.2 million fewer women in England had been screened between March 2020 and May 2021, compared to pre-pandemic levels.
- Largely as a consequence of this backlog, there are around 9,000¹⁴ women still living with undiagnosed breast cancer in England, as of November 2021.
- Clearing the screening backlog, finding, and treating these currently undiagnosed women must be an absolute priority, particularly for those at an increased risk of breast cancer.

The latest [Breast Screening Performance Data for England 2019/20](#) showed that the percentage of women taking up their screening invitation within six months was 69.1%, already below the national minimum standard of 70% as the pandemic began, and a decrease from 2018/19 (71.1%). We are currently waiting on the publication of uptake data for 2020/21, which will allow us to see more fully how COVID-19 has impacted the programme.

We recognise how hard NHS staff are working. But it is unlikely NHS England will meet their target to make up the shortfall in cancer patients starting treatment due to the pandemic by March 2022. Finding and treating the thousands of women still living with undiagnosed breast cancer must be an absolute priority.

The screening backlog also presents a risk to breast cancer performance in regard to early diagnosis, as breast cancer detected through screening are more likely to be diagnoses in the early stages or DCIS.

A decline or plateau in early diagnosis performance for breast cancer could potentially affect progress towards the Government's ambition to have 75% of all cancers diagnosed at stages 1 and 2 by 2028, as breast cancer accounts for 15% of all cancers diagnosed¹⁵. Therefore, maintaining and improving early diagnosis in breast cancer will be instrumental to meeting the pan-cancer target.

Health inequalities

Women from ethnic minority backgrounds are less likely to attend breast screening compared to white women in the UK^{16 17}, with uptake being particularly lower in South Asian women¹⁸. Later stage diagnosis is a contributing factor to the poorer survival outcomes experienced by women from ethnic minority backgrounds¹⁹, and it is likely that lower uptake of screening plays a role in this.

¹⁴ The number of people starting their first treatment for breast cancer under the 31-day wait from decision to treat between March 2020 and November 2021 (compared to data from the same months in 2019/20) in England. Calculated using Monthly Provider Based Data and Summaries, Cancer Waiting Times, NHS England.

¹⁵ Cancer Research UK (2021). Cancer incidence for common cancers. Accessed 1st February 2022.

<https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/common-cancers-compared#heading=Two>

¹⁶ Renshaw, C., Jack, R.H., Dixon, S., et al (2010). Estimating attendance for breast cancer screening in ethnic groups in London. BMC Public Health 10, 157.

¹⁷ Jack, R.H., Møller, H., Robson, T. & Davies, E.A. (2014). Breast cancer screening uptake among women from different ethnic groups in London: a population-based cohort study. BMJ Open, 4(10).

¹⁸ The health of people from ethnic minority groups in England. (2021). Kings Fund. Accessed 8th April 2021.

<https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england>

¹⁹ Jack, R.H., Davies, E.A. & Møller, H. (2009). Breast cancer incidence, stage, treatment, and survival in ethnic groups in Southeast England. British Journal of Cancer, 100, pp. 545-550

Some measures have been taken to try to improve the efficiency of the breast screening programme in order speed up recovery. In England, from the end of September 2020, women were sent ‘open invitations’ requiring them to call and make an appointment for screening, rather than being given a timed appointment.

However, we are particularly concerned that this change to the way women are invited to attend breast screening will result in a decline in uptake, especially amongst low uptake groups, which would then widen health inequalities:

- Previous research shows that the number of women making appointments through open invites is significantly lower than those attending timed appointments^{20 21}.
- Switching to an open invitation model could therefore accelerate the persistent decline we have seen in uptake of breast screening, especially amongst groups who are already less likely to attend screening²².

This could undermine work to address health inequalities through the [NHS Core20PLUS5 framework](#), which includes early diagnosis of cancer as one of its areas of clinical focus for reducing health inequalities.

It is vital that the impact of open invitations on the uptake of breast screening is fully assessed as we move forward. This must include an impact assessment on groups who are already less likely to attend screening and existing health inequalities related to breast cancer.

²⁰ Segnan, N., Seriore, C., Giordano, L., Ponti, A., & Ronco, G. (1998). Promoting participation in a population screening program for breast and cervical cancer: a randomized trial of different invitation strategies. *Tumori Journal*, 84(3), 348-353.

²¹ Eilbert, K. W., Carroll, K., Peach, J., Khatoon, S., Basnett, I., & McCulloch, N. (2009). Approaches to improving breast screening uptake: evidence and experience from Tower Hamlets. *British journal of cancer*, 101(2), S64-S67.

²² NHS Digital (2021). Breast Screening Programme, England 2018-19. Accessed 1st February 2022. <https://digital.nhs.uk/data-and-information/publications/statistical/breast-screening-programme/england---2018-19>