



**Clinical
Oncology
Workforce
Census
2023**

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Foreword

Dr Nicky Thorp

Medical Director, Professional Practice, Clinical Oncology

2023 brought encouraging developments in cancer care with promising research advances and more patients receiving a greater variety of treatments. Nonetheless the year was undeniably marked by persistent challenges. Staffing shortages and funding constraints continued to be felt keenly in cancer centres, and while the unwavering dedication of our oncologists has kept services afloat, long-term progress requires more than resilience.

The numbers paint a disheartening picture: a 15% shortfall of oncologists, a system strained beyond capacity. But behind these figures lie a human impact: delayed appointments, restricted access to treatment, and the immense pressure placed on our colleagues.

For the first time, we finally have an NHS Long Term Workforce Plan for England which commits to expanding the number of medical students. Funding has been allocated to support an eventual 27% increase in places by 2028/9.¹ However, these students will take more than a term of parliament to graduate. In just five years' time, our UK-wide shortfall of oncologists will have risen to 21%, equivalent to just over a fifth of the workforce.

Future doctors will not solve today's problem. We are 185 consultants short of what is needed to deliver an adequate level of care, yet the increasing prevalence of cancer and the need for more complex treatments shows no sign of slowing down. Meanwhile, more consultant oncologists are reducing their hours and leaving the profession at an earlier age than ever before.

Our three-point plan for supporting the oncology workforce focuses on what more we need to do today: **recruit, train and retain**. This involves attracting talented individuals to the field, growing specialty training places, investing in robust training pathways, and developing a supportive work environment that incentivises doctors to stay.



By fostering collaboration and taking concrete steps, we can shape a brighter future for oncology. Ultimately, our collective efforts will not only benefit doctors working on the frontlines of cancer care, but also the countless patients who rely on their expertise and compassion.

I am proud to introduce the 16th annual clinical oncology workforce census. I would like to especially thank all the cancer centre Heads of Service who, amidst their demanding schedules, took the time to contribute this crucial information. Their insights form the bedrock of this report, revealing emerging trends and shedding light on the key challenges we are all facing across the country.

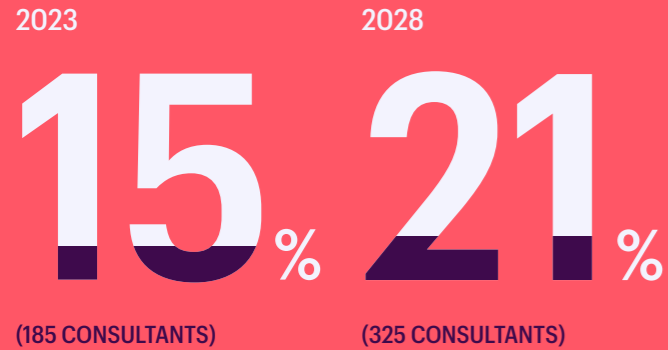
Let us use this report as a springboard for positive change, ensuring a thriving oncology workforce that delivers exceptional patient care now and for generations to come.

Key statistics

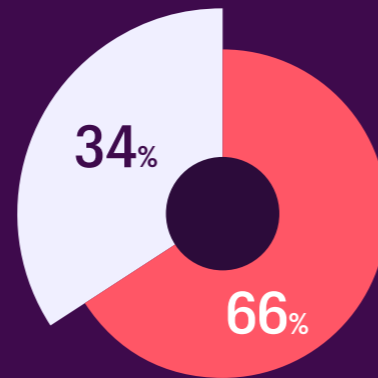
There are widespread shortages of clinical oncologists...

... which are having a worrying impact on patients, doctors, and the service.

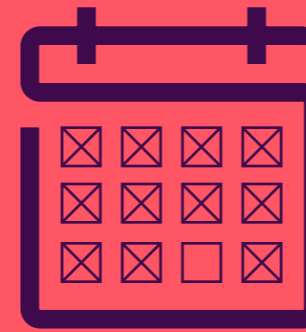
Clinical oncology consultant shortfall



2/3 of CO consultants who left the workforce were under 60



In 2023, patients were delayed from starting radiotherapy in 92% of centres and SACT in 95% of centres due to workforce shortages

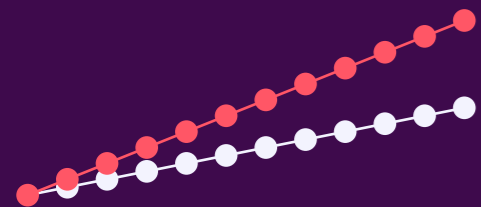


100% of cancer centre leaders are worried about doctors' wellbeing, burnout, and capacity for service development

85%

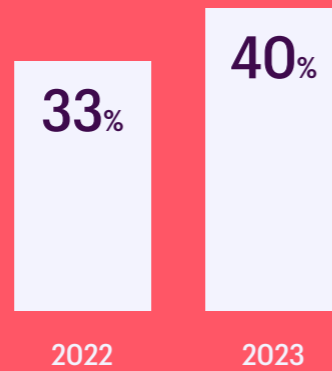
85% of cancer centre leaders are worried about workforce shortages impacting patient safety

While the rate of SACT delivery is rising by around 6–8% each year^{2,3}



The CO consultant workforce grew by 3.5% in 2023

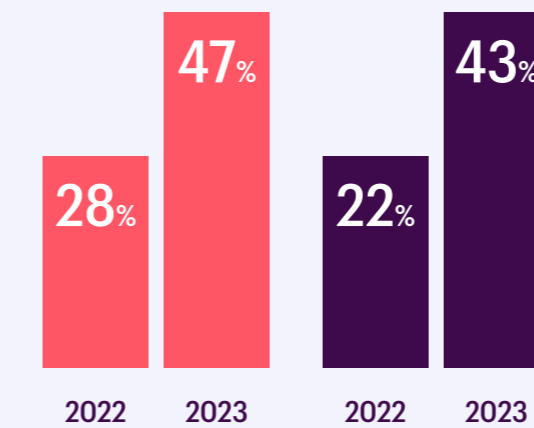
Consultants working less than full time



Median age of doctors leaving the workforce



Weekly SACT delays Weekly RT delays



A three-point plan

To deliver better oncology services*



1 Recruit

- a. The NHS should at least maintain the current number of expansion specialty training posts for clinical oncology to grow the future workforce. As more medical students begin to graduate in 2028, the government should work with the NHS to increase speciality training posts for clinical oncology to increase the number of oncologists.
- b. Hospitals, particularly those with a significant shortfall of clinical oncologists, should ensure they have a long-term funding plan for clinical oncology training and consultant posts to grow their workforce.
- c. NHS England should fund a recruitment campaign, in collaboration with the RCR and ACP, to attract trainees to oncology training posts. This should be replicated by the NHS in each nation.

