

**Clinical
Oncology**

The Royal College of Radiologists

Clinical Oncology Workforce Census

2022

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Foreword

Cancer outcomes have improved enormously, with survival rates doubling in the last 40 years, but the impact of a cancer diagnosis remains devastating for patients and their families.¹

Continuing improvements in care rely on patients having timely access to specialist teams. Demand for expertise and care is growing, meaning a greater workload for doctors, who need to consider the intricacies of treating more complex patients.

At the same time, while we are seeing huge strides in the approval rates of new treatments, each innovation creates more work for consultants to embed these within health systems and rapidly make them available for patients. Increasingly, these treatments are more effective but more complicated for doctors to deliver.²

While these developments haven't happened overnight, we are now facing a perfect storm, and the workforce is struggling to keep pace.

Health services in each of the four nations are facing a critical shortage in the cancer workforce. Clinical oncologists, responsible for cancer management and treatment (including radiotherapy and cancer drugs), are under immense pressure to cope with rising demands, increasingly complex patients, and innovative new treatments. Across the four nations, there is a 15% shortfall of clinical oncologists. Without action, this will rise to 25% by 2027.

Chronic understaffing means that the overall capacity of national health systems to treat patients is limited, prolonging waiting lists at every point of the pathway.³ Longer waiting times lead to slower diagnoses, delays in patients starting treatment and a higher risk of complications. Increasingly, we are struggling to provide reliably safe and effective care for our patients.



While these developments haven't happened overnight, we are now facing a perfect storm, and the workforce is struggling to keep pace.



Worryingly, in 97% of cancer centres, workforce shortages had resulted in patients' treatment being delayed over the past year. Unless action is taken, the 15% shortfall in clinical oncologists will result in poorer outcomes for patients. For each month a patient waits to start cancer treatment, the risk of death is increased by around 10%.⁴

All doctors want to be ambitious, go beyond the bare minimum and deliver the best possible care for our patients. UK governments and health system leaders want to achieve world-leading cancer outcomes and support their populations to live a long and healthy life. Investing in the workforce is the key to achieving these outcomes.



Dr Nicky Thorp,
Medical Director for Professional Practice, Clinical Oncology

Key statistics

98% of heads of service are concerned about the lack of time consultants have for service improvement.



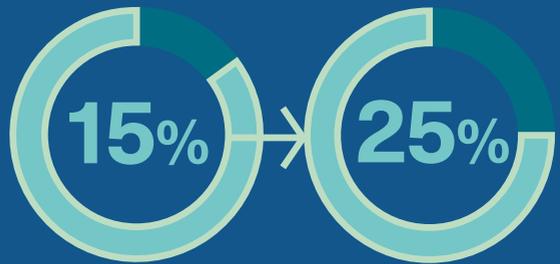
175 additional doctors are needed to deliver safe and effective standards of patient care.



96% of heads of service are worried about staff stress and burnout.



The 15% shortfall of clinical oncologists is projected to rise to 25% by 2027.



20% of clinical oncologists are forecast to retire in the next five years.



1 in 2 of cancer centres have patients delayed in starting their cancer drug or radiotherapy treatment in most months or every month.



Number of oncologists per 100,000 older people

10.2 LONDON

3.1 NORTH AND WEST WALES



Locum staff proportion growth over 5 years:

4% ²⁰²⁰ → **8%** ²⁰²²

50% of CO consultants are burned out.



Workforce

- The UK has a 15% shortfall of clinical oncologists. By 2027, it is projected that this will rise to 25%.
- There are currently 1,078 clinical oncologists working across the UK (headcount).
- 175 additional doctors are needed to deliver safe and effective standards of patient care.
- Over the next five years, one in five clinical oncologists are forecast to retire.
- More than half (54%) of clinical oncology (CO) vacancies have been open for over a year.
- The proportion of locum staff among the CO consultant workforce has grown from 4% to 8% in the last two years.

Impact on patient care

- In approximately half of cancer centres, patients are delayed in starting their cancer drug or radiotherapy treatment in most months or every month.
- In approximately one in four cancer centres, this is happening most weeks or every week.

Stress and burnout

- 96% of cancer centre heads of service are worried about staff stress and burnout.
- 50% of CO consultants are burned out.⁵
- 49% of clinical oncologists are considering reducing their hours, and 19% have already done so.⁵

Service improvement

- 98% of cancer centre heads of service are concerned about the lack of time consultants have for service improvement. 72% are highly concerned.

Inequalities in care

- In London, there 10.5 oncologists per 100,000 older people, and just 3.1 in North and West Wales.
- The number of clinical oncologists per 100,000 older people (50+) is 1.2 in North and West Wales, compared with 4.7 in South Wales.

Summary of recommendations

Recruiting more doctors into the system



1. To keep pace with rising cancer incidence, the NHS in each nation should increase and sustain medical school and post-graduate training places, and clinical oncology specialty training posts, targeted in areas with greatest shortages and long-standing vacancies. These must be matched with a rise in training capacity to accommodate training, and measures should be funded by the UK government accordingly.
2. The Department of Health and Social Care, and equivalent bodies in each nation, should review the funding of these posts. Ideally in the future, these should be fully funded directly to make it attractive for centres to train. In the interim NHS trusts and health boards should continue to fund the remaining 50% of training post costs.
3. Medical school curricula should be revisited to ensure that oncology is represented fairly.
4. Health services in each nation should adopt the toolkit produced by The Royal College of Radiologists (RCR) which aims to support oncology departments in persuading commissioners to prioritise funding clinical oncology training posts.
5. Health services in each nation and the RCR should work to develop mutually beneficial short-term global oncology programmes, where international staff can work on an 'earn, learn and return' basis.
6. The General Medical Council (GMC), in line with the Health and Social Care Committee's recommendation, should undertake a review of the Certificate of Eligibility for Specialist Registration (CESR) process, to enable international recruitment where appropriate.

Expanding training capacity and professional development



7. Trusts and health boards should ensure that every doctor, including SAS (Specialty and Specialist) doctors and those working less than full time (LTFT), has 1.5 supporting professional activities (SPAs) protected in their job plan for non-clinical commitments.
8. Health services in each nation should work with the RCR to develop pilot training programmes for healthcare professionals to upskill in areas identified as having significant capacity shortages and where the backlog of care is high.
9. Health services in each nation should promote the greater use of consultant team working and skill mix within departments and consider what mechanisms can be put in place for local systems to share examples of best practice.
10. NHS England and the RCR should co-develop a flexible portfolio training (FPT) programme, which protects 20% time in a doctor's job contract for non-clinical development, for clinical oncology which should be made available in areas with long-standing vacancies or low staff retention rates, and embedded in each nation's health system.

Retaining existing clinicians and healthcare professionals



11. Oncology departments should support the greater use of less than full time (LTFT) working to provide a more supportive working environment and to help minimise early retirement. However, the impact of work capacity loss must be factored into future workforce planning.
12. The RCR should develop guidance on how job plans can be adapted for those nearing retirement, including by reducing on call commitments, and oncology departments should promote this approach to senior consultants.
13. NHS trusts and health boards should fund, and hospitals make available, a range of measures for staff to feel supported at work, including effective IT infrastructure and pastoral care initiatives.

