The SACT workforce crisis in Scotland – a medical perspective

The importance of the multidisciplinary workforce

A multi-professional approach to the delivery of systemic anti-cancer treatments (SACT) is fundamental to optimising cancer care and achieving best outcomes. Clinical oncologists, medical oncologists and haematologists oversee the delivery of therapies, working closely with the wider multidisciplinary team. This ensures that patients receive optimal quality of care.

The Royal College of Radiologists and Association of Cancer Physicians together represent the doctors involved in the prescribing and oversight of all solid tumour SACT, while haematologists are responsible for managing cancers of the blood. As such, clinicians from all three specialties have developed this briefing, which provides a medical perspective on the challenges and issues facing the SACT workforce.

We are clear that the solution to the workforce crisis must be multidisciplinary. While we hope that this briefing supports the important work underway, we recognise that it absolutely does not provide all the solutions.

The challenge

In recent years, demand for cancer treatment has surged.

The rate of SACT delivery in Scotland has risen considerably in recent years. Since 2014, the number of patient appointments for SACT has risen by approximately 8% annually across the country.[i] The reasons for increasing demand are similar across the whole of UK, and include:

1. A growing and ageing population
2. Rising cancer incidence due to lifestyle factors
3. New drugs increasingly approved for use
4. Each course of treatment lasting longer and often indefinitely with more modern drugs
5. Increased number of new adjuvant therapies
6. Increased tolerability of new drugs - patients with more comorbidities can have treatment but are more complex to treat
7. Increased complexity of treatments, including combination therapies
8. Increased survival rates due to more effective treatment meaning patients are well enough for more lines of subsequent therapy when cancer returns or progresses.

An increasing number of cancer drugs are being approved by the Scottish Medicines Consortium (SMC).

Cancer medicines account for the highest proportion of new medicines introduced within NHS Scotland each year.[ii] 45% of all medicines currently under SMC consideration have indications for cancer.[iii] The pressure on SACT services to deliver these new medicines continues to increase.

To manage this trend, several ground-up initiatives are being explored, including a capacity planning tool, 'Once for Scotland' consensus treatment guidelines and national SACT protocols. The aim is that these will be rolled out across Scotland, supporting departments to implement new treatments at pace and avoid duplication of work.

However, the workforce is struggling to keep pace with demand.

SACT delivery is overseen by clinical oncologists, medical oncologists, and haematologists, and carried out by their specialist teams. Inadequate staffing levels means teams are struggling to meet the increased rate of treatment delivery. There is a 14% shortfall of clinical oncologists in Scotland (15 FTE consultants) which, without action, will rise to 22% by 2027.[iv]

In 2022 in Scotland, the clinical oncology consultant workforce grew by just one consultant, the haematology consultant workforce by two, and the medical oncology consultant workforce by three.[v]

Data on the non-medical workforce are poor, meaning shortages are difficult to measure. All centres are keenly aware of significant shortfalls particularly in the nursing workforce, non-medical prescribers, oncology pharmacists and other Allied Health Professionals (AHPs). Shortages, though present in all cancer centres, are variable in their severity. Staff are working above and beyond to provide a service required by patients. Many of those in advanced AHP roles are approaching retirement, meaning retention is a greater threat to services.

In 2022, the Government introduced a much needed centrally funded increase in specialty doctor training posts over a period of five years. However, there have been issues filling these posts. In 2023 so far, just 28% of these posts have been filled following two rounds of recruitment.[vi] In the North of Scotland, there was a 0% fill rate despite providing services for 25% of the population.

Demand continues to grow, as there is an increasing requirement to provide mutual aid. Clinicians report that all but one Scottish Cancer Centre have had to request this support in the last year.

A lack of support means staff retention is a significant concern.

Retention is a critical issue in the Scottish NHS. There is a sense that healthcare staff receive minimal pastoral support from employers, such as with working patterns, childcare and accommodation.

Many consultant jobs still have a 9:1 contract, meaning consultants undertake nine sessions of clinical work for every one session of Supporting Professional Activities (SPA). This limits time for service improvement and restricts training capacity. As consultants spend most of their working lives undertaking often demanding clinical duties, burnout rates are inevitably increased, and retention is more difficult. Consultants are denied opportunities for career development and the service is disadvantaged as a result.

Doctors struggle to find the time to perform key governance roles, including SACT lead, due to a lack of essential staff to cover clinical sessions. This further erodes the service, inhibits service development, and means local and national initiatives will fail to fulfil their potential. Uptake of national and regional roles is similarly affected.

Similarly, there is a sense that nurses are afforded fewer opportunities for career development, such as upskilling into a Clinical Nurse Specialist (CNS) or other AHP role. There is a potential reluctance from employers to promote this career pathway, as these positions are more expensive to fund and take general nurses away from general ward work. Initiatives to promote career development are not routinely

offered and this threatens the appeal of the oncology and haematology nursing profession, since applicants may recognise the lack of career progression opportunities.