2 Train

- a. Medical schools should increase exposure to oncology in their syllabuses to attract more trainees into the profession.
- b. As trainee numbers increase, the government should provide dedicated funding for an expansion of clinical and office space.
- c. Doctors should have funded supporting professional activities (SPA) time to provide training. Retired doctors should be encouraged and enabled to return to support education.
- d. The NHS should explore innovative solutions to expanding training capacity, including improved use of technology and cross-centre support.

3 Retain

- a. Trusts and health boards should ensure basic staff wellbeing measures are in place, including but not limited to, up-to-date computer hardware and software, sufficient administrative and clerical staff, and access to hot food and drink at all hours of the day.
- b. To hold hospitals to account, the NHS should work with stakeholders to develop metrics that measure how well hospitals are treating their employees.
- c. Flexible working patterns should be offered as a default to all existing and new NHS staff. Any associated loss of capacity should be factored into future workforce planning.
- d. Trusts and health boards should ensure that all doctors have sufficient SPA time protected in their job plans. This must include those working less than full time (LTFT) and specialty and specialist (SAS) doctors. Future workforce planning should accommodate this.
- e. Exit interviews should be conducted with all doctors leaving the service to understand the reasons for their departure.

* Unless specified, 'the government' refers to the individual government in each UK nation, and 'the NHS' refers to the central NHS body in each country (NHS England, NHS Scotland, NHS Wales and Health and Social Care Northern Ireland).

Introduction to the workforce census



For the 16th year, The Royal College of Radiologists (RCR) proudly presents the annual clinical oncology workforce census, offering an in-depth look at the specialty as of October 2023. For another year, we have achieved a 100% completion rate from all 60 cancer centre Heads of Service. This comprehensive response, unmatched by any other Royal College, ensures the data's accuracy and paints a clear picture of the current oncology workforce landscape.

But this report is not merely a snapshot; it is a call to action. We urge governments, the NHS, and trust and health board leadership to engage with its findings. Cancer survival rates remain lower in the UK than in many comparable countries.⁴ To help close the gap, stakeholders now need to work collaboratively to tackle chronic workforce shortages.

This data presents a unique opportunity to understand the needs and realities of the oncology workforce, paving the way for informed decisions and impactful policies.

100%

Response rate

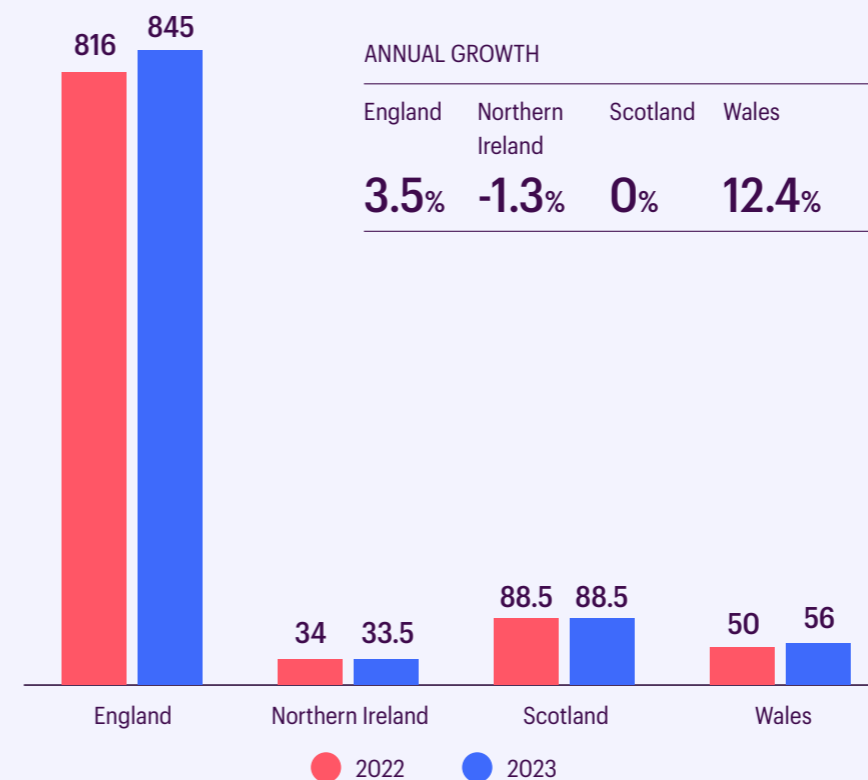
60

Cancer centre Heads of Service

Snapshot of the oncology workforce



CLINICAL ONCOLOGY CONSULTANT WORKFORCE (WTE)



Scale of the shortfall

There is a 15% shortfall in clinical oncology consultants, which is projected to rise to 21% by 2028.

This means today, we need an **additional 185 clinical oncology consultants** to deliver the required level of care (within contracted hours and with enough doctors per 100,000 older population). This is higher than in 2022, and by 2028, will rise to 325 consultants.

Despite this, there are 84 clinical oncology consultant vacancies—a 7% vacancy rate, meaning that due to a lack of funding, not enough posts are being advertised to fill the shortfall. Over half (57%) of vacancies have been open for over six months.

Workforce growth

In 2023, the consultant workforce grew by 3.5% (in line with the average annual growth over the past five years).