Introduction

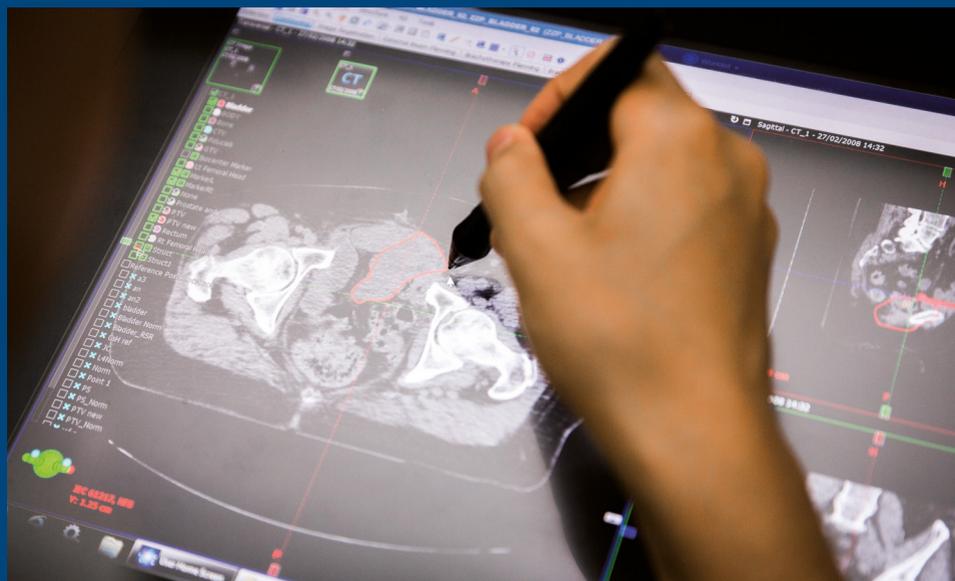
This is the 15th annual RCR clinical oncology census report - presenting a comprehensive picture of the clinical oncology (CO) workforce as it stood in October 2022.

We are hugely grateful to all those who took the time to provide this information. Once again, we have secured a 100% response rate, enabling us to speak decisively about the state of the CO workforce across the UK.

This data has been analysed and presented to highlight key challenges, trends, and opportunities for how we can support the workforce today and in the future. Given the predominance of data from England, some of the

recommendations in this report have been tailored towards the government and NHS in England, however, they should be applicable across all four nations in the UK.

The data shows a stark state of affairs but with sufficient ambition, collaboration and funding, it can be improved. The RCR is calling on the government and health leaders in each UK nation to take control of the workforce crisis, support our doctors, and strive for better patient care.



The state of the clinical oncology workforce

Clinical oncologists

Clinical oncologists (COs) are highly skilled specialists with unique expertise who play a critical role in cancer care. COs are responsible for developing treatment plans tailored to the individual needs of each patient and provide a range of treatment options, including chemotherapy, immunotherapy and radiotherapy. They work closely with other healthcare professionals to ensure that patients receive the best possible care throughout their journey.

There are **988 whole time equivalent (WTE) clinical oncology consultants across the UK**, and six oncology consultants per 100,000 people aged over 50.* Only nine out of the 38 people who left the workforce in 2022 were aged over 60. This suggests workforce growth could have been higher if younger doctors were retained within national health systems.

*The RCR uses the 50+ age range as 90% of cancers present in the over 50s.⁶

Medical oncologists

Medical oncologists specialise in the treatment of cancer with systemic anti-cancer therapies. Clinical oncologists perform the same role but also use radiotherapy to treat cancer, developing treatment plans and managing side effects.

The CO workforce grew by **53 consultants** – a 5% growth on 2021.

There are **998 WTE clinical oncology consultants across the UK.**

There are 547 WTE medical oncology consultants across the UK. There has been a 3% growth since 2021, which is slower than the CO workforce.

SAS (Specialty and Specialist) doctors

SAS doctors play an essential role in delivering high-quality care for patients. In addition to clinical responsibilities, SAS doctors participate in research, medical training and service improvement.

SAS COs have had a 3% average growth as a group over the past five years. In contrast, SAS doctors are the fastest growing group in the NHS – having grown almost four times the rate of consultants over the last five years.⁷

Excess Programmed Activities*

*Programmed activities (PAs) are blocks of time (usually four hours) in which contractual duties are carried out. A job plan will set out how many PAs you are working and how this time should be used (i.e., for direct clinical care (DCC) or supporting professional activities (SPAs)).⁸

44% of full-time NHS consultants work a 48 hour + week (12 or more PAs) excluding unpaid overtime. Among older (50+) consultants this increases to 56%. An ever-increasing number of PAs is unlikely to be sustainable and risks burnout, reduction in quality of care and poor staff retention.⁹

Less than full time (LTFT) working*

*LTFT describes a flexible working arrangement, where employees work fewer than the typical 10 PAs.

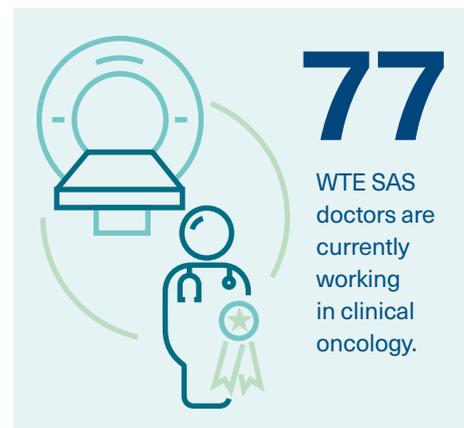
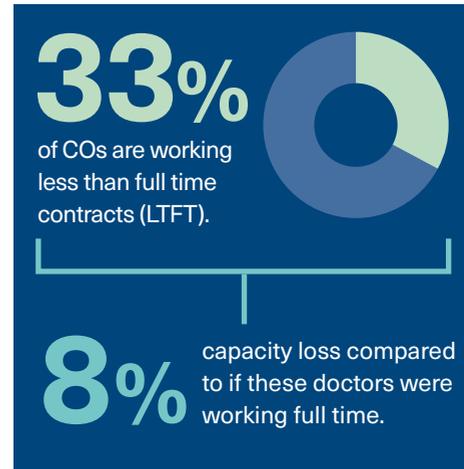
LTFT working is increasing – from 28% in 2017 to 33% in 2022. LTFT working is most popular among the older workforce and is increasingly common – 31% of those aged between 55-59 are working LTFT, compared to 22% in 2017.

Retirement

217 consultants, or one in five of the current workforce, are expected to retire within the next five years. Over the next ten years, 40% of the CO workforce are forecast to retire.

Trainees entering the system

In 2022, 109 doctors in training began CO specialty training. The average length of CO training is seven years.