Scotland's unique geography exacerbates these challenges.

The size and geography of Scotland make it much more vulnerable to these workforce challenges. There is a small total consultant workforce who can deliver cancer treatment (142 medical and clinical oncologists, including SAS doctors, and 104 haematologists)[iv, v] Many patients are treated in smaller hospitals with fewer consultants. Losing even one consultant earlier than expected can have a substantial impact on the ability of that department to keep up with demand.

Across Scotland, there are 6.2 clinical and medical oncologists per 100,000 older (50+) population, roughly in line with the wider UK average. However, significant pockets of inequality exist. In North Scotland, there are 4.9 clinical and medical oncologists per 100,000 older population compared to 10.5 in London and 9 in South East Scotland.[iv] These lower ratios prevent the effective delivery of care, especially due to the complicated geography. For instance, Inverness, despite being the smallest cancer centre, covers a region the size of Belgium. There are currently no haematology or oncology trainees in Inverness, which needs to be rectified to promote future recruitment.

Given the frequency of mutual aid requests, a siloed model may no longer be the best approach.

Due to the critical lack of consultants across the country, all regions aside from the South East are now requesting mutual aid, placing further strain on the country as a whole and affecting local morale. Clinicians working across health board boundaries and systems, each operating with individual governance structures and IT systems, introduces risks and inefficiencies, and there is clearly potential for more pragmatic governance arrangements. As a first step, a review of CEL 30 in the current context, which considers the delivery of SACT outside of the acute cancer treatment, would be helpful.

Patients are regularly moving between different cancer centres, often in different health boards, to receive care. For this to be safe and efficient, all bodies involved in cancer care delivery must be mutually interoperable. There is a need for shared national IT systems, which would improve standardisation of care and minimise health inequalities.

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

With limited resources and a lack of candidates available to immediately recruit, departments currently have four options:

1. Add delays to most or every patient's treatment to fit new patients in. If everyone waits longer to start treatment, more people can be accommodated. This causes potential harm to all patients and significant stress to staff who have to explain those delays.
2. Explicitly ration treatment by not treating certain patients with certain drugs, prioritising treatments thought to be most effective. Deciding which drugs or drug regimens not to make available in a centre or nationally is very difficult methodologically and morally. This course of action has previously been rejected by policy makers but is increasingly necessary as the situation worsens.

3. Work even harder – e.g., SACT departments could be kept open for longer with staff working additional hours. Given the extent of the current workforce crisis, this option is no longer feasible.
4. Find workarounds to create capacity, for instance sending patients to different parts of the country to receive care. Significant travelling distances are hugely disruptive for patients and their families and the variation in how these decisions are made may lead to inequalities in patient care. Taking patients away from smaller centres for a period may also threaten staff confidence and expertise.

All four options widen inequity of access to treatment, undermining the purpose of the SMC and NCMAG.

Recommendations

A meeting with the Chief Medical Officer has been requested, to discuss our recommendations and explore how we can work together to ensure patients receive equitable access to life saving cancer treatments.

1) **The Scottish Government, with support from clinicians, should engage in a national conversation, in a transparent manner, about realistic medicine access.**
   - In the current environment, it is not possible to continue to deliver all available approved SACT options to all eligible patients.
   - Policy decisions about which cancer treatments are made available should be focused on outcomes that matter to patients.
   - The SMC should consider the service capacity required to implement and deliver that treatment in its assessment – not doing so means that new treatments are approved without the additional staff or space to deliver them.
   - The Scottish Government, with support from clinical leaders, the SMC and NCMAG, should promote a conversation about realistic medicine access.

2) **The Scottish Government should provide clarity on the Oncology Transformation funding model and levels of funding.**
   - NHS Scotland's Oncology Transformation Programme will fail to fulfil its potential without significant new funding.
   - The Scottish Government's Cancer Action Plan committed £10m of funding towards supporting SACT services across the country. Clarity is needed on whether this money is still available, and how, and over what period, its allocation is planned.
   - To achieve meaningful change, we need a pragmatic, long-term, and whole system approach to funding the multidisciplinary oncology workforce.
   - It should be possible to move funding between different workforce groups. For instance, if a consultant post is not filled, this money should not be taken away but diverted to hiring a different professional.