In October 2023, there were 1,023 WTE clinical oncology consultants (1,145 headcount) – an increase from 988 in 2022 (1,078 headcount).[†]

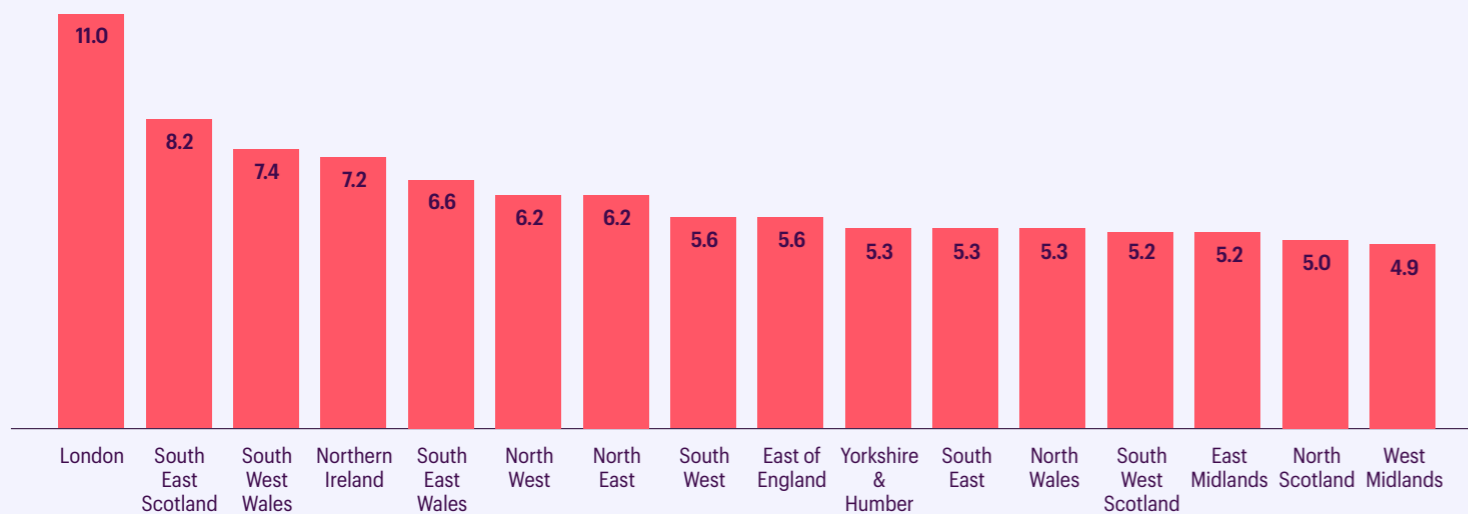
[†] Throughout the report, unless specified, all numbers refer to whole time equivalent consultants as this more accurately reflects capacity within systems.

Oncologists per 100,000 older population (50+)

Across the UK, there are 6.2 oncology consultants (clinical and medical) per 100,000 of the older population (we use 50+, since 90% of cases of cancer are in people aged over 50).⁵ This breaks down as 3.9 clinical oncology consultants and 2.3 medical oncology consultants per 100,000 older population.

While all regions are facing challenges, certain centres struggle more than others to provide an effective service. For instance, the number of oncologists per 100,000 older population varies drastically, with London having more than twice as many than the West Midlands (11 compared with 4.9).

CONSULTANT ONCOLOGISTS PER 100,000 OLDER POPULATION, 2023



Leavers / retirement

Two-thirds (66%) of clinical oncologists who left work in 2023 were under the age of 60.*

The average (median) age that consultants left the workforce in 2023 was just 54.

This has dropped from 57 in 2022; it is lower than the five-year average of 56 and represents a significant loss of accumulated expertise that the NHS can ill afford. When looking at those who are working less than full time (LTFT), the average age of leaving the service jumps up to 61 suggesting those working fewer hours are likely to stay working for longer.

Over a third (37%) of consultants who left in 2023 were under 45, showing that younger doctors are working in more flexible ways, including by moving overseas, taking time out for family and career reasons, and taking up locum posts.

* Leavers/retirement statistics based on the substantive consultant workforce, excluding locum consultants.



Almost half of our workforce is locum [which] leaves us vulnerable to sudden changes in cover. So, whilst we are technically fully staffed at the current time, this could change at any point.

In 2023, there was a 3% attrition rate, equivalent to 31 consultants leaving, in line with recent years. This remains lower than other medical specialties; GMC data indicates that the 2022 attrition rate for all specialties was approximately 3.5%.⁶ However, in Scotland the attrition rate for radiology consultants was higher at 8%.

Demographics

In clinical oncology, there is a 51:49 ratio of female: male doctors, which compares to a 39:61 for all specialist doctors on the GMC register.⁶ The median age of a clinical oncology consultant is 48. SAS-grade oncologists tend to be slightly younger with a median age of 45 years.

Composition of the rest of the workforce

Medical oncologists

Clinical oncologists deliver cancer drug treatments but also work with radiotherapy, often in conjunction with systemic anti-cancer therapies (SACT). Medical oncologists focus on delivering cancer drug treatments

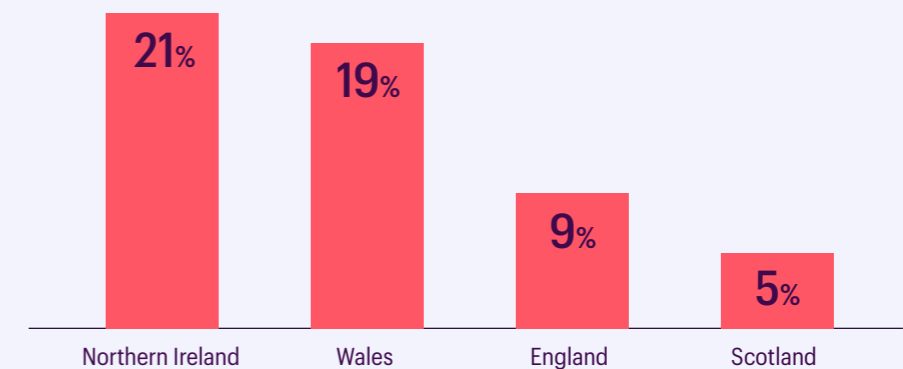
There are 654 medical oncologists (MOs) in the UK, equivalent to 589 WTE consultants. Over the past year, Scotland had a net loss of 4 MOs and Northern Ireland, 3 MOs. England, on the other hand, had an overall increase of 40 MOs and Wales has gained 8.