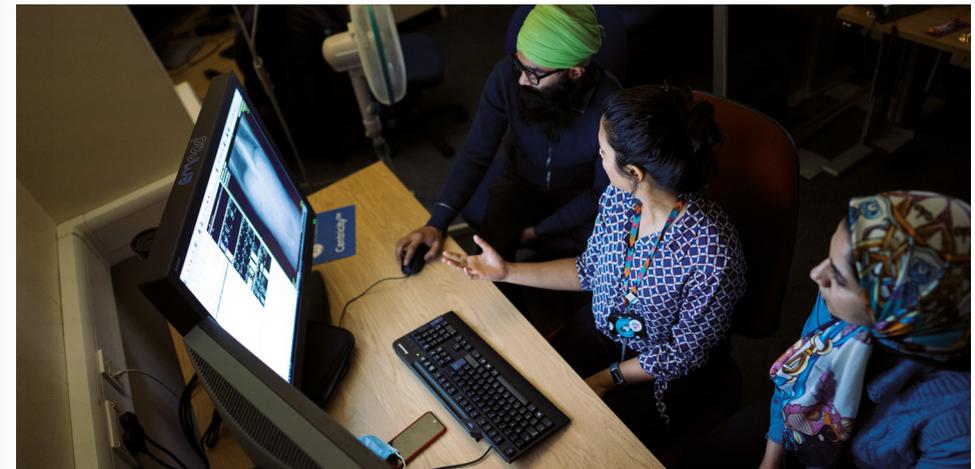


Workforce projections

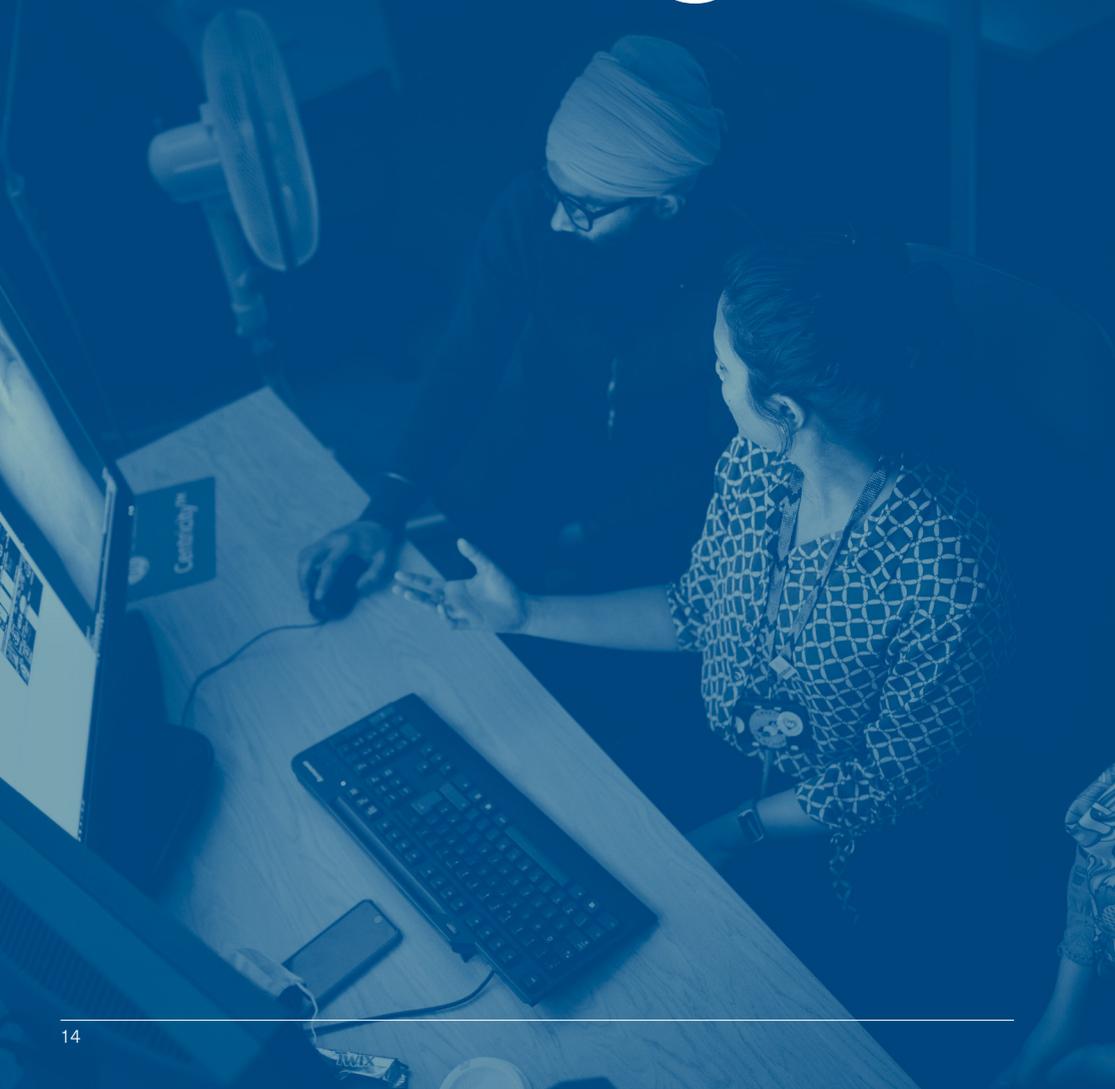
Considering vacancies and doctors working excess hours, the UK has a 15% shortfall of CO consultants. By 2027, the shortfall of CO consultants is projected to grow to 25%. The UK would need to hire 175 additional doctors today to deliver services in a way which is safe, provides a good patient experience and avoids doctors working excessive hours.

Vacancies

The UK has a 7% vacancy rate of clinical oncologists. Across the UK, there are 71 WTE vacancies. Every vacancy represents clinical and non-clinical commitments which will need to be redistributed among existing staff, or additional resource will need to be deployed to cover the shortfall.



Key challenges



Impact on patients

Despite doctors' best efforts to deliver effective patient care, the position remains precarious. Insufficient staffing levels are causing longer waiting times for appointments and cancer treatment delivery – 95% of heads of services said this was a concern.

Receiving timely treatment is fundamental to improved outcomes. For each four-week delay to cancer treatment, the risk of death is increased by around 10%.⁴

Radiotherapy

Half of services reported frequent delays in patients starting radiotherapy. In approximately one in five (22%) centres, this is happening most weeks or every week.

According to one head of service, prostate radiotherapy patients in their area were facing a 3-month minimum wait to receive treatment and breast cancer patients a 7–8 week wait. Delays in starting treatment not only affects eventual outcomes but causes significant anxiety for patients and their families.

In December 2022, 38% of patients in England were waiting over 62 days to start cancer treatment following an urgent GP referral, compared with 22% in December 2019. Costly medical devices, including linear accelerator (LINAC) machines used for radiation treatment, are forced to be switched off due to a lack of staff able to operate them.



44% of heads of service are highly concerned about patients' treatment being delayed *an increase from 29% in 2021.*



88% of heads of service are concerned about shortages impacting the quality of patient care.

"We have five long-term sick radiographers and... five others off for sickness reasons so we are struggling to keep all of our machines open. We will likely have to shut down a LINAC until radiographer staffing improves".

Artificial intelligence (AI) will play an important role in supporting the radiotherapy workforce and enabling consistent and high-

quality standards of care. To reap the benefits and avoid expensive pitfalls, staff must be trained in the use of these new technologies which may enable a reduction in routine, repetitive tasks and more streamlined workflows. Failing to invest in the staff that will work with this technology would be short-sighted, making it more likely that the opportunities afforded by AI are not seized.

As AI starts to be incorporated into treatment pathways, job plans will need to be adapted to include additional time for quality assurance and clinical evaluation of AI tools.

Systemic anti-cancer therapies

Patients requiring systemic anti-cancer therapies (SACT), including chemotherapy and immunotherapy, are facing similarly worrying delays.

The delivery rate of SACT is increasing at 6–8% per annum;¹¹ the number of new consultants is not sufficient to meet this demand. Patients are now having to wait longer for treatment and management of the condition – extending the patient pathway at every point of contact.

