NHS
Wessex
Cancer Alliance

Wessex Cancer Alliance Regional Report on the Capacity and Demand Review of SACT Units 2025

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Executive Summary

A comprehensive review of Systemic Anti-Cancer Therapy (SACT) units across the Wessex Cancer Alliance region was undertaken using a structured, data-driven approach. The objective was to assess current SACT unit activity, measure capacity of each unit along with SACT nursing establishments and identify operational challenges, and model future requirements to support sustainable delivery of high-quality care. The high-level, regional findings of the audit are included in this report, along with a number of recommendations based on findings. Individual SACT unit reports, including a summary of findings and horizon mapping have been shared with SACT teams at each NHS Trust and WCA with the expectation that each trust will develop a local action plan to address key challenges.

The audit provides evidence that there is currently inadequate chair capacity and SACT nurse capacity in many of the SACT units, resulting in significant pressure on the system. This is negatively impacting the ability of trusts to implement new NICE approved SACT within expected timeframes and promote clinical trial activity. The deficit in SACT capacity affects patient outcomes and experience with patients waiting longer than expected to start their cancer treatment.

The modelling suggests that in 5 years' time, without urgent action, there will be a combined deficit in SACT unit capacity in Wessex, with a gap in chair capacity of 53 & a gap in SACT nurse capacity of 52 WTE.

There will be some efficiency savings that can be made at each trust to improve the use of current SACT unit capacity which will need addressing alongside the development of local plans to increase SACT chairs and SACT nurse workforce to meet the growing demand.

It must be noted that there are significant pressures on other key parts of the SACT service including oncology pharmacy, aseptic services and medical oncology & haematology but these areas have not been scrutinised as part of this project.

1. Introduction

In response to the national planning pack 2025/26, Wessex Cancer Alliance has worked closely with the six acute hospital trusts in Dorset and Hampshire & IOW along with an external partner, Merck Sharp & Dohme (UK) Limited (MSD) to undertake a demand and capacity project, focusing on the activity in the day units where SACT is administered to adult patients and Teenage and Young adults (TYA). This project follows a previous similar project in 2023 which used the Cancer Insight Tool that has been developed by MSD. The tool has been widely used across NHS organisations in England, providing evidence of its credibility in this space.

The purpose of this report is to provide a summary of the key findings of the audit, from a regional perspective. It will provide useful insight into the regional SACT landscape which will provide helpful direction on the key themes that may require focus and development in order to meet the growing demand for SACT services.

The audit had a focus on these key areas within each trust:

- Current chair capacity in each unit
- Current SACT nurse capacity in each unit
- Current SACT activity in each unit
- Current non-SACT activity in each unit
- Number of on-the-day delays to patients starting SACT
- Numbers of deferrals of SACT
- Reasons for delays and deferrals
- Impact of delays and deferrals on capacity
- Modelling scenarios to anticipate impact of changes to demand and capacity.

All hospital SACT services have been actively involved in the data collection and validation of the outputs and have all received written reports pertaining to their own organisations. These reports go into detail about the individual Trusts SACT services and provide a rich source of valuable information to help them have a better understanding of their current services as well as horizon modelling.

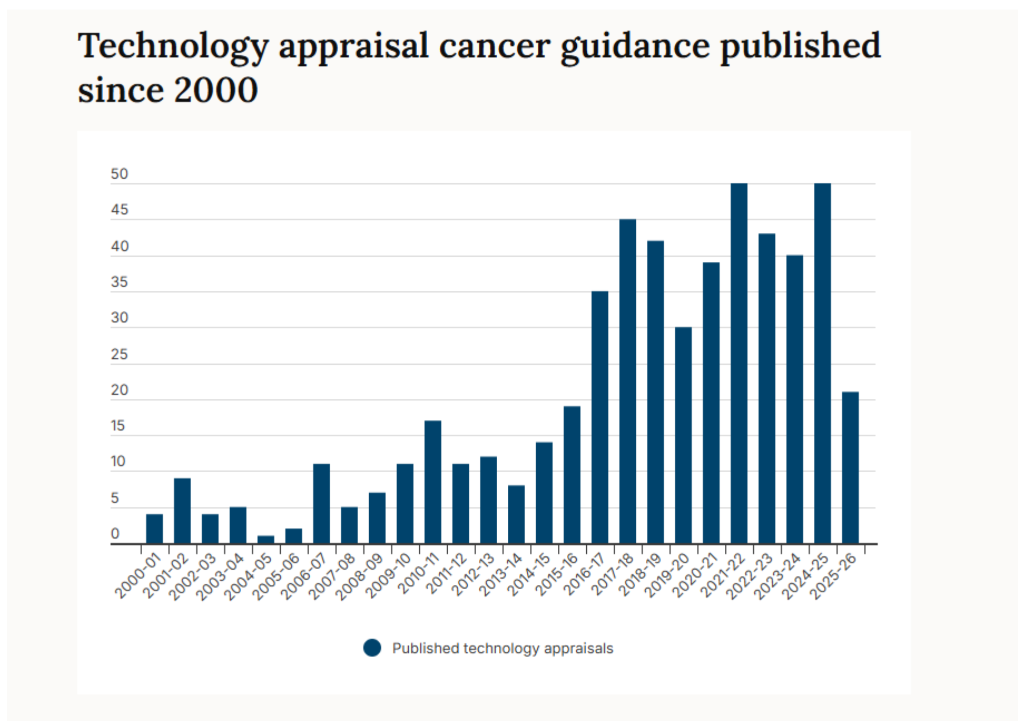
2. Background

Demand for SACT has increased significantly in recent years, with an expected growth of around 6% annually (Royal College of Radiologists 2023). This is driven by increased cancer incidence, prevalence, and significant development in SACT technology. Nationally, the expansion of available treatments within the NHS and the broader eligibility of patients have placed considerable strain on local SACT services. These pressures have compounded existing challenges for SACT services which are already struggling to meet rising demand and increased complexity of SACT treatment.

NICE continue to publish new technology appraisals of cancer treatment at an accelerated rate, resulting in more SACT treatments being made available to patients than ever before. Whilst the NICE approval process has demonstrated great efficiency

and facilitates improved access to SACT drugs for patients with cancer, providers struggle to keep up with the rate of NICE approvals, resulting in increased and unsustainable pressure and demand on SACT services.

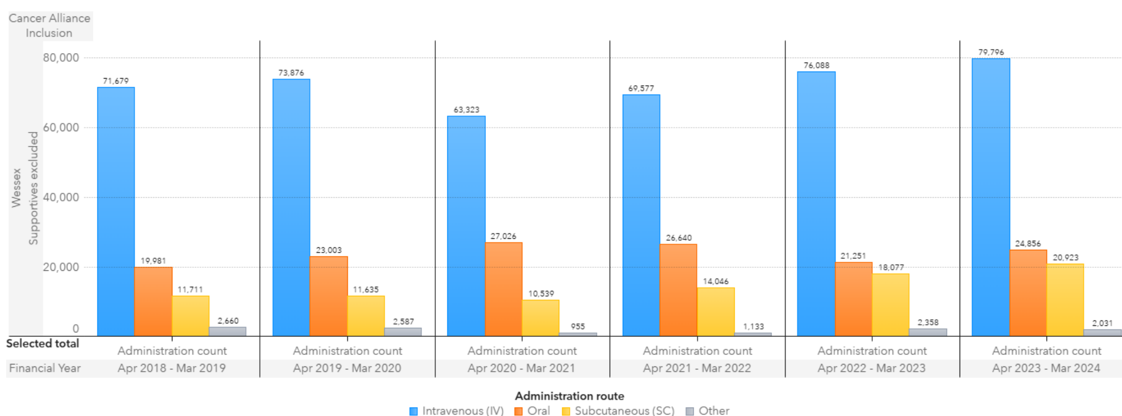
The graph below, illustrates the number of cancer technology appraisals approved by NICE annually since 2000. This data highlights a consistent upward trend, reflecting continued growth in the range of approved cancer therapies year on year. (Technology appraisal data: cancer appraisal recommendations | NICE Accessed 22nd Dec 2025)



3. Regional picture – SACT demand

Within Wessex Cancer Alliance region, there are six acute hospital trusts who deliver SACT within a day unit setting. Many of the trusts also support an in-patient SACT service and although the focus of the demand and capacity audit did not evaluate in-patient SACT activity, it is useful when considering service development, to understand the total SACT service for each trust, including in-patient and day case activity along with outpatient activity.

Regionally, there has been an overall increase in SACT, year on year across all administration routes. The graphs below have been taken from the national Cancerstats2 website and demonstrate the total number of SACT administrations for Wessex Cancer Alliance region, combining SACT data from Dorset, Hampshire, and IOW from 2018 to 2024. The columns represent routes of administration for each 12-month period.



The graph above and table below demonstrate overall growth in SACT activity across Wessex in the three main administration routes from 2018 - 2024. (https://cancerstats.ndrs.nhs.uk/sact/summarydb - Accessed 22/12/2025)

Administration Route	2018	2024	Difference in numbers of treatments	Increase of Treatments from 2018 - 2024 (%)
Intravenous	71,679	79,796	***8,117***	***11%***
Oral	19,981	24,856	***4,875***	***24%***
Subcutaneous injection	11,711	20,923	***9,212***	***79%***

From the nationally available, regional data, it is noted that the most significant increase in number of administrations has been seen in subcutaneous injection of SACT, with a notable rise from April 2021 to March 2024.

To summarise, the nationally available data supports a growing increase in SACT demand across the Wessex region.

4. Participating SACT units within the Wessex Cancer Alliance

The following six NHS trusts were included in the 2025 SACT Capacity and demand audit, made up by a total of 13 SACT units:

- Hampshire Hospitals NHS Trust (HHFT)
    - Winchester
    - Basingstoke
- Portsmouth Hospital Trust (PHT)
    - Haematology-oncology day unit (HODU)
    - Fareham Hospital Outreach SACT service
- University Southampton Hospital (UHS)

    - Hamwic House (HH)
    - Haematology Day unit (C7)
    - Teenage and Young Adult Cancer unit (TYA)
    - Lymington Hospital Outreach SACT Service
- Isle of Wight NHS Trust (IOW)
    - Chemotherapy unit
- University Hospital Dorset (UHD)
    - Poole Hospital
    - Royal Bournemouth and Christchurch Hospital
- Dorset County Hospital (DCH)
    - Fortuneswell day unit
    - Bridport Hospital Outreach SACT service

The audit does not include SACT activity that is delivered in hospital in-patient wards or SACT that is delivered by homecare providers.

5. Launch Event Overview

In January 2025, a successful launch event was held to initiate the upcoming SACT capacity and demand audit cycle across the WCA. The primary objective of the event was to engage with key stakeholders, introduce the audit process to staff who had not previously participated in earlier audits, while also providing an opportunity for experienced staff to refresh their understanding and learn about updates to the methodology.

The event was well attended, with representation from all six acute trusts across Wessex. Attendees included a diverse mix of clinical professionals, operational leads, and support staff, ensuring a broad perspective on service delivery and audit requirements. This inclusive approach fostered engagement and collaboration between organisations.

The event featured an interactive format designed to encourage discussion and knowledge exchange. Key topics included:

- **Audit Cycle Overview**: Explanation of the planned timeline for data collection, analysis, and reporting.
- **Data Collection Methods**: Review of the structured approach to gathering accurate and consistent data across all Day Units.
- **Analysis and Reporting Mechanisms**: Outline of how findings will be validated, modelled, and communicated to stakeholders.
- **Shared working**: Creating a collaborative environment where participants could share insights and raise questions about operational challenges.
- **Key project staff:** Identification of key project staff in each trust.

The event set a solid foundation for the forthcoming audit cycle, supporting a consistent and transparent approach to assessing SACT service capacity and demand across the WCA.

6. Scope of Review

The review focused on four key domains critical to service delivery:

1. **Demand and Capacity Assessment**
    - Analysis of patient attendances, chair utilisation, and staff utilisation across all trusts.
    - Identification of capacity constraints and alignment with projected growth trends.
    - Identification of all activity types including SACT and non-SACT activity such as blood transfusions, Central Venous Access device (CVAD) care and phlebotomy.
2. **Workforce Activity**
    - SACT nurse establishment review
    - Evaluation of current staffing models, including roles and responsibilities of SACT-trained nurses.
    - Agenda for Change banding of SACT nurses
    -
3. **Deferrals and Delays**
    - Measurement of delays and deferrals.
    - Investigation into the root causes of treatment deferrals and appointment delays.
    - Assessment of the operational and clinical impact of these disruptions.
4. **Modelling scenarios to illustrate changes to service.**
    - Each trust had the opportunity to choose what scenario's they wanted to model.
    - Examples:
        1. included removing non-SACT activity from SACT units.
        2. Removing s/c injectable immunotherapy from SACT unit
        3. Opening more chairs and impact on capacity
        4. Increasing nurse establishment and impact on capacity

7. Methodology

Following the launch event, a one-to-one meeting between WCA project staff and each NHS trust SACT team was arranged ahead of the data collection period. Trusts were encouraged to identify key clinical staff who took responsibility for the leadership of the project at each trust and made themselves available to support the data collection processes and teams involved with this.