Locum staff

The proportion of locums in the CO consultant workforce has increased marginally from 8% to 9% in 2022, equivalent to 23 more doctors (WTE).

In Wales and Northern Ireland, there is a strong reliance on locum staff which as well as being costly, potentially impacts the long-term stability of the service.

LOCUMS AS PERCENTAGE OF THE CLINICAL ONCOLOGY CONSULTANT WORKFORCE, 2023

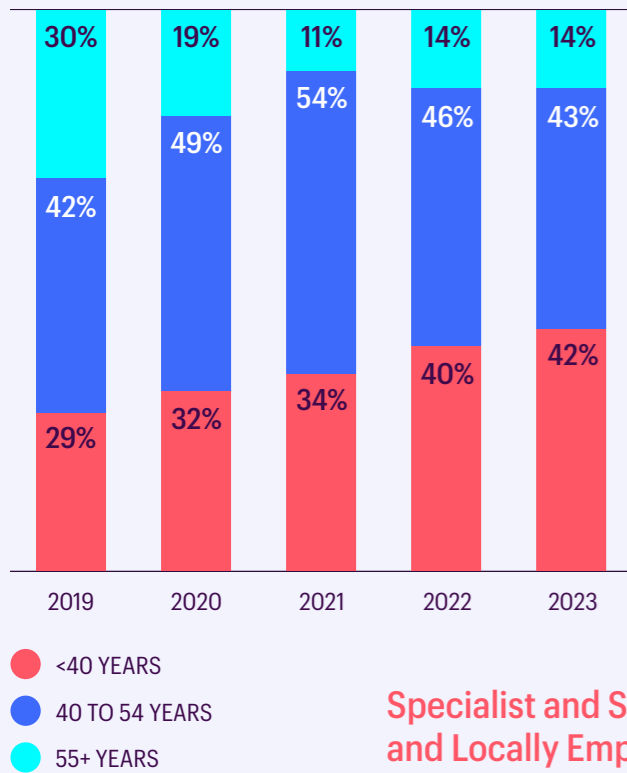




The locum versus substantive pay issue is huge for us in oncology.

Over the past five years, there is a trend of more consultants under 40 working as locums. This could be a result of better working conditions, flexibility and pay associated with locum working. However, services have told us that it can cause friction within departments.

LOCUMS (WTE) BY AGE CATEGORY – PAST FIVE YEARS



Specialist and Specialty (SAS) and Locally Employed (LE) workforce

The SAS and LE workforce has grown by an average of 8% per year over the past five years. SAS and LE doctors make up 9% of the total CO workforce, equivalent to 102 WTE doctors. This is considerably lower than the wider workforce – SAS and LE doctors make up 30% of all licensed doctors.⁷

There is a 4% attrition rate among SAS clinical oncologists (excluding locums), compared to 3% for CO consultants. In all specialties, SAS and LE doctors have a high turnover rate, citing a lack of continuous professional development (CPD) opportunities, and a culture of undermining and bullying behaviours as key reasons for why they leave the service. Many are international medical graduates (IMG) and may join the UK workforce under fixed-term arrangements.⁶

To attract more staff into the profession, the RCR has recently developed a SAS Professional Network and launched a SAS engagement strategy, which furthers the College's ambition to promote the diverse and valued contributions that SAS doctors make to the workforce, and to support both their educational and professional development.

Portfolio pathway (CESR) applications

An increasingly common route to specialist CO registration is via the Portfolio Pathway (formerly known as CESR), which allows doctors who have not completed a GMC-approved training programme to demonstrate they have the knowledge, skills and expertise required to practice as a consultant.

In 2023, 12 Portfolio applications were granted for clinical oncology – compared to four in 2022 and just one in both 2020 and 2021.



Our shortfall is in medical oncology so that the radiotherapy side of each tumour site is having to spread out more thinly to allow more clinical oncologists to cover.

Specialist trainees

Trainees are the future of our speciality and make up 32% of the current CO workforce. 88 new clinical oncology trainees started in 2023, equal to the five-year average of 88. 78 achieved their CCT (Certificate of Completion of Training). It takes an average of 7.1 years to complete clinical oncology training.

Over the past four years, 90% of trainees took up a consultant post within three years of completing their specialist training.

Working patterns

Less than full time (LTFT) working

40% of the workforce are working less than full time contracts – a rise from 33% in 2022.

While this trend is likely to support staff retention, departments must factor this into future workforce planning. The average doctor on a LTFT contract works 8 PAs, equivalent to a 32-hour week.

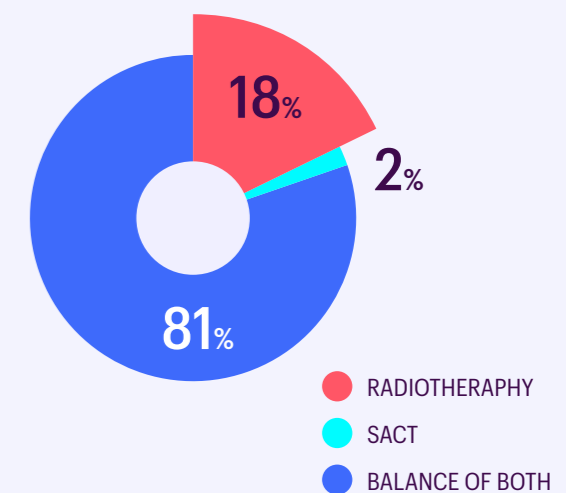
Predominant workload

Radiotherapy is the main workload component for 18% of consultants, with drug or systemic anti-cancer therapy (SACT) the main workload component for just 2%. Four out of five (81%) consultants spend their time working across a balance of both therapeutic modalities.