- In over half (55%) of cancer centres, patients face delays in starting their treatment in most months or every month.
- Over 1 in 4 heads of service say this is happening most weeks or every week.
- Only 62% of patients in England started their treatment within 2 months of an urgent GP referral in December 2022.¹⁰

Staff are having to find workarounds to the problem – working harder, keeping departments open for longer, adding more

delays to lower priority patient waiting times, or explicitly rationing treatments.

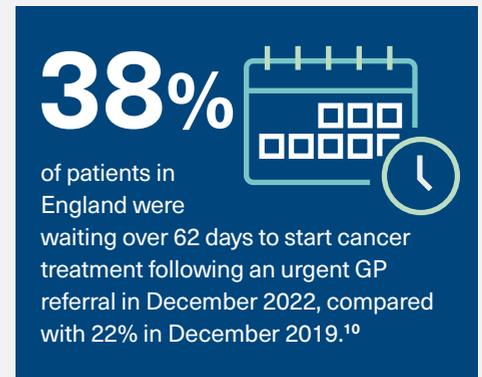
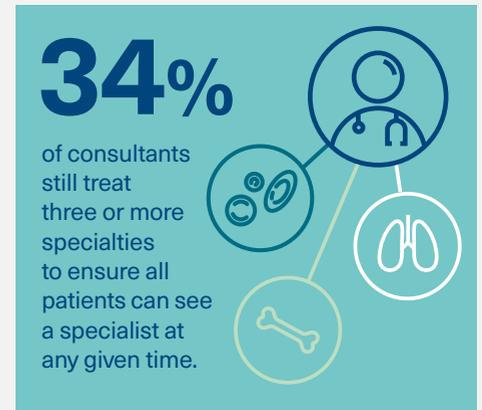
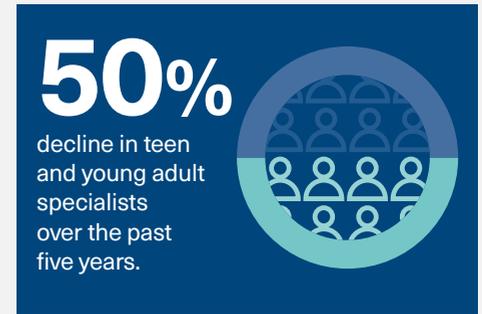
Site specialty consultants

The growth in the CO workforce has not been equally spread among tumour site specialties. Over the past five years, there has been a drop in the number of acute oncology, breast, sarcoma, and teen and young adult specialists.

There are often not enough consultants in certain specialties to see the number of patients requiring treatment. In trusts that have just one site specialist, appointments can be delayed during periods of consultant leave due to a lack of cross-cover. Nearby departments are unable to offer support due to their own pressure points.

Over the last five years, there has been a general trend of consultants working on fewer site specialties – the average number now being two, in line with the **RCR's recommendations**. However, workforce shortages mean consultants often must take on more specialties. A third (34%) of consultants still treat three or more specialties to ensure all patients can see a specialist at any given time.

Taking on more than two specialties is difficult, and doctors are less likely to be able to keep up with advancing treatment options, Continuing Professional Development (CPD), multidisciplinary team (MDT) and peer review requirements.



Case study



Over the last two years our breast consultant oncology workforce has dropped from 13 consultants (10 WTE) to eight consultants and shortly to five consultants (3.7 WTE).

The reduction in consultant numbers has resulted in an unsustainable workload of 470 new patients for each consultant in a year. RCR guidance recommends taking on no more than 150–200 patients

per annum. Staff are under enormous pressure which is impacting their health.

Our workforce issues resulted in us [delaying] the implementation of NICE approved treatments...and we are now having to explore options for external support which may include some patients having to travel further for treatment. This is heart-breaking for both the patients affected and the staff involved in the service.

Acute Oncology Services

Acute Oncology Services (AOS) provide cancer-specific expertise in an acute hospital setting. Patients frequently present to emergency care with complications arising from their cancer and treatments. AOS are vital for providing consistent, high-quality care for patients. Funding for AOS has been historically piecemeal, meaning the provision of services is inconsistent across the country. Workforce shortages deepen these inequalities further.

“AOS has been identified as an area [that needs] expanding by the government, but they have provided practically no support to do this. Given that we cannot even cover our core services, there has been no ability to expand on previous plans to develop AOS services across the region.”

While doctors and healthcare professionals strive to deliver the best possible care, shortages mean that fewer patients can be seen and waiting lists continue to grow.

22%

of cancer centres offer 24/7 AOS services even though emergency centres are open around the clock.



37%

of centres offer no dedicated assessment or admissions unit for AOS, meaning emergency cancer patients are dealt with by non-cancer specialists.



Impact on staff

Doctors strive to keep patient care at a high-level despite these challenges, which is having a disturbing impact on the staff delivering services themselves. Stress and burnout are rife among clinical oncologists.

96%

of heads of service are concerned about the impact of shortages on staff stress and burnout in their service.

80%

of which are **highly concerned** about the impact of shortages on staff stress and burnout – increasing from 73% in 2021.

50%

of clinical oncologists said they were burned out, with an additional 37% feeling slightly burned out.

For some doctors, stressful conditions can cause them to burnout. As a result, they report being unable to switch off, being increasingly concerned about making errors and having problems sleeping. Many staff are on long-term sick leave due to stress-related illnesses, with those left in the system taking on additional clinics to ensure patients are seen.

“One of our oncologists took a 12-month sabbatical because of excessive workload affecting her health and has returned to find her workload essentially unchanged.”

As a result, more than a third of clinical oncologists have left or are considering leaving the NHS to work elsewhere, and more than one in five (22%) are considering stopping work altogether. 49% of clinical oncologists are considering reducing their hours. This is a destructive cycle for the NHS. Staff suffering from stress have two options: reduce their workload (either by retiring early, cutting working hours, or taking leave of absence), or continue to work, taking on the workload of their colleagues, and heightening the chance of burnout. Higher burnout rates mean more time off, further shortages and a greater impact on patient care.

Impact on the service

Supporting professional activities (SPAs) are an important component of a doctor's job plan. SPAs encompass non-clinical commitments, including medical training, clinical research, and service development. However, the overwhelming demand for care is taking consultants away from these commitments.

Clinical trials are vital for gathering more information about specific cancers and helping to find better ways to treat cancer. However, recruitment to clinical trials has dropped in most tumour sites, partly because consultants do not have the capacity to engage in clinical research.

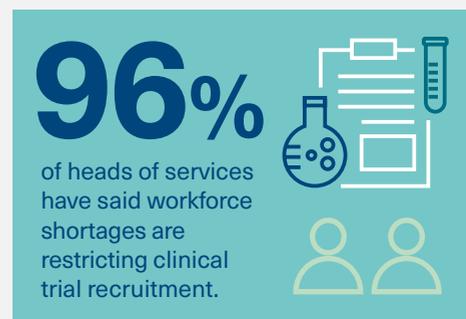
Service improvement covers a wide range of tasks including clinical governance and embedding technological advances. Over the past year, national-level policies (such as the transition to Integrated Care Systems (ICSs)) have been introduced, which require clinical engagement to introduce the change to the health system. Similarly, when NICE approves new cancer treatments, clinicians must work to make these available for patients at a local level. However, doctors do not have the time to consider and implement these changes, meaning top-level innovations are unlikely to reach their full potential.