WCA made a limited funding opportunity available for all trusts to support backfill of the key staff involved with the audit although not all trusts accepted this offer.

Where possible, the data was collected via reporting mechanisms from electronic SACT prescribing systems in each trust. However, there was significant real-time manual data collection required to supplement any electronic reporting.

Data was collected by SACT teams from each SACT day unit over two consecutive weeks, providing a representative snapshot of activity. Each trust had a different two-week data collection period and there were no public holidays during the two-week period of data collection.

The initial data collected included patient NHS numbers to allow cross-checking and cleansing by the clinical teams and WCA SACT team, however, the NHS numbers were excluded thereafter and not shared with MSD or other parties to ensure patient confidentiality.

The key data items that were collected for the audit included the following:

- Chair capacity in each unit.
- Chair opening times each day to give total chair availability in hours per day and per week.
- SACT nursing workforce real-time establishment at the time of the audit, including grading of staff.
- Breakdown of clinical and non-clinical activity for all SACT nurses by grade per week including direct SACT administration, patient facing time.
- Agreed SACT nursing time allocation for each clinical activity.
- Number of SACT appointments scheduled each day.
- Name of SACT regimen
- Type of SACT -Immunotherapy (Including targeted therapy) or chemotherapy
- Appointment duration for each SACT regimen
- Route of administration for each SACT regimen
- New or subsequent SACT appointment
- Number of non-SACT activities scheduled each day.
- Name of non-SACT activity
- Appointment duration for each non-SACT regimen
- Route of administration for each non-SACT regimen
- New or subsequent non-SACT appointment
- Delays to start times for all scheduled appointment.
- Reason for delays
- Deferrals to scheduled appointments.
- Reasons for deferrals

Following the collection of the data items by each trust, they transcribed this into a master spreadsheet which was shared with WCA project team. The raw data required significant checking and cleansing before being validated through discussion with key SACT staff from each trust before being shared with MSD for analysis.

Key findings from each audit were presented during face-to-face review meetings with clinical and operational leaders, where qualitative insights were gathered to complement the quantitative analysis.

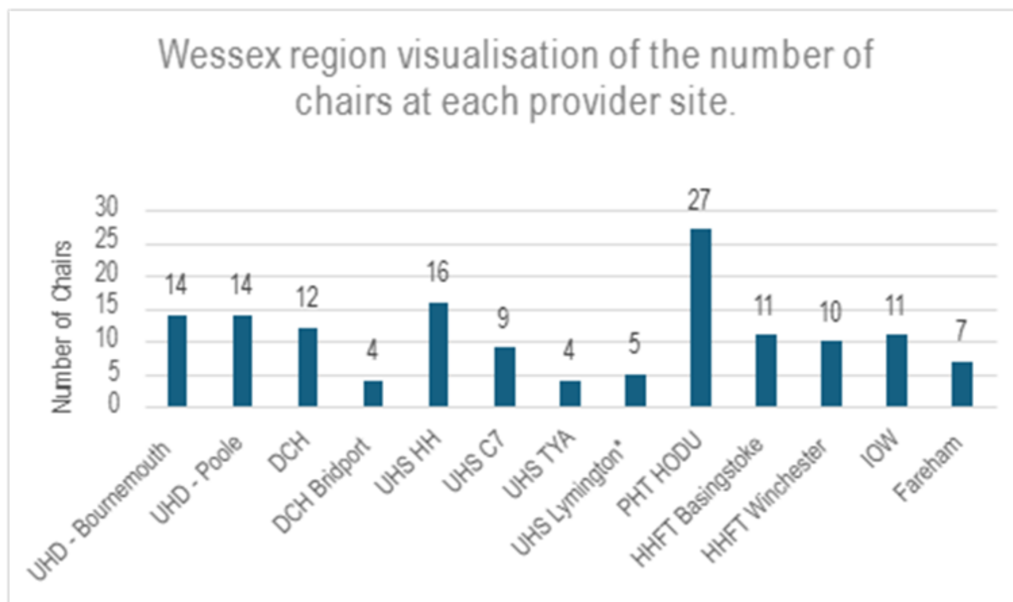
8. Key Findings

8.1 Chair capacity – current capacity.

There were a range in the total number of chairs in each SACT unit. Chair numbers ranged from four in one of the outreach units to 27 in the largest SACT unit. There was a total of 144 commissioned chairs available for SACT across the region.

This can be broken down into 44 in Dorset trusts and 100 across Hampshire and IOW.

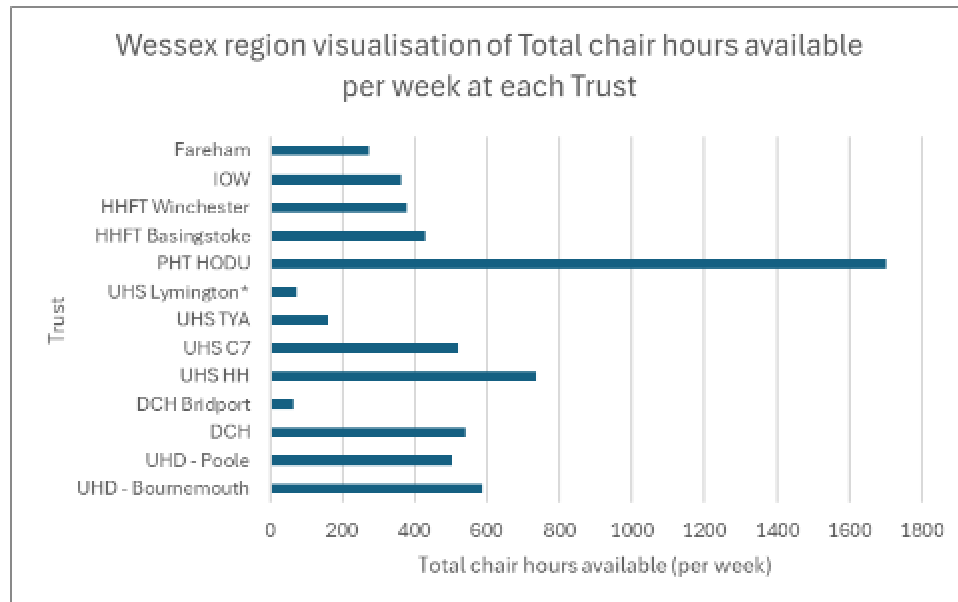
The graph below shows the number of chairs per SACT Trust unit.



Chair opening times were routinely staggered in most units to mitigate against all patients being scheduled to arrive at the same time which would not be practical. For example, most units have scheduling rules where they allow a small number of patients to arrive every ½ hour from the unit opening, ensuring there is adequate SACT nursing staff to care for each patient as they arrive for their appointment. A reverse process tends to occur at the end of the day where a proportion of chairs will be closed for new admissions after a certain time when there are less staff on duty. Some units block

arrivals over lunchtime to mitigate against an influx of patients arriving when staff may be on scheduled lunch breaks.

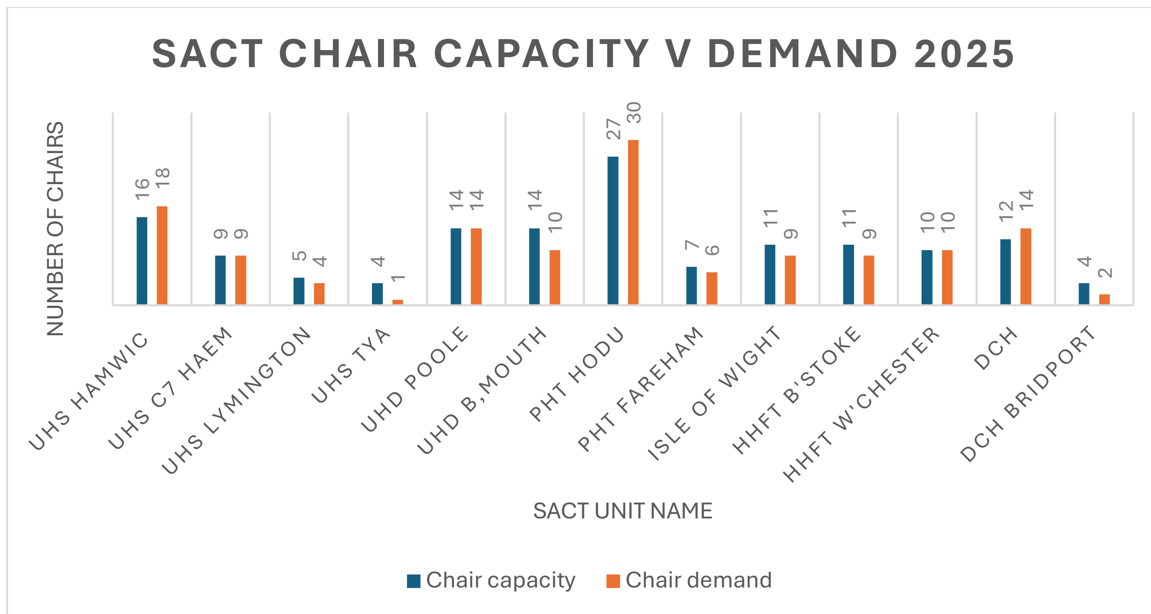
The graph below shows the total number of chair hours that are available in each SACT unit per week, considering, chair numbers, days of operation and chair opening times.



8.2 Current chair capacity versus demand

8.3 The findings suggest that overall, 136 chairs would be required to deliver the total activity across the region per week compared to the 144 chairs that were available. Although this suggests that collectively, there are sufficient chairs for current demand across the region, this is not the situation in most SACT units where demand exceeds capacity.

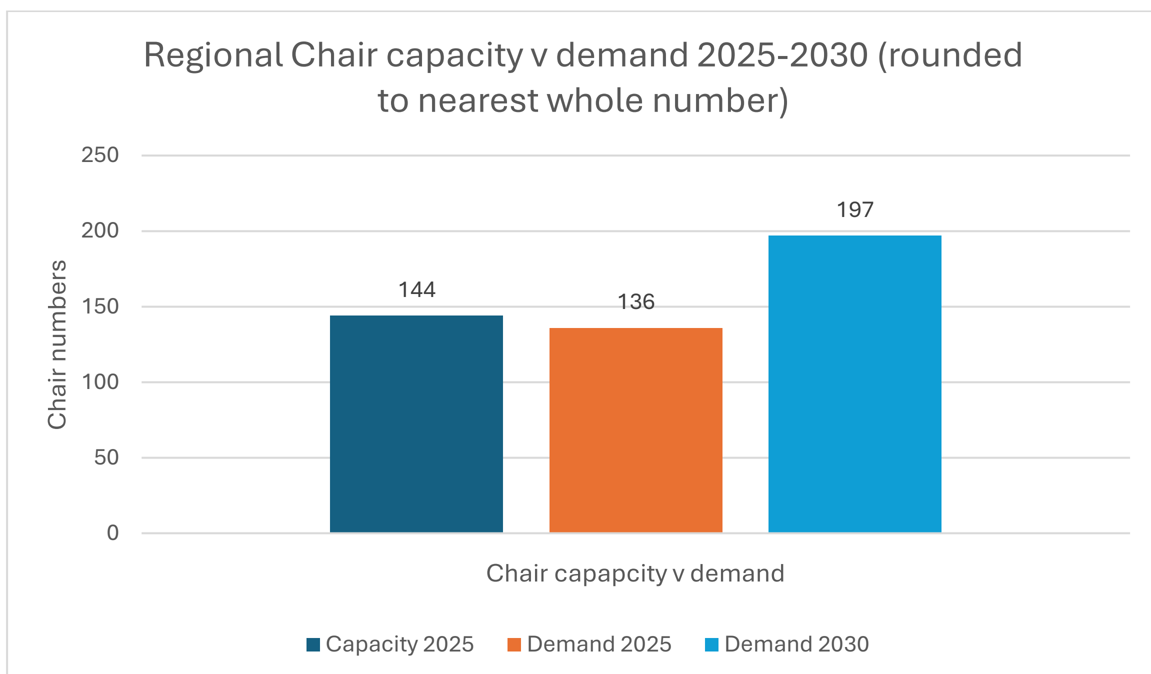
The graph below demonstrates the chair numbers required and the chairs available for the weekly demand for each SACT unit in 2025.