3) **NHS Scotland should take national responsibility for resolving the SACT capacity crisis.**
   - Currently, there are 14 different health boards, all operating and making decisions as separate legal entities. This complicates and duplicates decision-making, causes a lack of clarity and collaboration on important choices, and inevitably leads to a postcode lottery of care. At a minimum, all health boards should be operating with the same working patterns and IT systems that enable seamless intra-operability.
   - The increasing frequency of mutual aid requests between health boards and the subsequent pressure to accept the additional workload demonstrates the need for a nationally planned, resourced and managed service to make the most efficient use of all staff groups.
   - NHS Scotland should support a national approach to SACT delivery, workforce provision and the service overall. Multidisciplinary workforce planning should be an immediate priority.

4) **NHS Scotland should increase the number of oncology and haematology consultant training places in areas of greatest need.**
   - The workforce shortage problem is not unique to the UK.[vii] This means that we cannot rely on overseas recruitment to solve this problem. Training more staff domestically needs to be a significant part of the answer.
   - NHS Scotland should increase the number of training posts outside the central belt, where the need is greater. Smaller centres find it more difficult to recruit and to train so NHS Scotland should increase support for these centres to expand capacity and take on additional trainees.
   - While these smaller centres may not have trainees for the full five years, NHS Scotland could encourage rotations to smaller centres by supporting costs of travel and accommodation.
   - Imaginative solutions to training and recruitment should also be considered, such as increased use of remote consultations and training. Flexibility over how and when trainees are appointed should also be encouraged.
   - The North of Scotland has excellent universities training medical students. Since we know that people tend to stay where they graduate, further work should be done to explore how to encourage people to stay in those areas and how to attract others to work there.
   - Greater support for trainees and SAS doctors to apply for specialist registration may also support recruitment and retention.

5) **NHS Scotland should reform and introduce new innovative training pathways for the non-medical workforce.**
   - Training the non-medical workforce should be a priority and an innovative approach should be taken.
   - NHS Scotland should explore fast-track training routes for existing healthcare professionals into roles across the cancer pathway. Nationally recognised ‘qualifications’ for CNSs, non-medical prescribers and AHPs could be introduced to incentivise recruitment and support career progression.

- In areas with potentially the greatest capacity to train, specifically Glasgow and Edinburgh, short-term national training programmes (i.e., two years) for non-medical roles could be developed, where trainees know they will be posted to more rural areas to support shortfalls.
- For instance, Edinburgh and Glasgow could commit to training a set number of advanced nurse practitioners for specific cancers a year, to provide a pipeline of new nurses to fill shortages across Scotland. As well as providing patient support, these nurses should be able to prescribe SACT. Staff should be supported with funding for travel.

6) **The NHS in each of the four nations should enable medical and non-medical healthcare professionals to move smoothly between organisations across the UK.**
   - To enable all staff to move between NHS organisations quickly and easily, their history of mandatory and clinical training should be collected in an NHS Digital Staff Passport, which should be recognised by each individual NHS employer.
   - This should be standardised across all trusts and boards across the four nations. Not only would this speed up application processes, but it would also reduce the need for duplicate training, repeat form filling and background checks, making local services more efficient.
   - Non-medical staff should have the same portability of training as doctors.

7) **NHS Scotland should prioritise measures to retain the cancer medical and non-medical workforce.**
   - Retention is an issue at all levels of the cancer career pathway. Senior doctors are considering retiring early due to difficult working conditions and junior doctors are exploring moving abroad due to better pay and more attractive working conditions.
   - No advertised consultant post should be on a 9:1 contract. These posts attract fewer applicants, increase the risk of career dissatisfaction and burnout, reduce service development, research and teaching opportunities and, in the end, are short-sighted and are detrimental to high quality patient care.
   - Career development opportunities should be prioritised for the non-medical workforce, including nurses, pharmacists, and therapeutic radiographers, who are less likely to stay in their roles without support or career development.
   - The Scottish Government and NHS Scotland should place a greater focus on retention by increasing support for childcare and with relocation and accommodation costs, particularly with Scotland's unique geographical challenges.

This briefing has been developed by a group of clinicians invested and experienced in Scottish SACT services, with support from The Royal College of Radiologists and Association of Cancer Physicians.

- **Dr Frances Yuille** – Consultant Clinical Oncologist, NHS Lothian and Chair, The Royal College of Radiologists Scottish Standing Committee
- **Professor David Cameron** – Consultant Medical Oncologist, NHS Lothian and Chair, Scottish National SACT programme board
- **Dr Sophie Barrett** - Consultant Medical Oncologist, NHS Greater Glasgow and Clyde and SACT Lead, NHS Greater Glasgow and Clyde (until August 2023)
- **Dr Peter Forsyth** - Consultant Haematologist, Raigmore Hospital, Inverness and SACT Lead, NHS Highland
- **Dr Fiona Cutler** – Consultant Haematologist, NHS Ayrshire and Arran and Regional SACT Lead, WoSCAN
- **Dr Tom Roques –** Vice President, Clinical Oncology, The Royal College of Radiologists

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