Medical education is also covered in SPA contracted hours, including the supervision of junior medical staff on the wards, and upskilling allied healthcare

professionals and nurses. As health systems seek to expand the number of staff working in the system, they must ensure that time is protected for consultants to train the next generation of doctors.

Decline in contracted SPAs

Over the past five years, the average number of SPAs for clinical oncologists has gradually decreased. In recent years, more doctors are working LTFT – a growth of 5% of the workforce over five years. LTFT contracts are most popular among older doctors – 44% of those aged 55+ work LTFT – and are a preferable option to staff leaving the system altogether.



However, given its significance for future service development, SPA time should not be reduced for those working LTFT. This is especially important for those in their early career who need protected time for SPA for professional development.

Specialty and specialist (SAS) doctors

A number of doctors working in clinical oncology are SAS doctors. These staff have at least four years of postgraduate training, two of which are in a relevant specialty, but have chosen not to enter or progress to higher specialty training. SAS doctors play a vital role delivering patient-facing care, but there is scope for extending their non-clinical responsibilities.

SAS doctors are the fastest growing group in the NHS. Over the last five years, they have grown at almost four times the rate of specialists, and by 2030 will form the largest group in the medical workforce.⁷ SAS doctors are underrepresented in clinical oncology and further consideration is needed to ensure this group are attracted to the profession, to ensure the specialty does not miss out on their expertise.

72% of SAS doctors in the CO workforce were trained outside of the UK and are therefore likely to have different priorities for development compared to UK-trained doctors. In addition, a major reason cited by SAS

doctors for why they leave the NHS is due to barriers in career development and a lack of opportunity to progress to specialist roles.¹³

While SAS doctors are only contractually required to have one PA in their job plans for SPA activities, the RCR actively encourages employers to give SAS doctors greater time for SPAs.

Protecting hours for SPAs within SAS doctors job plans could unlock several opportunities: boosting capacity within departments, helping staff retention and morale, training future doctors, embedding technological advances, progressing service development, and attracting this key group to the oncology profession.

In 2022, SAS doctors made up just **7%** of the CO workforce compared with **20%** of the total medical workforce.¹²



Widening inequalities

Across the UK, the workforce is under immense stress. However, there are blatant inequalities in the level of care people can receive depending on where they live.

Urban-rural split

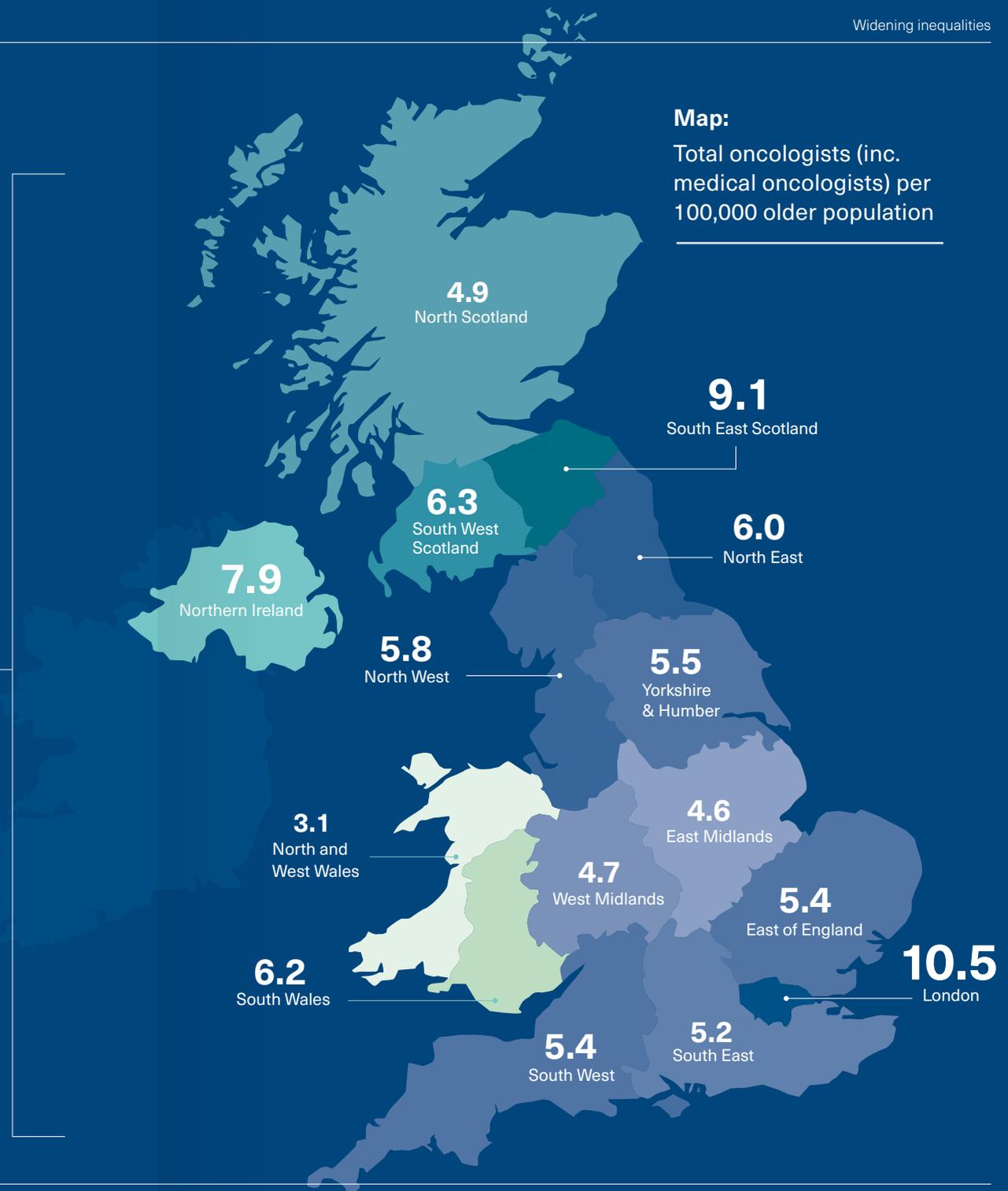
There are notable trends concerning major cities in each of the four nations. The CO rates proportional to the older population are much higher in London, South East Scotland (Edinburgh and Dundee) and South Wales (Cardiff and Swansea), than in the other regions. This shows a stark urban-rural split whereby people living in rural communities may receive second-tier care.

Patients in rural areas generally travel longer distances to receive their treatment, which has been identified as a potential barrier to care

and responsible for worse health outcomes.¹⁴ The vacancy data supports these inequalities.

- London has a 2% vacancy rate. 33% of vacancies have been open for 12+ months.
- The South West has an 11% vacancy rate. 82% of vacancies have been open for 12+ months.

If governments across the UK want to meaningfully address health inequalities, medical school and training places should be tailored to areas that have the greatest need.





Expanding training places

A necessary approach for managing shortfalls is through increasing the number of specialty training posts for clinical oncology. In England, Health Education England (HEE) introduced 50 new posts in 2021 to address the rising demand for services.

However, applicant and fill rates are not increasing in line with new posts. Just 77% of the newly introduced posts were filled and when these roles were readvertised, the competition ratio significantly narrowed, and the fill rate was just 27%. Similarly in Scotland, 15 new training posts were created in 2022. Just over half (53%) of these were filled.¹⁵ In Northern Ireland, while five posts were offered, just three were accepted.¹⁶

The reasons for this shortfall are not fully understood, but all specialties have seen the impact of COVID-related burnout on entries into posts – many have delayed their entry into training or taken time to go abroad.