8.3 Future demand for SACT chair capacity.

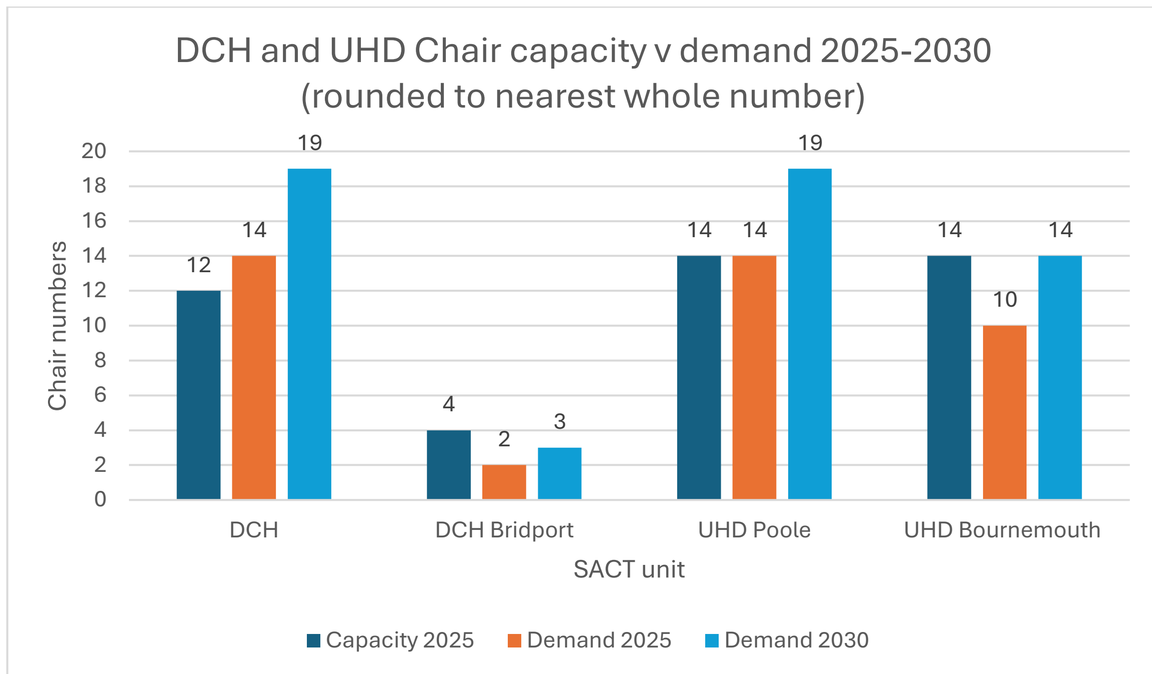
Based on current chair capacity and demand as baseline and then forecasting growth based on at least 6% increase of SACT annually, there will be a year-on-year increase in the number of chairs needed to meet anticipated increased demand across the region.

The graph below illustrates the total number of chairs available across the region in 2025, the number of chairs required in 2025 and the number of chairs that will be required across the region in 2030, based on anticipated growth in SACT activity.

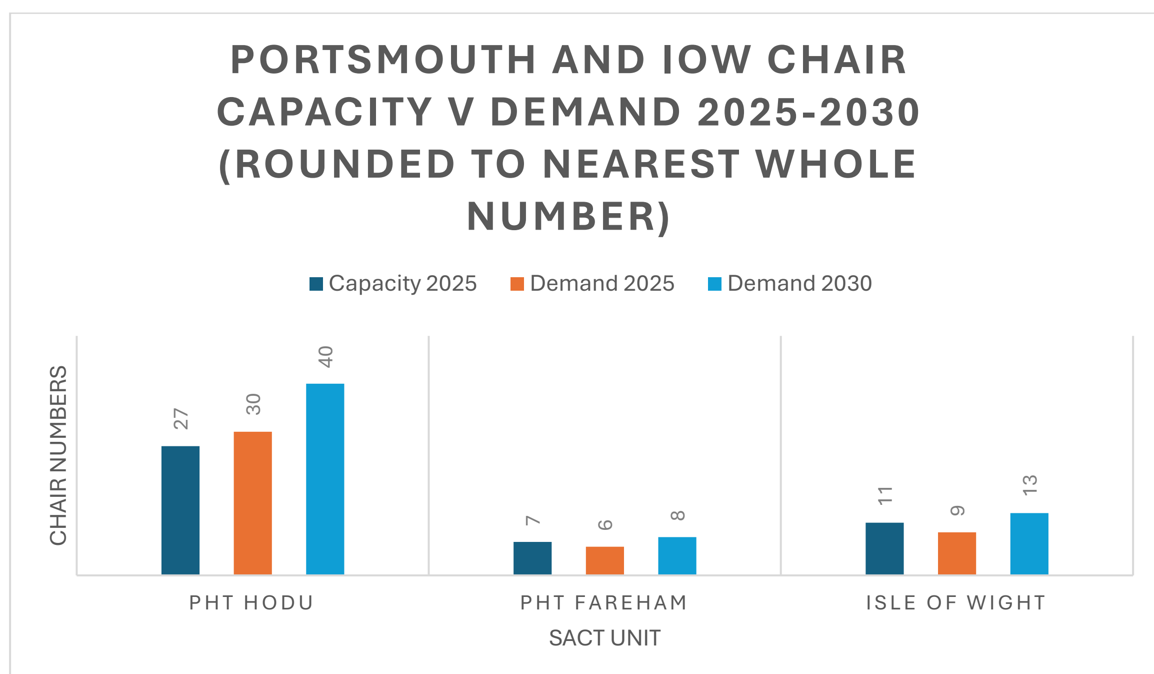


The Chair capacity and demand can be broken down to look at individual trusts in Dorset and Hants & IOW separately which may be helpful for comparison and to help inform planning.

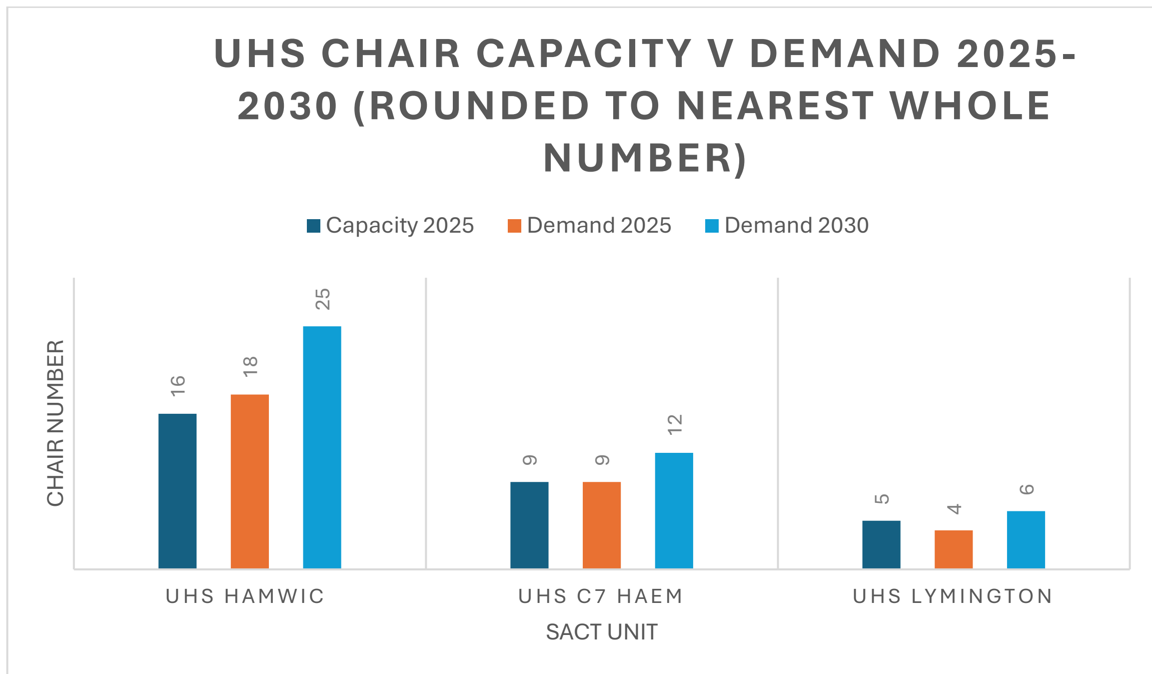
The graph below illustrates the current chair capacity and demand and future demand for SACT units in Dorset.



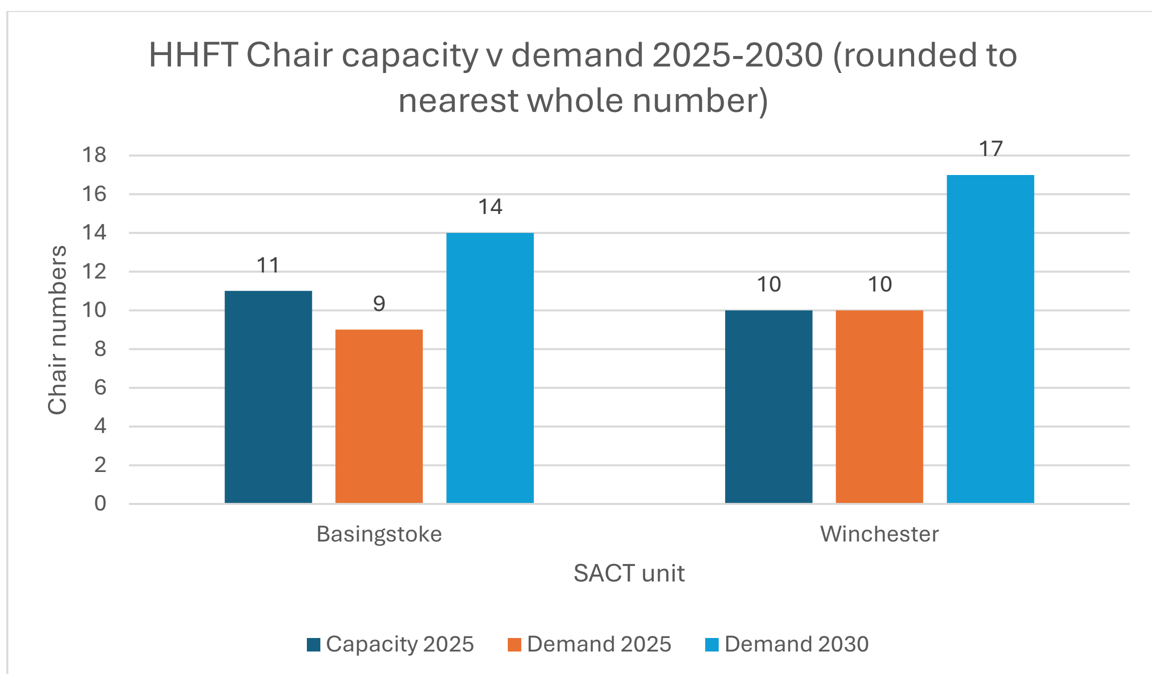
The graph below illustrates the current chair capacity and demand and future demand for SACT units in Portsmouth and IOW.



The graph below illustrates the current chair capacity and demand and future demand for SACT units in University Hospitals Southampton.



The graph below illustrates the current chair capacity and demand and future demand for SACT units in Hampshire Hospitals.



8.4 SACT unit activity

The SACT units vary across the region in terms of the activities that take place. The majority of SACT units care for a combination of patients with solid tumours and haematological malignancy although one trust has separate SACT units for oncology and haematology patients. There is one principal treatment centre for Teenage & Young Adult Cancer Unit where SACT takes place.

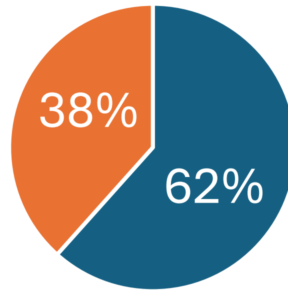
Some of the SACT units deliver a mix of non-SACT and SACT activity, whilst others focus primarily on SACT administration and are assisted by other day units who are responsible for the care of patients who require supportive, non-SACT activity such as blood transfusions and iron infusions.

The patient facing activities that are routinely carried out in SACT units include varying combinations of the following:

- SACT
- Blood product infusions
- Apheresis procedures (excluded in this audit)
- Therapeutic venesection
- Central venous access device care (including PICC insertions and removal)
- Phlebotomy
- Bone marrow biopsy
- Bisphosphonate infusions
- Other non-SACT injectable and infusion medicine
- Patient education

The pie chart below shows the overall percentage split of SACT and non-SACT activities that occur across all the SACT units in the Wessex region. This provides evidence of the significant amount of non-SACT work that is being undertaken in SACT units.