Over the past five years, the data shows a trend towards specialisation and away from a balance of both. There has been a 24% average annual rise in the number of consultants whose predominant workload is SACT, reflecting rising demand for cancer drug treatments and similar capacity constraints in the MO workforce.

The average number of tumour site specialties was two. RCR CO job planning guidance recommends that oncologists do not specialise in more than two tumour sites so they can keep up to date with treatment options and be active multidisciplinary team members. Despite this, a third of CO consultants have three or more site specialties in their job plan.

PREDOMINANT WORKLOAD OF AN NHS CLINICAL ONCOLOGY CONSULTANT

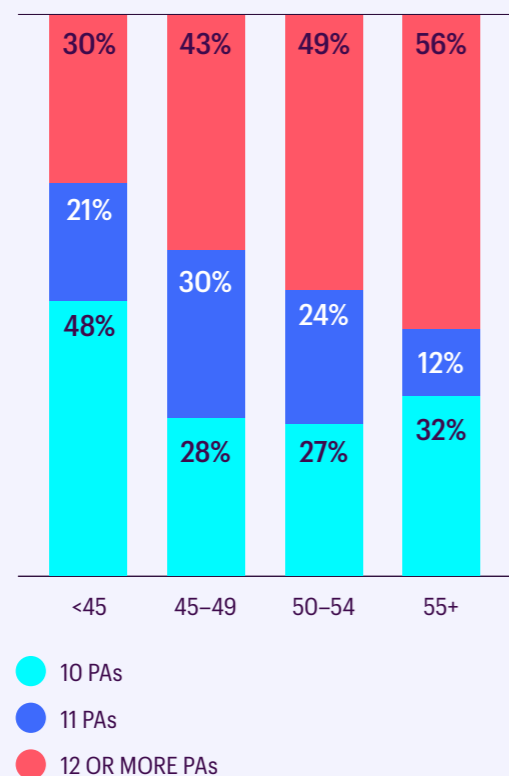


Programmed activities for full-time NHS CO consultants

A Programmed Activity (PA) is a four-hour unit of time (3.75 in Wales) allocated to doctors in their contracts. A standard full time job plan consists of 10 PAs, equivalent to a 40-hour week.

42% of all consultants, and over half of those aged 55 or over, are working a 12 PA or more contract. Doctors should be supported and encouraged to work 10 PA contracts to improve retention and wellbeing.

TOTAL PROGRAMMED ACTIVITIES (PAS)
BY AGE GROUP, 2023



Supporting Professional Activities

SPAs underpin clinical care and contribute to ongoing professional development. They include activities such as service development, leadership, teaching and training, clinical governance and preparation for appraisal and revalidation. The minimum recommendation for CO consultants is 1.5 SPAs in their job plan (equivalent to six hours per week). However, the BMA job planning guidance recommends 2.5 SPAs for consultants in England, Scotland, and Northern Ireland (equivalent to ten hours per week). In Wales, (where one PA is equal to 3.75 rather than four hours), three sessions of SPA time are recommended (equivalent to just over 11 hours per week).⁹

13% of full-time consultants had fewer than 1.5 SPAs in their job plans. This rose to 41% of those working LTFT. The average (median) number of SPAs in a full-time consultant's job plan in England and Northern Ireland was 1.5, compared to 2 in Scotland and 3 in Wales. Among consultants over 55, 56% had fewer than 1.5 SPAs in their job plan.

If doctors are not allocated sufficient SPAs, this has a direct impact on training capacity and wider service development.

Skill mix

Skill mix is a common approach to managing overwhelmed SACT and radiotherapy services, freeing up consultant's time to see new patients. This involves understanding what the teams' capabilities are and designing the service around the patient's needs, so that the right skills are available at the right time.

9 in 10 services use skill mix to support the workforce, although only 30% to a great extent.



AOS has borne the brunt of understaffing. Those who did have AO in their job plans have withdrawn to provide more tumour group cover resulting in limited support for the AOS nurses, and deteriorating relationships with medical teams.

This suggests there is still some capacity to increase the use of skill mix to support workforce shortfalls. Skill mix can support retention and job satisfaction, especially for the nursing and radiotherapy workforce, by providing opportunities to upskill and for career progression. However, there are limitations to its use. Departments must factor in the consultant time required to supervise staff upskilling and undertaking new roles.

Acute Oncology Services

Acute Oncology Services (AOS) assess and treat patients who present with symptoms resulting from their cancer or side effects from cancer treatment. AOS are vital for providing consistent and high-quality care for cancer patients, for optimising clinician time and expertise, and for ensuring the best use of resources.¹⁰ An effective AOS can therefore deliver a more patient-centred service, with quick specialty advice and fewer emergency admissions. For the service to be fully effective, it should be operating 24/7.

Our data demonstrates variation in the extent of acute oncology provision. 75% of cancer centres now have a dedicated admissions or assessment unit which is a welcome increase from 63% in 2022. However, the majority are not open at weekends and only 7% are covered by a dedicated consultant with most being covered by the on-call consultant.

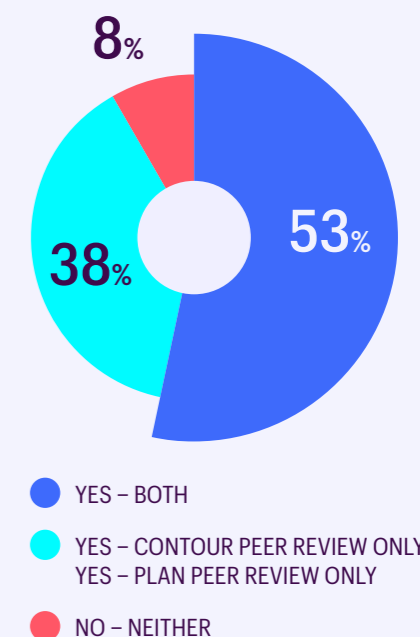
While almost all tumour sites have seen workforce growth over the past five years, the AOS CO consultant workforce has shrunk by 16% from 113 consultants to 95 in 2023.