There is now concern that if these HEE-funded posts are not filled, they will be withdrawn permanently, with funding redistributed. The RCR is undertaking work to understand why these training posts are not being filled and to increase fill rates. We urge HEE to continue these training places, which are needed to address shortfalls and cope with rising demand, in future years.

Due to insufficient funding, NHS trusts and health boards may also be unwilling to fund their component of additional training posts. The RCR has trialled various initiatives to support oncology departments in their attempts to secure this funding. To date, we have provided heads of service with national and regional level data, produced a template business case to be adapted for local use, and spoken at national-level meetings with audiences of chief executives and finance directors on the importance of the cancer workforce.

Oncology departments now need national-level action to persuade trusts of the value and overwhelming need for more clinical oncologists in the system.



There is now concern that if these HEE-funded posts are not filled, they will be withdrawn permanently, with funding redistributed.

Locum staff



The CO workforce is increasingly relying on agency staff, with a notable leap in the use of locums in 2022. Hiring locum staff comes at a significant and unsustainable financial cost. In 2021, the NHS in England spent £3 billion on agency staff.¹⁷

The increasing reliance on locums in the workforce also places NHS staff under greater obligation to take on non-clinical commitments, since agency staff are not required to do so. Their presence also raises concerns about departmental morale.

Locum roles, which are readily available, may be an increasingly attractive option for overstretched consultants. Those who would not have previously considered this career path may be leaving permanent posts to take up temporary positions.

2-year increase in proportion of locum staff:



60% of CO locums are working for departments on a long-term basis (over a year) and 60% of CO locums are over 40 years old.

“The reliance on a locum consultant workforce makes the service vulnerable and creates resentment among the substantive workforce who see locum colleagues (excellent clinicians that they may be) taking home large salaries, favourable job plans, and not contributing to departmental development.”

Team restructuring



Hiring locum staff and restructuring the team to absorb the workload were the two most common solutions to managing workforce shortages in cancer centres.

Team restructuring has inevitable consequences on stress and burnout levels within the department. When vacancies go unfilled and trusts are unable to hire a locum or internationally, the intended

workload for that vacancy is redistributed among existing staff, allocating additional sessions to stretched consultants.

Most vacancies are long-standing – 54% have been open for over a year. By factoring in doctor’s overtime plus these vacancies, the number of additional clinical oncologists needed to deliver standard care is at least 175, or 15% of the UK workforce.

International recruitment



The NHS’ reliance on international medical graduates (IMGs) is rising.

The growth of the CO workforce has been supported by global recruitment, especially those from non-EEA countries. These doctors play a critical role in the NHS and their contribution should be highly valued.

However, international recruitment is not a long-term solution. Consultant attrition rates are much higher for doctors who trained outside of the UK. International recruitment must also be managed in an ethically responsible manner, with consideration of shortages in the global healthcare professional workforce.



28% of the CO workforce was made up of IMGs in 2022, compared to 24% in 2017.



7% average growth of the non-EEA consultant workforce over the last five years, compared to 3% of the UK workforce.



6% of IMG consultants left the workforce in 2022, compared to 2% of UK consultants.

Skill mix and consultant teams



In efforts to overcome staff shortfalls, oncology departments are expanding the use of skill mix to deliver core services. Skill mix refers to the provision of care based on expertise, not job title. In this approach, allied health professionals (AHP), including clinical nurse specialists, therapeutic radiographers and other members of the multi-professional cancer team, can be empowered to take on additional clinical commitments.

However, there are barriers to extending skill mix within health systems, including workforce shortages in allied health professional groups. As of December 2022, there were over 43,000 nurse vacancies, limiting the delivery of critical cancer services.¹⁸ Growing the AHP workforce and streamlining their funding sources within ICSs will both be important to expand the benefits of skill mix.

Consultant team working is another method of ensuring patients receive timely and high-quality care. This approach overcomes the traditional siloed approach of cancer care, enabling patients to see the first available specialist. However, there are challenges associated with expanding the use of consultant teams. In departments which are operating with only one specialist for a certain tumour site, patients with that specific cancer may receive a lower standard of care if that specialist is away, and they are seen by another consultant.

Geography is an additional barrier; 37% of consultants still work across more than

one hospital site in a regular working day limiting the possibility of team working. Several doctors told us that the territorial nature of some senior staff, who like to keep ownership of their patients, can limit this new approach. Capacity issues also pose a challenge – while some teams aspire to utilising consultant teams, they have little time to introduce this new approach.

53%

of departments say that all or almost all their consultant oncologists work as part of consultant teams.

88%

of cancer centre heads of service reported using skill mix in their departments to support the workforce.

ONLY

38%

of cancer centres use skill mix extensively, suggesting room for expansion.

Limiting patient care



Despite attempts to overcome the capacity loss caused by insufficient staffing levels, patient care has been, and will continue to be, impacted by staff shortages.

We know that patients are facing longer waiting times to receive a diagnosis, see a specialist and start treatment.

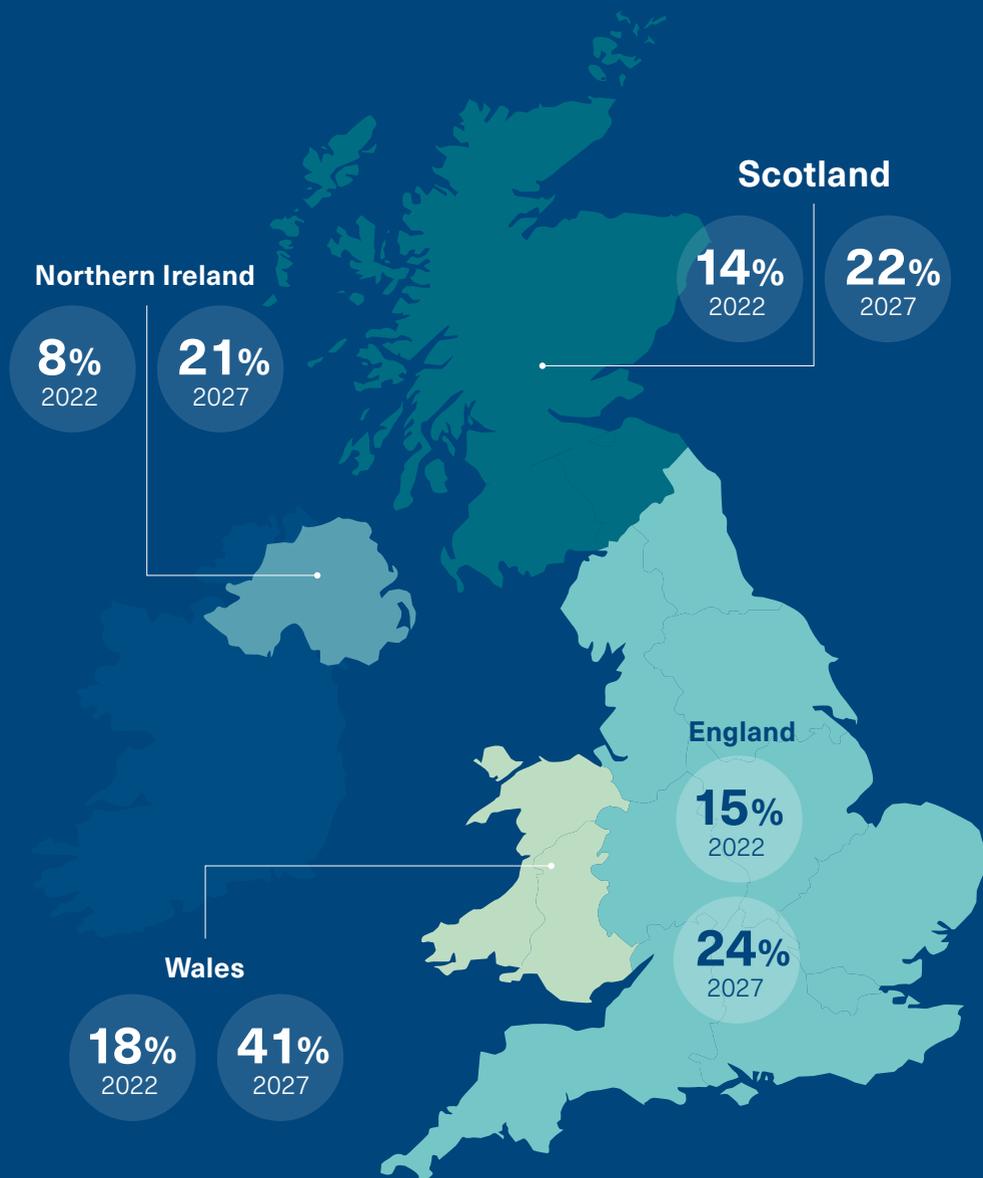
In December 2022, 93% of patients started treatment within the recommended 31 days, below the 96% target.¹⁹ This target was last met in Q3 2019/20. Many doctors feel regardless that 31 days is too long a timeframe for patients to start treatment and masks capacity issues in SACT and radiotherapy departments.