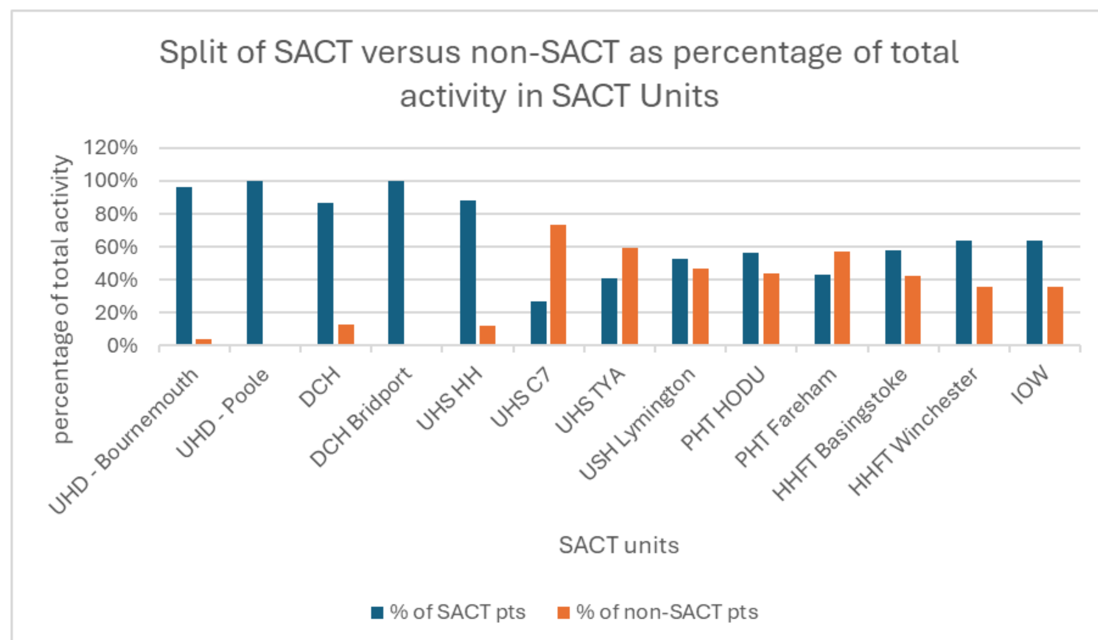
Distribution of SACT and Non-SACT Treatments across Wessex



■ SACT Activity average/week ■ Non-SACT Activity average/week

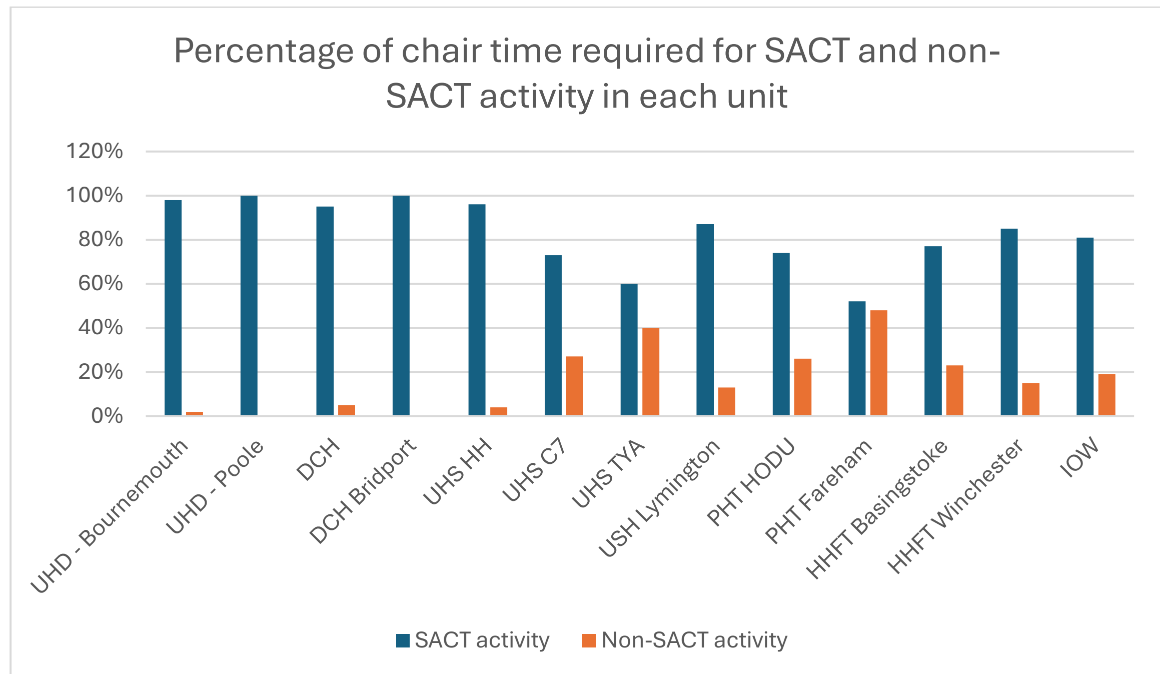
For the purposes of this audit, apheresis and standalone phlebotomy and CVC clinics were excluded. The staffing associated with these activities was also excluded.

The distribution of patients attending for SACT and non-SACT activity per week for each SACT unit can be seen as a percentage for each in the graph below. This indicates wide variation of SACT versus non-SACT activity in each unit. Further details can be seen in appendix 1.



The chair time required for SACT and non-SACT was also measured in each SACT unit, and the graph below illustrates the percentage of chair time used for the care of

patients having SACT and non-SACT per week. In all SACT units, non-SACT activity required less percentage of chair time than SACT over a period of one week.

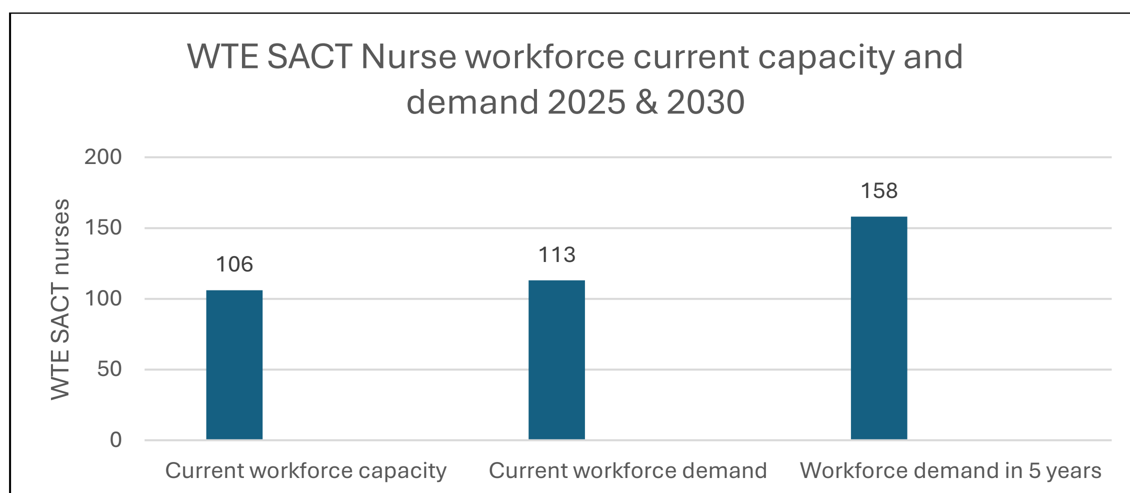


8.5 Workforce

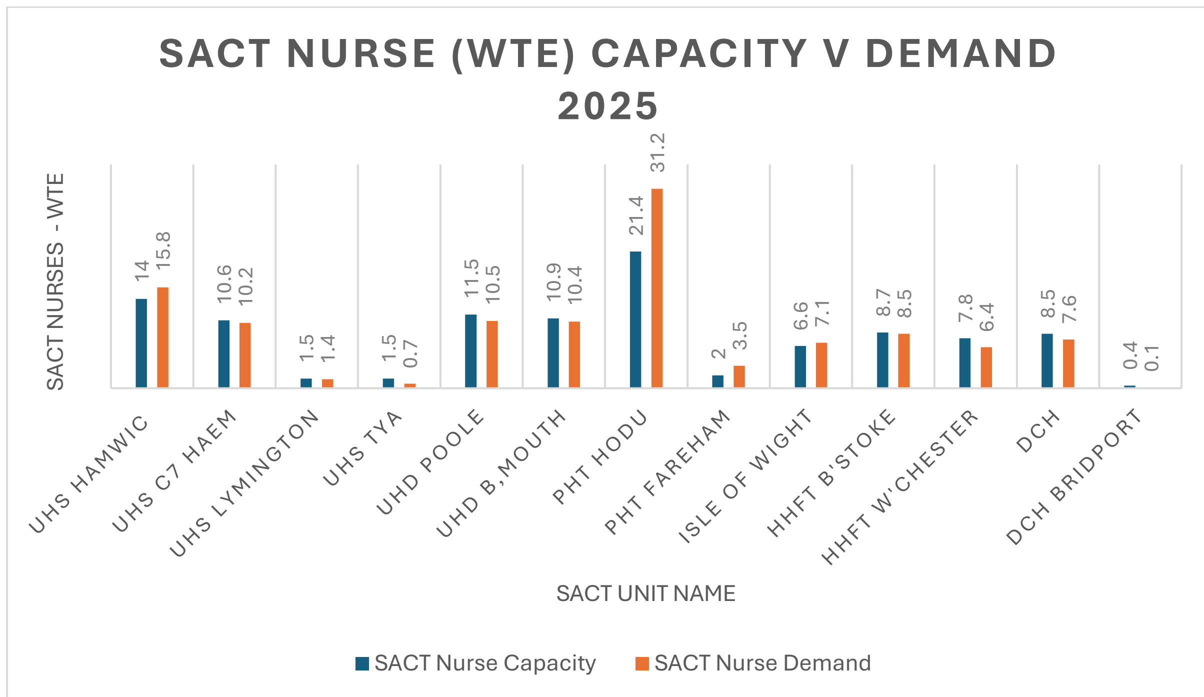
The audit found that overall, there are insufficient SACT nurses for the current regional SACT units' activity, with a total SACT trained nurse workforce of 106 WTE and a requirement for 113 WTE, leaving a regional overall shortfall of 7 WTE for the current demand.

In line with anticipated growth of 6% annually in SACT activity, workforce demand will grow correspondingly and there will be an overall regional shortfall of 52 WTE SACT nurses in 5 years' time.

The chart below illustrates workforce capacity and demand now and in the future.