Peer review of radiotherapy contours

Peer review is vital for quality assurance. When radiotherapy errors occur, they can be devastating for patients and costly for the NHS. The RCR's peer review guidelines recommend that radiotherapy contours and plans are subject to systematic review by appropriately trained and experienced peer professionals.¹¹ Only 53% of cancer centres are routinely undertaking contour and plan peer review.

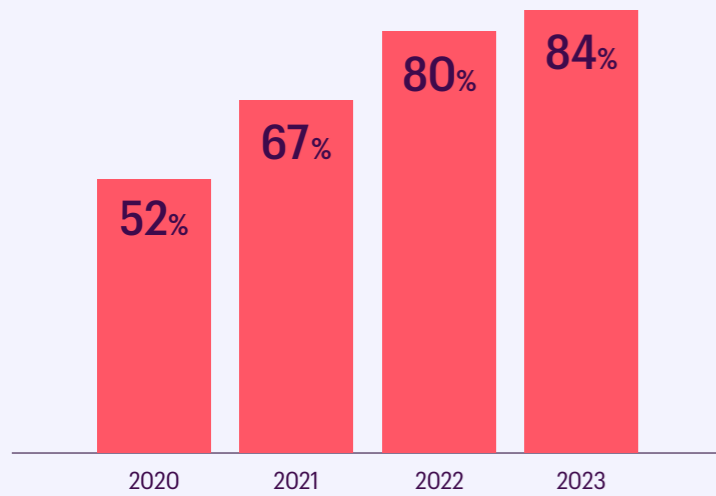
Inadequate staffing levels means there is often not enough clinical time to undertake routine peer review.

DOES YOUR CANCER CENTRE UNDERTAKE ROUTINE RADIO THERAPY PEER REVIEW?



Impact of oncology workforce shortages

PROPORTION OF CANCER CENTRES WHERE WORKFORCE SHORTAGES ARE IMPACTING PATIENT CARE



Some patients' performance status has deteriorated to the point they are no longer fit for SACT by the time they are seen.

Patient care

There is a 15% shortfall of clinical oncologists, meaning we are 185 consultants short of delivering adequate care. It is well recognised that these shortages impact the quality of patient care that doctors are able to provide.

Rising demand for cancer services and treatment – for instance, the rate of SACT delivery increases by approximately 6-8% per year across the UK – means that the 3.5% growth in the workforce has simply not been enough.^{2,3}

84% of cancer centre Heads of Service said workforce shortages were affecting the quality of patient care, and 85% said that they were concerned shortages were impacting **patient safety**.

Treatment delay

A major concern is that medical workforce shortages are starting to routinely delay patients starting treatment, which has a clear impact on outcomes. There is evidence to show that a patient's health often deteriorates while on a waiting list, and for every four weeks treatment for some cancers is delayed, the chance of cure falls by approximately 10%.¹²

95% of cancer centre leaders told us that they were concerned about workforce shortages delaying treatment.



Some of these would be category 1 patients who have had treatment delays, which would impact cure rates.

SACT was delayed in almost all (95%) centres over the past year due to workforce shortages. SACT treatment was delayed most months in two thirds (68%) of centres.

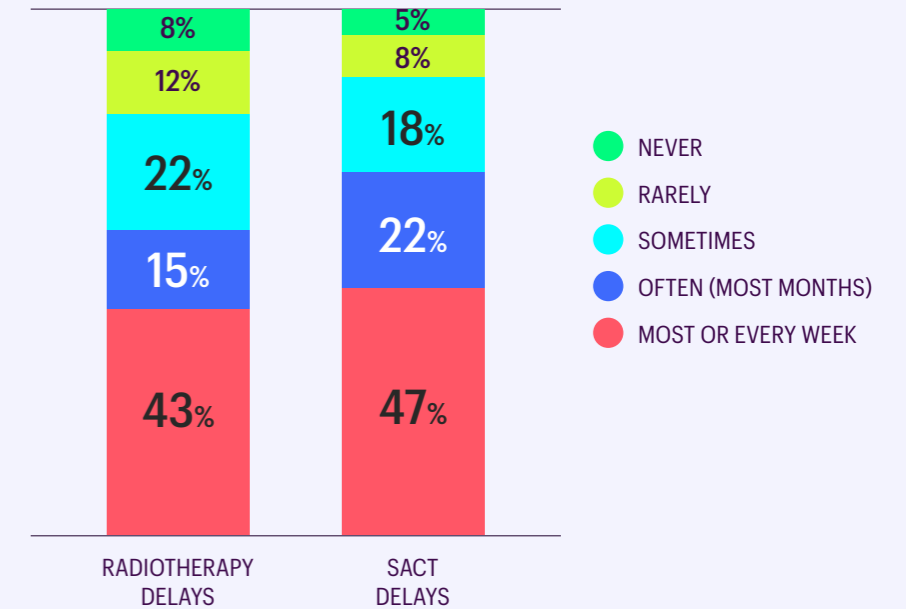
Over the past year, the number of cancer centres with weekly SACT delays has risen from just over a quarter (28%) to almost half (47%).

Radiotherapy was delayed in 92% of cancer centres due to workforce shortages. This happened most months in most (58%) centres, and in two in five centres (43%), delays were happening most or every week.