Short-term solutions – such as those discussed here – will clearly not fix the workforce crisis. In fact, many of these are likely to add further pressure on to the overstretched workforce, risking greater numbers of staff leaving the system altogether.

The national picture

Estimated shortfalls of clinical oncologists 2022 / 2027



Wales

- There are 50 WTE CO consultants working in Wales – an increase of three WTE consultants over the past year, equivalent to 5% growth.
- 56% of consultants are still regularly required to travel to more than one site in a working day.
- Across Wales, there are 5.5 oncologists per 100,000 older population, the lowest among the four nations.
- Forecast retirement rates are very high in Wales. One in four (25%) is expected to retire in the next five years. This rises to nearly one in two in the next ten years.
- As a result, Wales' workforce is projected to shrink over the next five years, with a negative growth of -1% a year.
- Wales has an 11% vacancy rate, significantly higher than the national 7% average. Over 4 of 5 have been unfilled for more than 6 months.
- In North and West Wales, there are just 3.1 oncologists (medical and clinical) per 100,000 older people, compared to 6.2 in South Wales.
- Similarly, there are just 1.2 clinical oncologists per 100,000 older people in the area – compared to the UK and Wales average of 3.8.
- Wales is the only nation where the level of concern of shortages affecting the quality of patient care has not increased over the past two years.

Scotland

- There are 88 WTE clinical oncologists working in Scotland.
- Scotland has had the highest annual growth of COs over the past five years – at 6%.
- Over the past year, the workforce has grown by just 1%. The CO consultant workforce has increased by just one (WTE) consultant.
- The vacancy rate in Scotland is 9%, above the national UK average. This has been gradually increasing since 2019. 57% of these vacancies have been open for 12 months or more.
- Scotland's reliance on locum staff has significantly increased over the last year. In 2022 there were five locums in the CO workforce, compared to only two in 2021.
- There is a particularly low proportion of SAS doctors in the workforce, making up just 1%, compared to 7% across the UK.
- In the North of Scotland region, there are 4.9 oncologists per 100,000 older people, whereas in South East Scotland, there are 9.1 – nearly double the amount.
- 100% of heads of service said that workforce shortages had affected the quality of patient care, compared to 80% across the UK.

Northern Ireland

- Northern Ireland has 7.9 oncologists per 100,000 older population, the highest among the four nations.
- Northern Ireland also had the highest growth in the CO workforce among the four nations over the past year – increasing the workforce by 7% to 34 WTE consultants in 2022.
- However, the workforce has still only grown by four WTE consultants over the last five years, the lowest among the four nations.
- Reliance on locums has grown significantly in recent years. In 2019, locums made up 3% of the total workforce, rising to 11% in 2022.
- Nearly one in four COs are expected to retire in the next five years.
- The growth of COs has not been equally spread. Over the past five years, the number of breast specialists dropped from 12 to nine. In 2022, there were no consultants specialising in sarcomas or teen and young adult cancer.

England

England makes up over 80% of the data submitted in the census reports, and therefore the trends closely reflect those highlighted in the UK's summary.



So, what needs to happen?

The RCR is calling for each nation to implement a long-term, fully funded workforce plan, which includes independently verified workforce projections. Any strategy must include measures to address recruitment, training and retention.

Recruiting more doctors into the system

To deliver cancer services, reduce the backlog and alleviate pressure on staff, health services in each UK nation must create additional capacity. Doctors should be entering the system at every level.

1

To keep pace with rising cancer incidence, the NHS in each nation should increase and sustain medical school and post-graduate training places, and clinical oncology specialty training posts, targeted in areas with greatest shortages and long-standing vacancies. These must be matched with a rise in training capacity to accommodate training, and measures should be funded by the UK government accordingly.

2

The Department of Health and Social Care, and equivalent bodies in each nation, should review the funding of these posts. Ideally in the future, these should be fully funded directly to make it attractive for centres to train. In the interim NHS trusts and health boards should continue to fund the remaining 50% of training post costs.



3

Medical school curricula should be revisited to ensure that oncology is represented fairly.

4

Health services in each nation should adopt the toolkit produced by The Royal College of Radiologists (RCR) which aims to support oncology departments in persuading commissioners to prioritise funding clinical oncology training posts.

Short-term recruitment strategies

While the workforce undoubtedly needs new people entering the system, there must be recognition that it takes a minimum of nine years from graduating from medical school to qualify as a clinical oncologist. Short-term strategies will be important to fill the interim period.

International recruitment should not be considered a long-term solution, given higher consultant attrition rates and the ethical challenge of recruiting internationally during a global health professional shortage.

However, there is scope to bolster the quality and volume of the NHS workforce through global education and workplace exchanges. In these programmes, IMGs are recruited for a short period of time (e.g., three years) on an 'earn, learn and return' basis. The NHS can benefit from a global perspective and additional capacity to deliver services. International doctors can develop new knowledge and skills in the NHS, before returning to implement positive developments in health systems in their home country.

The expansion of these schemes avoids an overreliance on IMGs but would give much-needed breathing space for the next generation of UK doctors to train.



5

Health services in each nation and the RCR should work to develop mutually beneficial short-term global oncology programmes, where international staff can work on an 'earn, learn and return' basis.

6

The General Medical Council (GMC), in line with the Health and Social Care Committee's recommendation, should undertake a review of the Certificate of Eligibility for Specialist Registration (CESR) process, to enable international recruitment where appropriate.