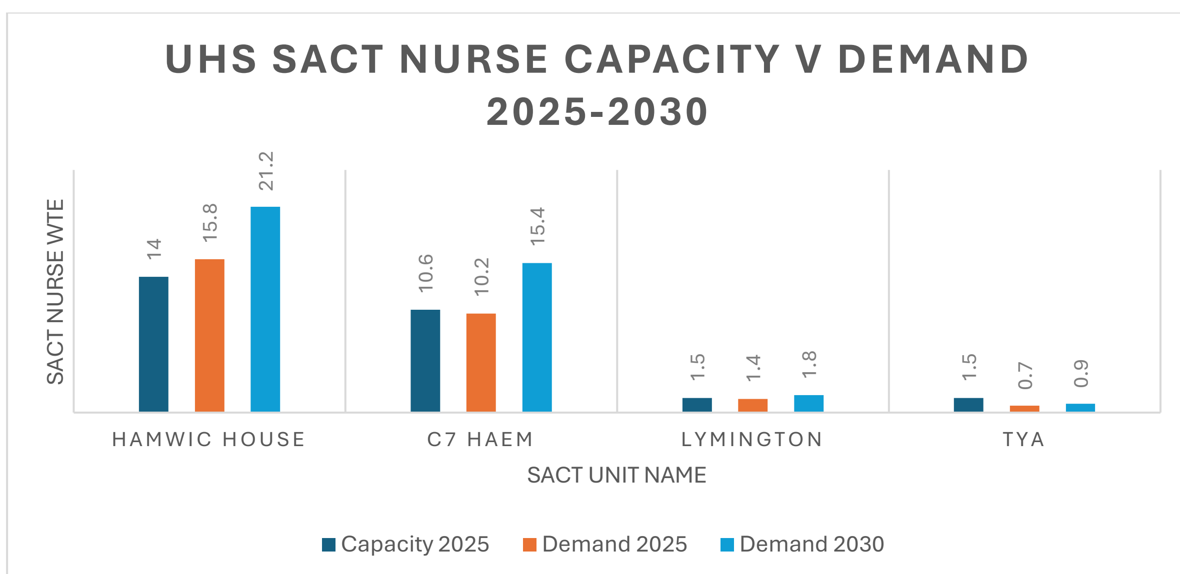


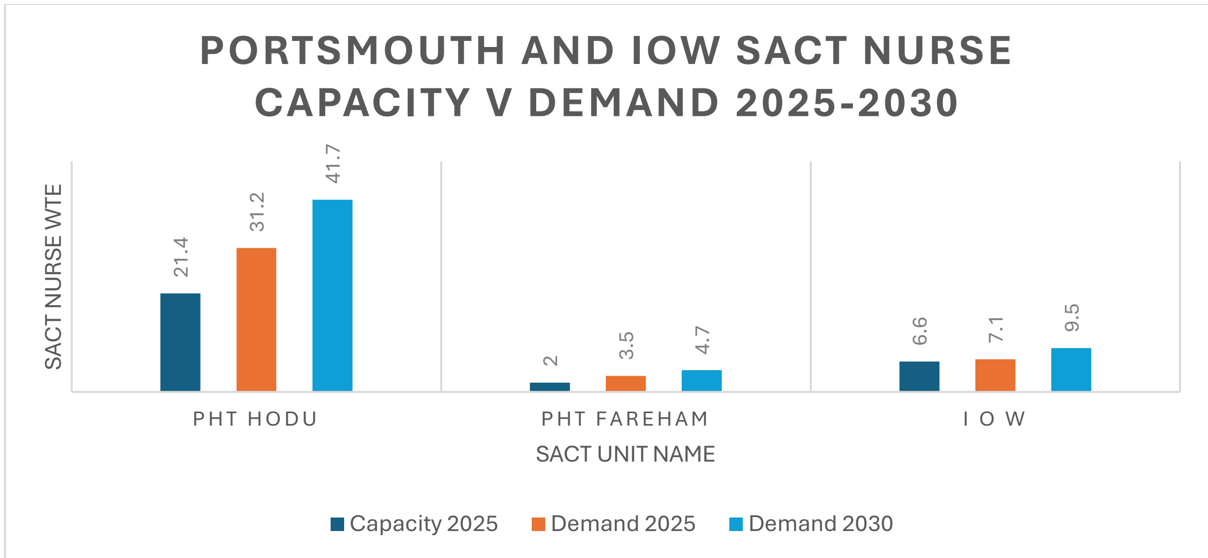
There is wide variation in the SACT workforce capacity across the region with three of the SACT units having gaps in workforce based on current demand, as illustrated below.

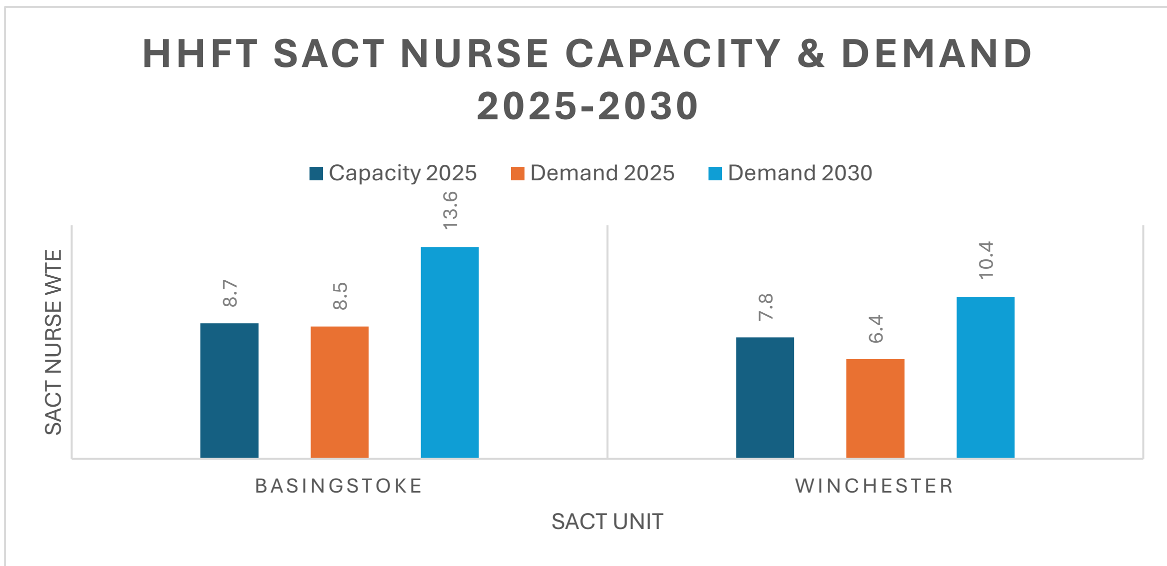


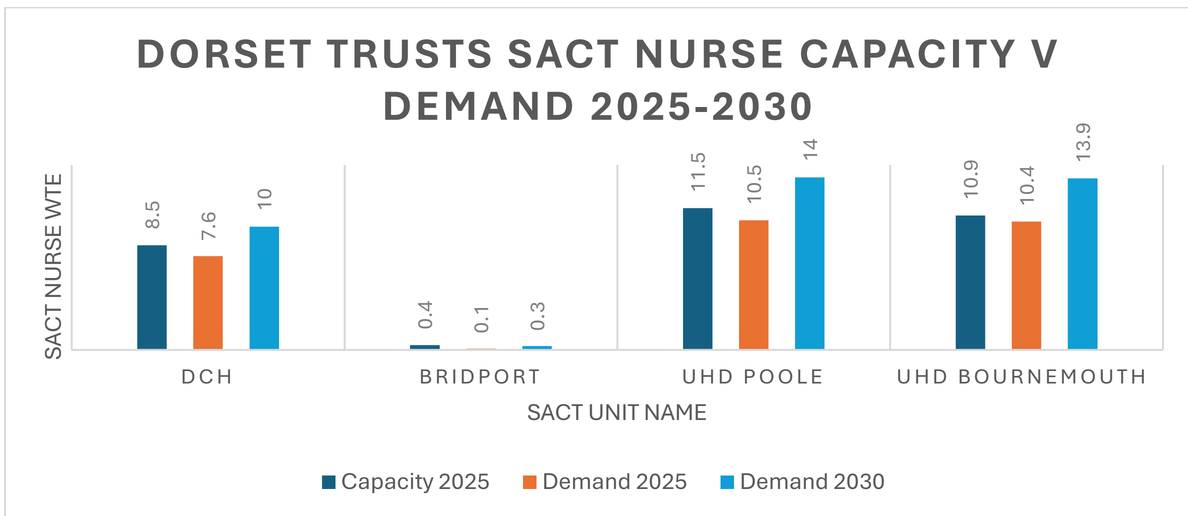
It is helpful to understand pressures on workforce in each trust and the following graphs illustrate current capacity and demand in terms of whole time equivalent (WTE) establishment of SACT nurses according to trusts in Dorset, Hants & IOW. The graphs below illustrate current and future demand versus current SACT nurse capacity.

The greatest pressure on SACT nurse workforce is noted in UHS Hamwic House (oncology) and PHU Haematology and oncology Day Unit (HODU).



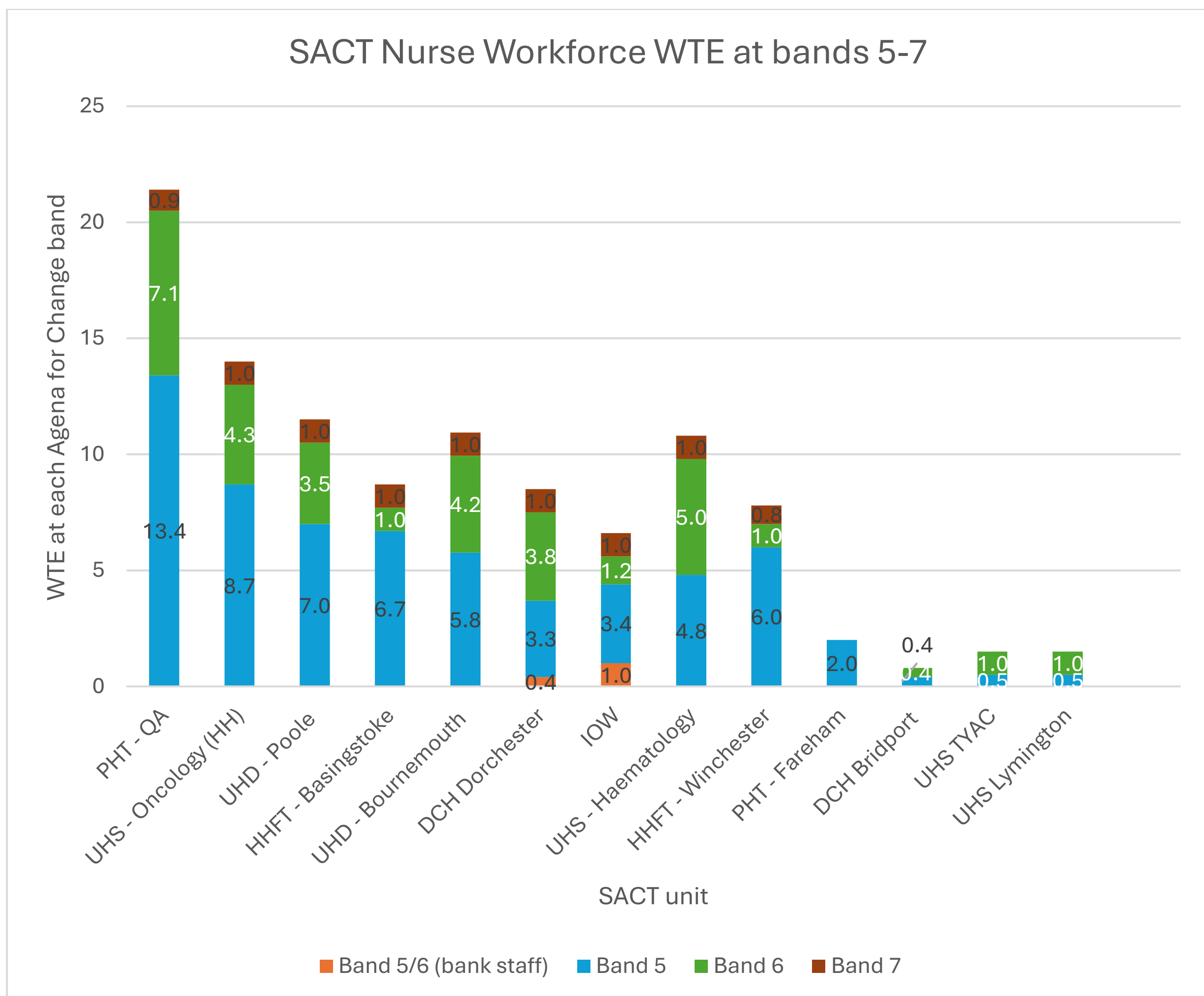

PORTSMOUTH AND IOW SACT NURSE CAPACITY V DEMAND 2025-2030
SACT NURSE WTE
21.4
31.2
41.7
2
3.5
4.7
6.6
7.1
9.5
PHT HODU
PHT FAREHAM
I O W
SACT UNIT NAME
Capacity 2025
Demand 2025
Demand 2030


HHFT SACT NURSE CAPACITY & DEMAND 2025-2030
Capacity 2025
Demand 2025
Demand 2030
SACT NURSE WTE
8.7
8.5
13.6
7.8
6.4
10.4
BASINGSTOKE
WINCHESTER
SACT UNIT


DORSET TRUSTS SACT NURSE CAPACITY V DEMAND 2025-2030
SACT NURSE WTE
8.5
7.6
10
0.4
0.1
0.3
11.5
10.5
14
10.9
10.4
13.9
DCH
BRIDPORT
UHD POOLE
UHD BOURNEMOUTH
SACT UNIT NAME
Capacity 2025
Demand 2025
Demand 2030

The audit recorded the Agenda for Change banding of all SACT nurses to gain insight into the establishment and skill mix in each unit. There was a similar distribution across all hospitals with each main SACT unit having one whole time equivalent band 7 charge nurse. The band 7 also took responsibility for nurse leadership of the SACT outreach services linked to those trusts. The large majority of SACT nurses are band 5 with a smaller proportion being band 6, illustrating levels of experience, roles, and responsibility within each team.

The graph below illustrates the SACT nurse establishment in each unit and skill mix of SACT nurses according to their banding.



The unregistered workforce plays a pivotal role in the SACT unit activity at all trusts within the region. It was outside the scope of this audit to include these staff & the activities they undertake & the impact they have but they must be considered as integral members of the SACT team. Understanding their roles and responsibilities is key when considering service development. The role of non-registered staff will be reflected in the discussion and recommendations.

8.6 Delays to starting SACT on the day of treatment

A delay on the day of treatment is any delay in scheduled appointment time beyond an accepted delay of between 5- 15 minutes as agreed in each unit. Delays are important for two reasons; firstly, as they impact patient experience in a negative way and secondly because they result in patients being in the SACT chair for longer than they need to be which has a negative impact on chair capacity and SACT nurse workforce.