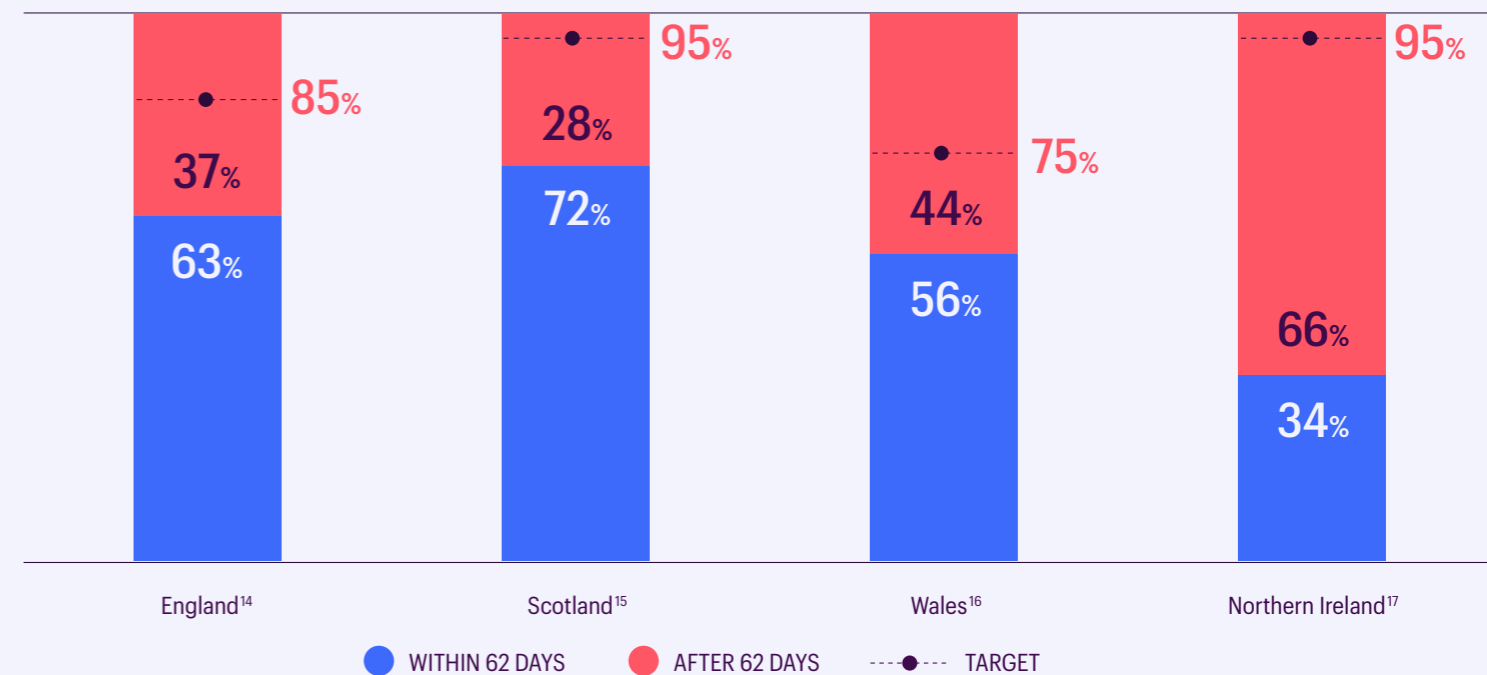
Patients are now waiting too long to start treatment.

Waiting times for first definitive treatment following an urgent referral or consultant upgrade for suspected cancer (62-day target), October 2023*

RADIOTHERAPY AND SACT DELAYS 2023



PATIENTS SEEN WITHIN 62 DAYS OF AN URGENT REFERRAL FOR SUSPECTED CANCER



* Data taken from the release tracking performance closest to October 2023. Northern Ireland's data is taken from July–September 2023 due to data completeness.



Adjuvant breast radiotherapy waiting time is currently nearing 20 weeks post-op due to the wait to see a CO consultant.

The 62-day target measures waiting times for a first cancer treatment following a referral, which might be radiotherapy, SACT or surgery. Poor performance against national targets is not just a result of oncological workforce shortages but demonstrates limited capacity in the whole pathway, including radiology, pathology, oncology, and surgery.

Patients also face hidden delays, which are not captured in the cancer waiting times data. Services report that patients who need subsequent cancer treatment (such as radiotherapy following surgery) are facing long waits to see an oncologist to sign off the second treatment, limiting the value of both treatments.

Severe shortages can mean patients have to travel elsewhere to access treatment in an appropriate timeframe. In just over a quarter of centres (27%), patients were sent elsewhere for treatment, which can incur long travelling times and be expensive.

Other centres told us how urgent cancer cases are usually prioritised to avoid any impact on patients, but this comes at the expense of the health and wellbeing of consultants working overtime, risking further attrition and more capacity issues in the future.



Regional disparities exacerbate inequalities.

Regional disparities introduce a postcode lottery of care, where patients living in one region are likely to have quicker access to a specialist than those in regions with fewer oncologists. We are starting to see the impact of these inequalities on the severity of delays. In 2023, just over a third (36%) of patients in London received their first treatment (all types) after 62 days of an urgent referral for suspected cancer, compared to nearly half (46%) in the Midlands.¹³

To address these inequalities, the NHS has committed to distributing medical school and training places in areas of greatest need, and we continue to support this approach.