Expanding training capacity and professional development

There are opportunities within the current workforce to expand capacity, enabling heads of service to engage with service development responsibilities and other non-clinical commitments. Health services must think creatively about how existing job roles can be reimagined, how healthcare professionals can be supported to take on additional work, and new ways of working can support the delivery of care.

Protected time for supporting professional activities (SPAs)

Consultants currently do not have the capacity to undertake service development or to educate and support doctors in training and other team members. To facilitate the increase in trainees entering the system, new avenues will need to be explored to ensure doctors have time and availability to educate these new recruits.

7

Trusts and health boards should ensure that every doctor, including SAS doctors and those working less than full time, has 1.5 supporting professional activities (SPAs) protected in their job plan for non-clinical commitments.

Expanding capacity within the existing workforce

8

Health services in each nation should work with the RCR to develop pilot training programmes for healthcare professionals to upskill in areas identified as having significant capacity shortages and where the backlog of care is high.

9

Health services in each nation should promote the greater use of consultant team working and skill mix within departments and consider what mechanisms can be put in place for local systems to share examples of best practice.



“

To facilitate the increase in trainees entering the system, new avenues will need to be explored to ensure doctors have time and availability to educate these new recruits

There are also opportunities to extend portfolio training among new doctors. Following a working group in which medical registrars reported that protected time for professional development could improve the quality of specialty training, the flexible portfolio training (FPT) initiative was launched.²⁰ This scheme protects one day a week (or 20% time equivalent) within training contracts for professional development. FPT manages to meet the demand for flexible working, while also supporting hard to recruit specialties in hard to fill areas.

10

NHS England and the RCR should co-develop an FPT programme, which protects 20% time in a doctor's job contract for non-clinical development, for clinical oncology which should be made available in areas with long-standing vacancies or low staff retention rates, and embedded in each nation's health system.

Retaining existing clinicians and healthcare professionals

It is important to remember that we cannot rely on recruiting and training staff alone. If we are to get through the next decade, UK health services need a renewed focus on retention and staff wellbeing.

A recent RCR survey* of clinical oncologists showed:

30%

are considering leaving the NHS but continuing to work elsewhere.

22%

are considering retiring altogether within the next year.

49%

are considering reducing their hours.

** Survey shared with a representative sample of 335 clinical oncologists. Results were based on 117 responses, equating to a 35% response rate.*

Flexible working

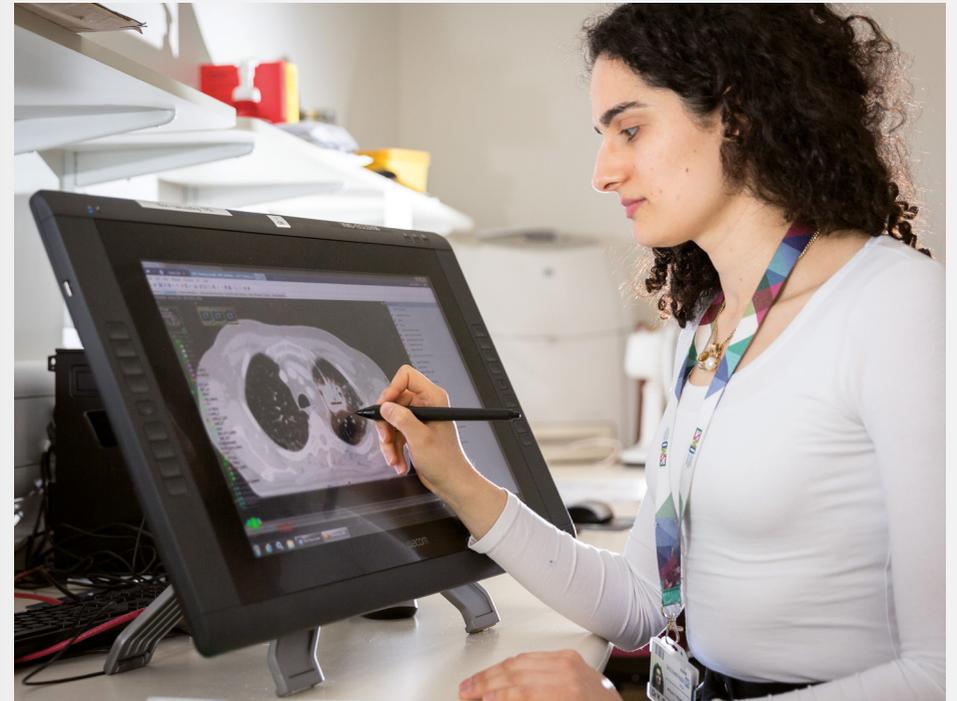
A common reason doctors leave the NHS is due to 'work-life' balance, with staff feeling that they do not have the flexibility they need to achieve the right balance for them.²¹ In 2022, just 44% of medical staff said they were satisfied with the opportunities they have for flexible working patterns.²² Less than full time working (LTFT) is a clear solution to this.

11

Oncology departments should support the greater use of less than full time (LTFT) working to provide a more supportive working environment and to help minimise early retirement. However, the impact of work capacity loss must be factored into future workforce planning.

12

The RCR should develop guidance on how job plans can be adapted for those nearing retirement, including by reducing on call commitments, and oncology departments should promote this approach to senior consultants.



Staff wellbeing

Persistent shortages and excessive workloads have taken an immense physical and emotional toll on NHS staff.²³

To support healthcare professionals to deliver safe and high-quality patient care, the NHS in each nation needs to ensure that it is looking after its employees. Currently, just 57% of NHS staff would recommend their organisation as a place to work, and approximately one in five (21%) said that every working hour is tiring for them.²²

To help staff feel supported at work, doctors need effective IT infrastructure and pastoral care initiatives such as Schwartz Rounds

and Balint Groups, ensuring staff can take regular rest/refreshment breaks with suitable facilities, a range of staff support programmes, access to work-based mental and physical health services and a mentor system for new staff.

13

NHS trusts and health boards should fund, and hospitals make available, a range of measures for staff to feel supported at work, including effective IT infrastructure and pastoral care initiatives.

Conclusion

The UK governments and national health systems have ambitions to be world leaders in cancer outcomes.

However, progress to date has been limited by systemic problems and a lack of determination to engage with these issues. The workforce is a prime example of this.

Shortages in the cancer workforce are the major barrier to meeting cancer targets and achieving world-class cancer outcomes. There are simply not enough doctors to see the volume of patients needed. Furthermore, staff do not have the headspace to consider service improvement, health inequalities are widening, and increasing pressure and pay concerns is leading to an exodus of staff – either voluntarily or due to stress and burnout.

There are no quick fixes for the cancer workforce crisis, but several avenues do exist for the government and health services in each of the four nations to engage with. We need action to support the workforce including recruiting new doctors, training existing staff to fill new roles, and introducing measures to make the national health system a place where staff are empowered to work and want to stay.

This census report represents the state of the clinical oncology workforce and is based entirely on the views and experiences of those delivering care.



The results are concerning, but we have clarity on what is needed to ensure that waiting times are met, consultants feel supported to work, and people living with cancer have a greater chance of living longer and better lives.



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Correction: The population for 'Hywel Dda University Health Board' in Wales has been reallocated from 'Betsi Cadwaladr University Health Board' to 'Swansea Bay University Health Board' following notification that the 'South West Cancer Centre' is the primary cancer centre for the population of 'Hywel Dda University Health Board'. Oncologist per population data (Welsh regions) have been updated accordingly.



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