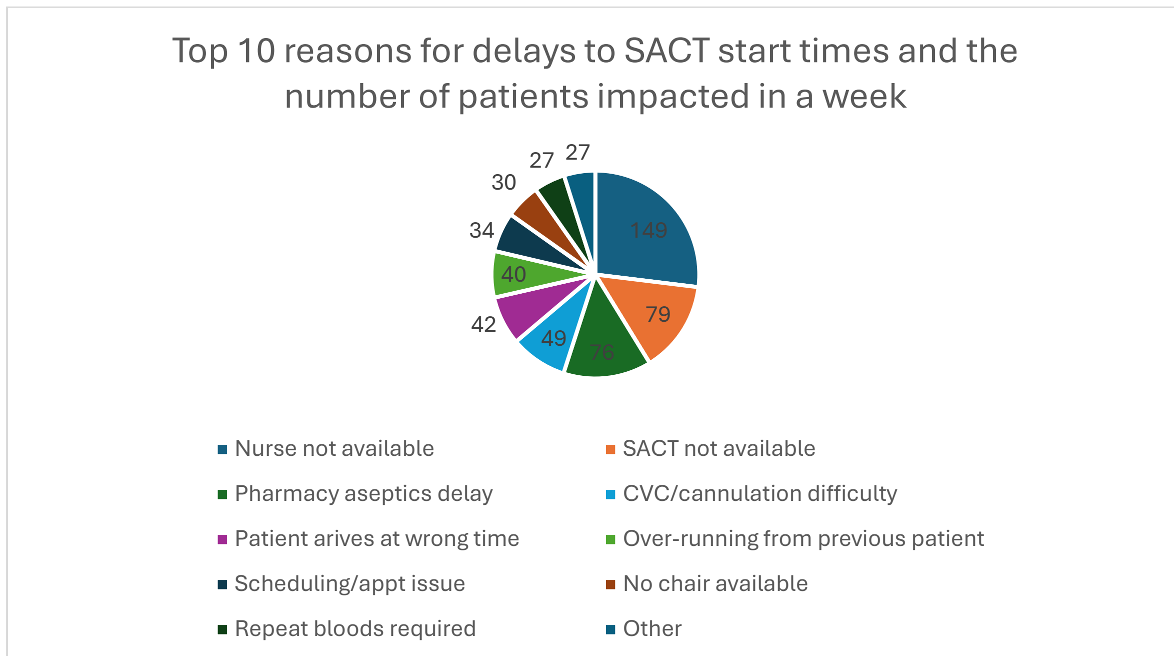
Bar one, all SACT units recorded delays on the day to patients starting their treatment, with anything from a small proportion of patients, upwards to 78% of patients being affected by a delay. Across the region, 655 people were affected each week by a delay to their start time.

The outreach SACT units had the lowest reported number of delays, and this can be explained by the different model of care compared to the larger, on-site SACT units. The SACT is prepared in advance for the majority of outreach services, to allow timely delivery of all SACT at the start of the clinic. The percentage of outreach unit SACT delays ranged from zero to 19% of all attendances.

The top four SACT units who were most affected by delays ranged from 54% to 78% of patients each week who were affected by a delay to their scheduled start times. This suggests there is opportunity for understanding delays in more detail and resolving the causes of the avoidable delays in the pathway to improve patient experience and increase use of chair and workforce.

There were a variety of reasons given for the cause of delays in each unit. The main reasons for delays were similar across the region but there was some local variation, and each trust has access to this data for further scrutiny.

The top 10 reasons for delays and the number of patients impacted in a week across the region as a result of these reasons were as follows:

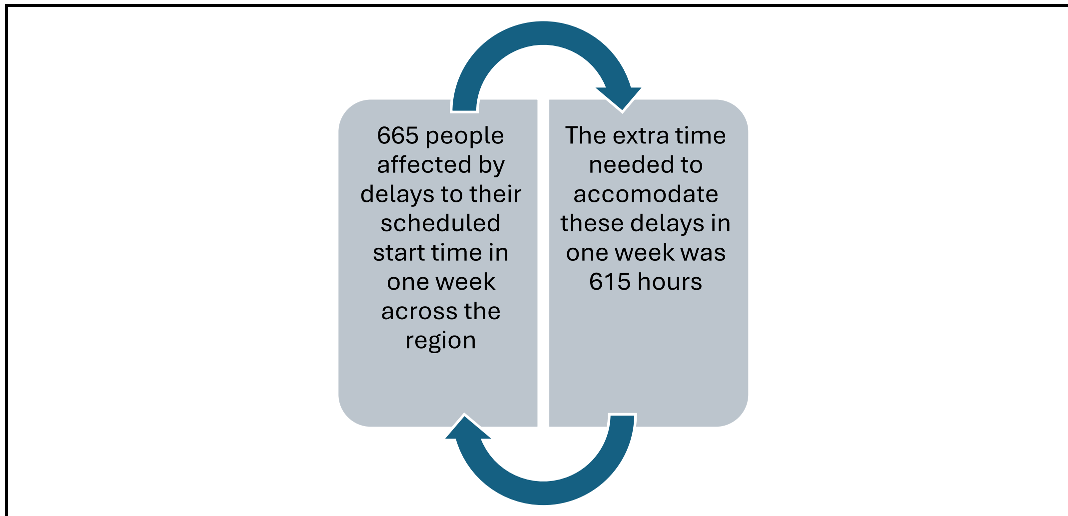


8.7 Avoidable v non-avoidable delays

The audit recorded details of whether delays were avoidable or unavoidable. Whilst the focus of further work in this area is likely to focus on avoidable delays, it is recommended that unavoidable delays should also be scrutinised as these may be amenable to pathway changes to reduce their impact.

8.8 Impact of delays

The impact of delays across the region can be calculated in both numbers of patients affected by delays but also, the extra hours of chair time required to manage the delayed patients. If delays could be prevented and patients treated on time, these hours could be used for other patients on the waiting list. It would also have a positive impact on patient experience.



The diagram above illustrates the total number of patients across the region who were affected by delays to their scheduled appointment time and the impact of these delays on extra hours needed to treat these patients.

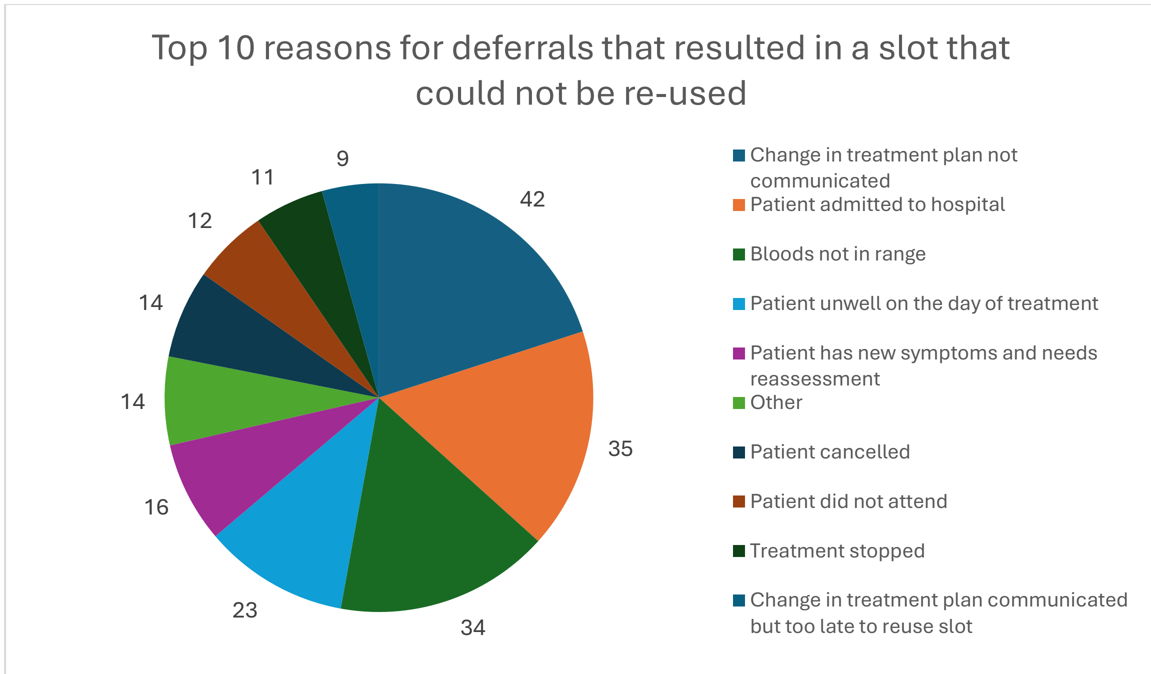
8.9 Deferrals of SACT appointments

Deferrals are those SACT unit appointments which are cancelled or postponed for a variety of reasons. In a non-surgical cancer treatment environment, it is widespread practice that there will often be last minute changes to a patient treatment plan including deferrals, changing SACT regimen or stopping treatment. These decisions are made following patient assessment and review of toxicity and investigations which are required to be undertaken close to the scheduled treatment date. However, deferrals have the potential to cause wastage in the system including chairs not being utilised fully each day and workforce being underused on any given day.

There is a challenge to schedule other patients into the vacated slots at short notice for several reasons including, oncology pharmacy capacity, aseptic unit capacity, incomplete pre-SACT investigations and patient choice.

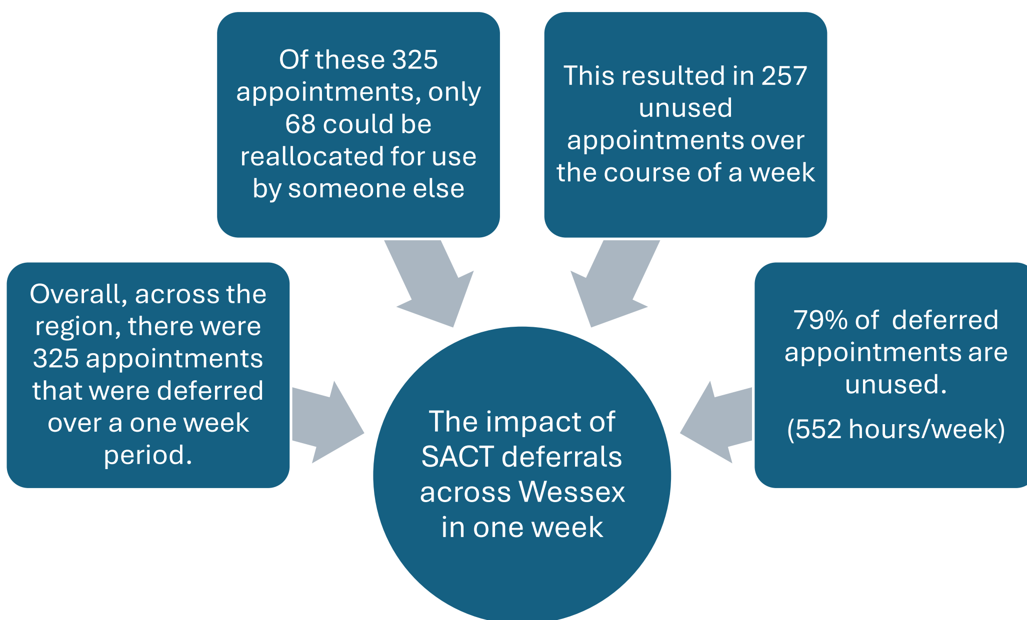
There are also challenges when it comes to re-scheduling a deferred patient due to lack of short-notice chair capacity in most units which can result in patients waiting longer than recommended to receive their deferred SACT. This could have a negative impact on patient outcomes and also on psychological wellbeing for patients who will be anxious to have their treatment.

The audit identified that patients were deferred for a variety of reasons, some deemed avoidable and others unavoidable. The chart below illustrates the 10 most frequent reasons for deferrals to SACT appointments that could not be re-used for another patient.



8.10 Impact of deferrals

The impact of deferrals can be quantified across the region. The diagram below illustrates the number of appointments and hours effectively lost over the course of a week. This provides evidence that there is significant wastage of SACT unit capacity through deferrals and the impact of being unable to reuse vacated slots through ineffective processes.



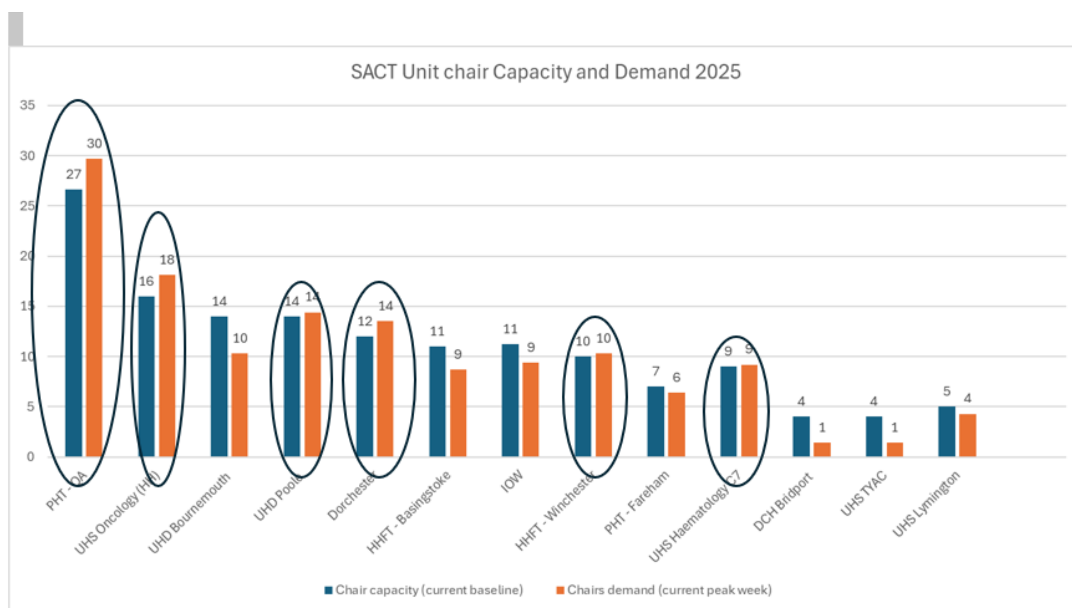
9. Discussion

The key findings of each element of the audit will be discussed.

9.1 Chair capacity

The audit found that there is currently inadequate chair capacity based on demand in six of the thirteen SACT units, with the most pressure currently seen in Hamwic House, UHS and HODU, Portsmouth. The graph below highlights the regional view including the SACT units where current demand exceeds capacity (circled).

The picture has worsened since 2023 when the previous audit reported 4 units having gaps in chair capacity (appendix 2).



Adding all the chairs up across Dorset, Hants and IOW (N= 144) and understanding the demand (N= 136), the data suggests that there is adequate chair capacity for the SACT demand. However, this calculation should be viewed with caution. Current limits on aseptic unit activity in both Dorset trusts and under usage of chair capacity in outreach services are likely to have skewed this regional picture.

Whilst there is no defined benchmarking for chair occupancy rates in SACT units nationally, it would seem reasonable to have a small degree of flexibility in the system to accommodate unexpected delays.

Looking ahead, 11 of the 13 SACT services will have inadequate chairs to meet demand in 5 years' time with only the 2 smallest outreach SACT services continuing to have enough chairs.

Insufficient chair capacity will have a negative impact on the SACT service and patients in a number of ways including:

- Delays in implementing NICE SACT technology approvals causing:
    - Treatment variation
    - Post code lottery.
    - Sub-optimal treatment affects patient outcomes.
- Longer than expected waits to start a course of SACT.
- Delayed treatment impacting patient outcomes.
- Some patients become deconditioned whilst waiting to start SACT and are then not fit enough for treatment.
- Anxiety for patients waiting to start SACT.
- Overcrowding of SACT units with use of un-commissioned chairs
- Difficulty in rescheduling deferred patients, causing long gaps in treatment cycles which may affect treatment outcomes.
- SACT units staying open beyond their scheduled opening hours to accommodate demand.
- Nurses will work beyond their end of shift causing fatigue & burn-out.
- Difficult ethical decision making for clinicians who have to consider SACT unit capacity as part of treatment decision discussions with patients.

The chair opening times are governed by SACT nurse availability and SACT production capacity from aseptic units. In response to this, most units operate a system where they stagger the number of patients arriving in the mornings and throughout the day to minimise the development of bottlenecks and delays for patients.

This diary management practice results in some chairs being empty at the start and end of the day with increased utilisation from mid-morning to early afternoon when the bulk of chairs are in use.

Expanding the opening hours of the SACT units and the chair opening times would be one way to increase capacity, but this could only be considered if there were an increase in the wider workforce including, doctors & non-medical prescribers to review and prescribe SACT; oncology pharmacy & aseptic staff to prepare SACT & SACT nurses to treat the increased number of patients. Without addressing these wider workforce issues, expanding chair opening times would only serve to worsen the problem of delays on the day due to lack of nurse availability, SACT nurse fatigue, anxiety and burnout and poor patient experience.

The increasing demand on chair capacity and the need to open more chairs is a prime opportunity to consider and implement new ways of working and lends itself to delivering SACT closer to home. In line with the NHS 10-year plan (2025) which promotes a shift from hospital to community, along with the goals of National Cancer Plan (DH 2026) and WCA Cancer Plan (2025) and WCA SACT strategy (2025), any plans to increase chair capacity should be prioritised as a gateway to delivering SACT closer

to where people live and work, reducing the footfall through hospital settings and enhancing patient experience.

9.2 SACT unit activity

The activity that takes place in the SACT units varies, with evidence of non-SACT activity as well as SACT activity taking place in all units. In some cases, patients attend for a combination of SACT and non-SACT activity.

Patients commonly require supportive, non-SACT activity as part of their treatment plan and this needs to be delivered in a suitable venue but in most cases, this does not need to be in a SACT unit. Reconfiguring non-SACT activity to be delivered elsewhere would provide an opportunity to increase capacity for SACT administration, but this model does come with some potential challenges.

For some patients, they are receiving non-SACT activity only such as blood transfusions, blood tests and CVC care which could safely be done in alternative locations such as community hospitals, GP practices or in hospital based medical day units. Most of these supportive treatments could be delivered by non-SACT nurses, although in situations where both SACT and non-SACT treatments are prescribed, it can be impractical and inconvenient for these to be given outside of the SACT unit. Non-SACT activity does not usually require the specialist knowledge and skills of a SACT trained nurse and some of this care could be safely delivered by non-SACT registered nurses and for some activities such as CVC care and phlebotomy, non-registered staff such as healthcare support workers and phlebotomists.

However, it must be recognised that there will likely be benefit for patients with cancer being cared for by nurses who have expertise and knowledge in cancer care (including SACT nurses), and if care was to be delivered by non-specialised nurses, then these staff should be supported to develop the fundamental level of knowledge and skills in cancer care, to ensure these patients are not disadvantaged by being treated outside the SACT unit.

The aseptic pharmacy services in both Dorset trusts have challenges with workforce and workplace and this has resulted in strict limits on the amount of SACT that can be produced each week in each organisation. This capping of SACT activity promotes safe working practice for aseptic services but limits the number of patients that can be treated on any given day. It is anticipated that once the workforce and workplace issues have been addressed through increased resources in these trusts, the current cap on activity can be amended to allow increased SACT production. This will have a positive impact on this part of SACT capacity in the affected SACT units.

It is important to administer SACT via the most efficient and convenient route for the patient. Some SACT, particularly immunotherapy is now available in sub-cutaneous injectable form, reducing the need for longer intravenous infusions. Switching to these formulations should be standard practice (unless contra-indicated) and as well as being

beneficial to patients, it will reduce aseptic preparation time, SACT chair and nurse time, all resulting in the potential for increased capacity in the SACT unit.

Optimal scheduling is key to supporting flow, optimise the use of chairs and staff and reducing bottle necks in the SACT pathway, in both the SACT unit and the aseptic unit. It is vital that both departments communicate with each other and agree on optimal scheduling rules to prevent peaks and troughs in the flow of activity. This will increase efficiency, reduce delays, improve patient, and staff satisfaction.

The scheduled length of appointments for SACT regimens and non-SACT activity may not always be accurately calculated or adjusted if treatment plans change resulting in wasted chair capacity. For example, if a patient has scalp cooling with their SACT, they may require a 4-hour appointment but if they later decide to stop the scalp cooling, the appointment time will reduce by 2 hours. If this is not adjusted in the schedule, there will be 2 hours of wasted capacity.

9.3 Workforce

The numbers of SACT nurses regionally, based on current demand is an immediate issue with Hamwic House at UHS, HODU at PHT and IOW having inadequate staffing for the current SACT activity being delivered in these units. The majority of SACT units will face SACT nurse workforce challenges over the next year and will face a much worsening picture in 5 years' time, with an expected SACT nurse deficit of 52 WTE by 2030 across the region.

The picture has worsened significantly since 2023 when the previous audit reported 3 of the SACT units having gaps in SACT nurse capacity (appendix 2).

Based on expected growth of SACT at 6% annually, and making no other changes, HODU at PHT will need to double the size of its SACT nurse establishment from 21.4 to 41.7 WTE by 2030, and Hamwic House at UHS will need to increase its SACT nurse establishment from 14 to 21.2 WTE by 2030 to cope with the demand for SACT. As discussed in this report, there may be local actions that can be taken to facilitate optimal use of SACT nurses, but this will not fully address the growing workforce gap which will require significant resource investment.

It will be important to consider the core activities of the SACT nurses and understand what non-SACT activities they are undertaking that could safely be done by non-SACT nurses and other staff. Utilising the skills of the whole SACT workforce in an optimal way, whilst promoting job satisfaction for each staff group is vital to ensure retention of SACT nurses and other key staff, as well as making SACT nursing an attractive career option. In many units, SACT nurses are involved with activities including patient review, patient education, apheresis, blood transfusions, CVC insertions & CVC care and adjusting their workload to remove these activities to focus on SACT administration alone might be an unattractive proposal. A balance will need to be found with regard to this, but it is important that skilled SACT nurses are recognised for their expert

knowledge and skills and utilised in the best way to optimise use of this limited resource.

Although not included in this audit, understanding the roles and capabilities of the non-registered workforce is key to the success of the staffing model in SACT services in each organisation. The non-registered workforce, both clinical and non-clinical staff will have knowledge and skills in key clinical and non-clinical tasks and could potentially be more efficient with administrative tasks and some non-specialist clinical tasks than SACT nurses. Having a broad range of staff and making the best use of their skillset is fundamental for releasing SACT nurses to focus on their specialist function in the SACT pathway.

This audit focused purely on capacity and demand in SACT units and did not consider other equally crucial elements of the SACT service. Having a comprehensive understanding of oncology pharmacy and aseptic services and the challenges they face are essential as their services are essential to the work in the SACT unit. Having a good understanding of significant pressures faced by oncologists, haematologists and non-medical prescribers is also going to be key as, like pharmacy, they are all key players in the SACT pathway. Supporting these wider SACT services to increase productivity through efficiency measures as well as growth of workforce will be key to meeting the increasing demand on SACT units.

9.4 Delays and deferrals

The data demonstrates that delays and deferrals contribute to wasted capacity in the SACT services regionally with evidence to suggest that some trusts are negatively affected significantly more than others. It will be helpful to learn from those trusts that demonstrate least capacity wastage through effective management of delays and deferrals and explore how practice differs in those organisations. Mapping pathways to identify bottle necks is the first step before focusing on solutions. It is likely that there will be multiple factors contributing to the delays and adopting a no-blame culture where all opportunities for improvement can be explored in an objective way will support this work.

Delays to scheduled starting times causes patients and their family's anxiety and distress; it causes extra disruption to their lives, such as impact to their work & childcare responsibilities. Where delays are commonplace, they are at risk of becoming accepted practice by staff who may feel that they are caused by factors outside of their control. Appointment times may be extended to accommodate anticipated delays which hides the underlying challenges.

Delays to one patient's scheduled treatment time can have a knock-one effect for the rest of the day with other patients being delayed as a result of the chair then not being available. This also has significant impact on the SACT nurse workforce who have to manage the pressured situation, deal with distressed patients, stay beyond their scheduled shift to ensure patients can have their treatment and manage the impact on their own health and wellbeing. Working in pressured situations like this will inevitably

cause fatigue and burnout for some staff which worsens the challenges in the SACT workforce.

Deferrals to planned SACT appointments occur in all SACT units and are sometimes unavoidable. However, it is key that all trusts have appropriately trained and skilled, scheduling staff to effectively manage and optimise SACT unit capacity each day. This will include having a process for filling vacated appointment slots with patients waiting to start SACT, re-scheduling deferred patients without unnecessary delays, ensuring cancellations/deferrals are removed from the diary in a timely way and communicated to wider team.

SACT units may wish to consider overbooking by an agreed percentage each day with the knowledge that there is evidence from this audit that a proportion of patients get cancelled/deferred each day. This would promote better use of capacity, but other associated factors would need to be considered for this proposal such as patient preparedness and pharmacy/aseptic capacity.

Ultimately, delays and deferrals result in wasted SACT unit capacity, but they also provide an opportunity, through changes to processes and pathways, to increase available capacity so more patients can be treated with SACT in a timely way.

10. Recommendations

The results of the audit have highlighted some of the current challenges in SACT services as well as a worsening picture in the coming years as demand continues to grow and exceed capacity. Increasing chair numbers and SACT nursing establishments will be essential to help meet this increasing demand along with improving efficiency in the SACT services which may have the potential to increase available capacity in SACT units.

Based on this piece of work and aligning to regional and national strategic cancer documents such as the National Cancer Plan for England (DH 2026), WCA Cancer Strategy (2025) and NHS 10-year plan (DH 2025), there are a number of recommendations that are being made to hospital providers of SACT services alongside the expectations from Wessex cancer Alliance and commissioners in this workspace:

Hospital Trusts

1. For each of the six acute trusts to review their individual SACT service reports and note the key challenges in their SACT services and develop an action plan to support delivery of solutions to manage the increasing SACT demand.
2. For all trusts to ensure they use subcutaneous injections of immunotherapy and other SACT over intravenous infusions where available and appropriate to free up chair and nurse capacity.
3. For all trusts to maximise working with homecare providers to move low-risk injectable SACT administration out of the hospital setting.

4. For all trusts to consider the development of pathways to support self-administration of sub-cutaneous SACT and supportive medicines.
5. To ensure any local plans to expand chair capacity are seen as an opportunity to provide SACT closer to home rather than more hospital delivered SACT.
6. For all trusts to identify the impact of non-SACT activity that takes place in SACT units and explore options for delivering this in alternative places by non-SACT nurses. This should include phlebotomy, CVC care, and non-complex blood transfusions as the minimum.
7. For trusts to review scheduling models and ensure these are developed in collaboration with pharmacy & aseptic units to promote flow, maximise use of SACT unit capacity and minimise bottle necks in the system.
8. For trusts to use pathway mapping to better understand causes of delays to scheduled treatment start times. Work with the wider SACT workforce to develop solutions to reduce delays in the SACT pathway as part of local action plan.
9. For trusts to better understand deferrals in the SACT pathways and develop robust process for managing deferrals and optimising use of vacated capacity.
10. For all trusts to undertake a review of the SACT unit workforce to ensure they have the optimal skill mix in both SACT nurses and support staff (clinical and non-clinical), to optimise use of available skills needed for the care of patients attending the SACT unit. This could create extra SACT nurse capacity for SACT delivery, both in hospital and outreach sites.

Wessex Cancer Alliance

1. WCA team to meet with SACT clinical leads and senior trust leadership team to support the development and delivery of a local action plan to address challenges, as identified through trust level reports.
2. WCA to meet with key clinical leads in trusts to offer expert advice to support the trust development of and delivery of a local action plan.
3. WCA to communicate findings of this audit to the commissioners covering Dorset and Hants & IOW, to ensure they are fully sighted on system pressures relating to SACT and the projected gaps in SACT nurse workforce and SACT chair capacity to support service plans.
4. WCA to communicate with commissioners regarding other pressures on SACT services that are outside the remit of this audit but are unequivocally as vital as SACT unit capacity and include:

    a. SACT workforce pressures outside of SACT nursing including Aseptics, oncology pharmacy and medical staffing.
    b. The rate of new NICE Technology publications for SACT and inability of all trusts to implement all NICE TAs in cancer in timely way, creating inequity of access to SACT across Wessex.

5. WCA to set up and lead three sub-groups of the SACT Clinical Advisory Group to progress key workstreams that link to SACT capacity and demand.

    a. SACT closer to home
    b. Self-administration of s/c SACT
    c. Workforce innovation and development of roles

6. WCA will develop regional evidence-based policies and protocols that will support trusts to progress workstreams as set out in point 5. This will reduce duplication of effort and promote a consistent approach to SACT related work. For example, WCA will produce a patient education film & instruction leaflet to support how to self-administer sub-cut SACT.
7. WCA to collaborate with the digital team (DiiS) to pursue the development of a digital SACT dashboard to publish relevant SACT activity from local trusts, including outputs from SACT capacity and demand work.
8. WCA to continue to develop and source education opportunities relating to SACT including initial SACT training programme and further offers for established SACT nurses and other staff working in SACT pathway.

Commissioners

1. It is anticipated that this report will ensure commissioners have a realistic picture of current and future pressures of SACT services within Dorset, Hampshire and IOW in light of the growing demand.
2. It is anticipated that future growth of SACT demand as illustrated within the report will help inform commissioners in relation to where increased resources are needed to support delivery of increased capacity within provider trusts.
3. The findings of the report will inform commissioners that the necessary expansion of SACT services could be supported by the development of SACT closer to home models, meeting increased demand and improving patient experience.

11. Conclusion

The WCA SACT capacity and demand audit has been an invaluable project, providing detailed insight and understanding of the SACT day unit services within the Wessex region.

Unsurprisingly, the audit has demonstrated evidence of pressure in SACT services, including chair capacity and workforce and this is expected to worsen year on year unless action is taken to address the challenges.

This audit has been the first step towards identifying the key areas of challenge both regionally and locally. Further focused investigation will be necessary as a key part of trusts action plans which will focus on steps needed to increase much needed capacity through service redesign and other solutions to manage the growing gap between demand and capacity in SACT services.

Many trusts face similar challenges, and it is hoped that working more closely together via the SACT CAG with WCA providing support and direction will be beneficial to help lessen or solve some of the issues identified.

The WCA SACT Clinical Advisory Group (CAG) has multi-professional membership from across the region, from all acute trusts as well as other key stakeholders. This group of interested and engaged staff will play a huge part in helping shape change and support trusts to manage some of the challenges they face in their endeavours to meet the increasing demand for SACT.

Whilst the report has described many challenges in the SACT unit provision across Wessex, it must be noted that without exception, all the SACT teams who are involved in the preparation, patient assessment and delivery of SACT and supportive treatments do so with the utmost professionalism and compassion, endeavouring to treat patients as soon as possible, despite limited resources and increasing demand.

We would like to thank all the staff who gave up valuable time to participate in this valuable piece of work and we look forward to building on the many successes that are clearly apparent in each organisation.

12. References

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13. Appendices

Appendix 1

Table to illustrate average patient numbers per week, per SACT unit.

Includes SACT and non-SACT activity and the percentage split of SACT v non-SACT activity.

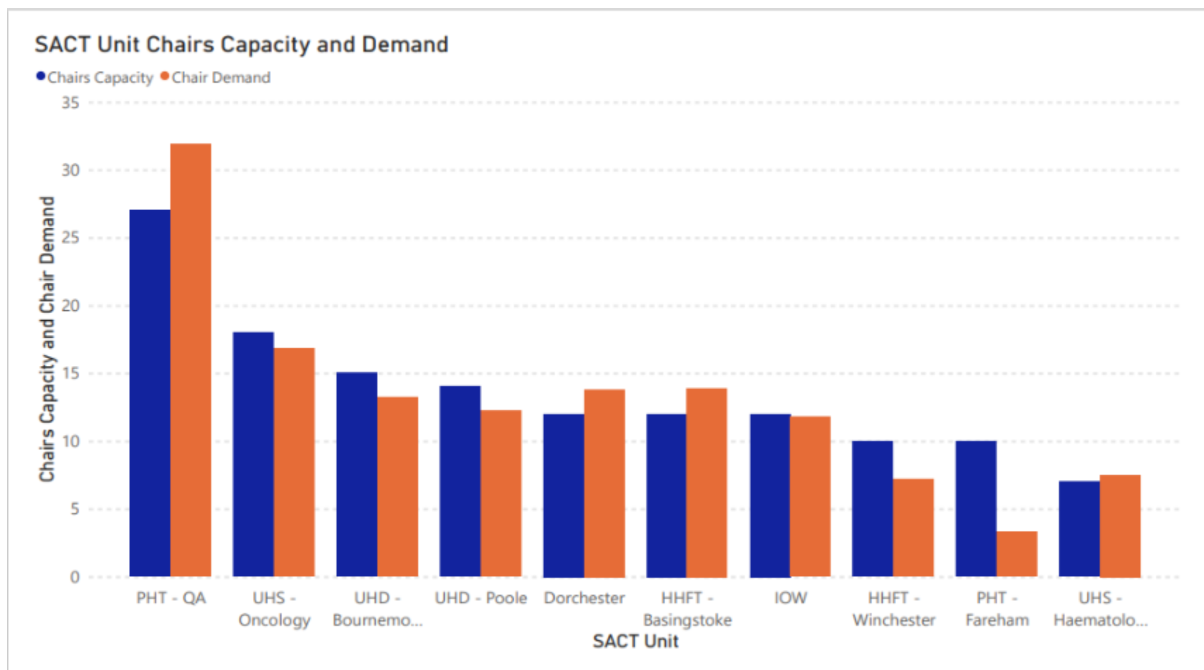
The time allocated to SACT and non-SACT is illustrated as percentage.

Trust	SACT Patient numbers average/week	Non-SACT Patient numbers average/week	SACT Activity percentage of total time average/week	Non-SACT Activity percentage of total time average/week	SACT patient numbers percentage per week	Non-SACT patient numbers percentage per week
UHD –B'mouth	123.5	5	98%	2%	96%	4%
UHD - Poole	121	0	100%	0%	100%	0%
DCH	91.5	14	95%	5%	87%	13%
DCH Bridport	6	0	100%	0%	100%	0%
UHS HH	226	31.5	96%	4%	88%	12%
UHS C7	63	174	73%	27%	27%	73%
UHS TYA	7	10	60%	40%	41%	59%
USH Lymington	14	12.5	87%	13%	53%	47%
PHT HODU	276	213	74%	26%	56%	44%
PHT Fareham	50.5	68	52%	48%	43%	57%
HHFT B'stoke	109	80	77%	23%	58%	42%
HHFT Winchester	100	57	85%	15%	64%	36%
IOW	99	55	81%	19%	64%	36%

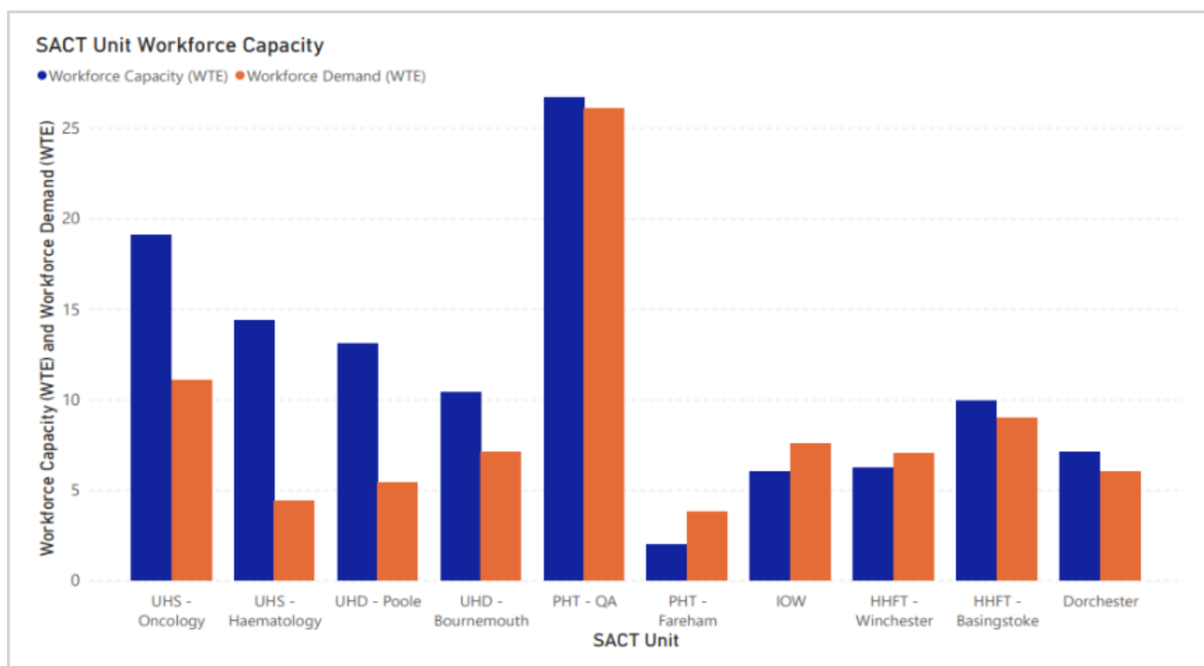
Appendix 2

The graphs below give some of the key findings of the 2023 SACT capacity and demand audit. Comparison with 2025 suggest both capacity and workforce pressures have worsened regionally.

2023 SACT audit on chair capacity v demand



2023 SACT audit workforce capacity v demand



2023 SACT audit SACT nurse workforce establishment and banding