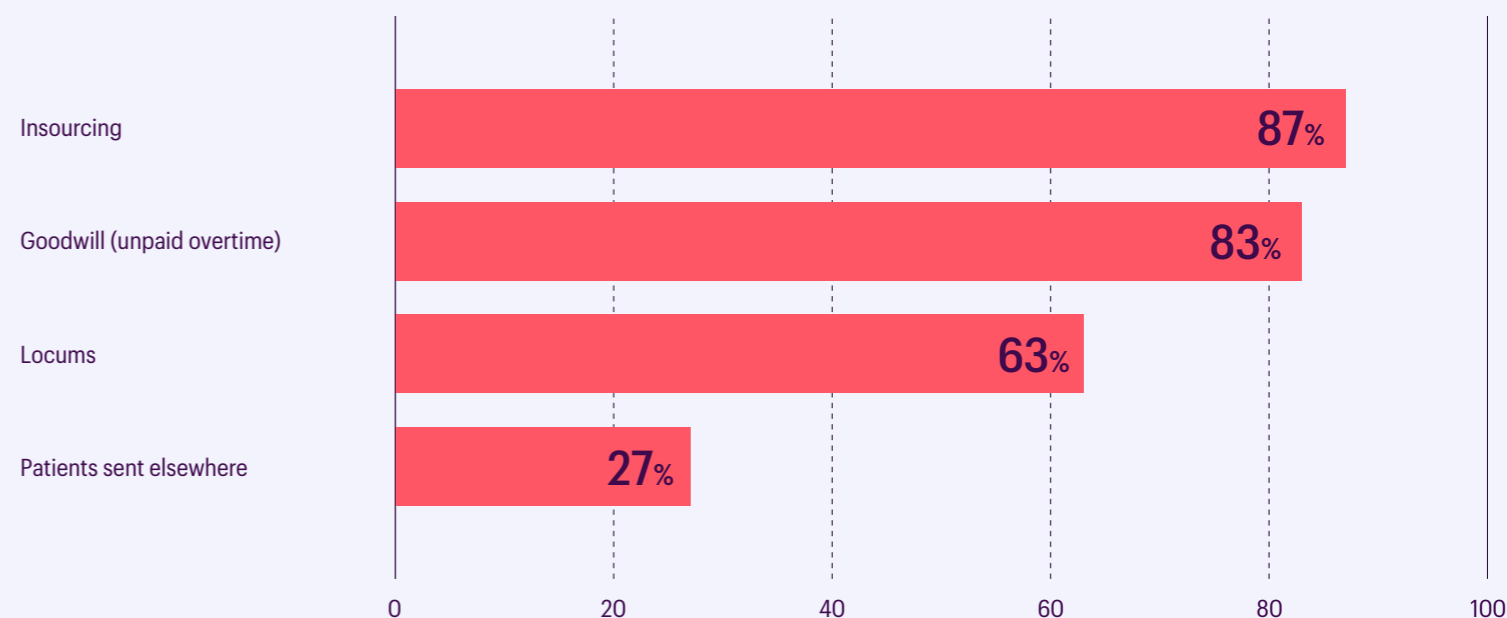


Colorectal SACT treatment actually had to be suspended for 2–3 weeks as there was no consultant, which caused great anxiety for the patients and staff.

Managing shortfalls

Four in five cancer centres were unable to keep up with the level of clinical demand with their existing workforce and had to rely on unsuitable and often costly alternatives.

METHODS OF MANAGING SHORTFALLS



For several months, a cohort of patients had to receive their treatment across the border in another cancer centre, meaning some patients travelling 100 miles for treatment.



If we had trainees more regularly and across all tumour sites, it would off load the pressure of the service and create time for the consultants to supervise and educate them.

Training future doctors

We need to expand the number of clinical oncology trainees to grow the workforce. For the first time this year, we asked services whether they would be able to increase their number of clinical oncology training places. Half (53%) said they would be able to do so in 2024.

In total, cancer centres told us they would be able to accommodate an additional 87 trainees within the next year – falling short of the 185 consultants needed immediately to deliver the best possible care.

Training place applicants

There are longstanding difficulties attracting doctors into clinical oncology and medical oncology training posts across the UK.

In 2023, the fill rate for Clinical Oncology training places in England was just 53%.

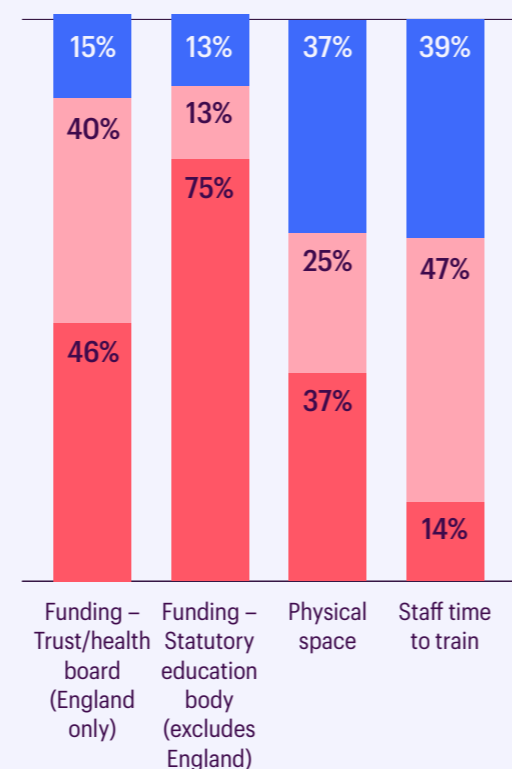
If 100% of these posts had been filled in 2023, it is estimated that this would produce an additional 40 WTE consultants in approximately seven years' time.

There are several contributing factors to this, including little oncology in medical school syllabuses and a lack of junior doctor exposure to the specialty. An RCR insight panel survey identified that negative perceptions of the specialty were driven by the radiation physics component in the curriculum, and perceived poor patient prognoses.

Barriers to delivering training

Services are increasingly reporting challenges in accommodating trainees. When asked about barriers to increasing the number of trainees in the centre, Heads of Service told us the following:

DO YOU FACE THE FOLLOWING BARRIERS TO INCREASING TRAINING PLACES AT YOUR CANCER CENTRE?



- SIGNIFICANT BARRIER
- BARRIER TO SOME EXTENT
- NOT A BARRIER



The lack of space is a huge problem. We're getting the point where even if we could recruit, we'd have nowhere to put anyone.

Funding from trusts and health boards

The biggest reported barrier to expanding training places, reported by cancer centres in England was accessing funding from the trust. In England, trusts are required to fund 50% of a trainee's costs, with the remaining 50% funded by the central statutory education body (NHS England).

85% of cancer centres in England said trust level funding was a barrier, with 46% saying it was a significant barrier – the biggest barrier of all three.

Trusts are facing extreme financial pressures, with rising waiting lists, high inflation rates, and the impact of strikes all posing a challenge.¹⁷ This means that financial directors or chief executives are often reluctant to release funding for additional trainees. Short term budget planning presents further challenges, since funding a training post is a multi-year commitment.

Central NHS funding

In Scotland and Northern Ireland, the statutory education body provides funding for the full training place, with health boards and trusts paying on-call or any additional payments. In Wales, training posts have historically been funded in a combination of ways, but new posts from 2020 onwards are also fully funded by Health Education and Improvement Wales.

88% of centres in Scotland, Wales and Northern Ireland said NHS funding was a barrier, with 75% saying this was a significant barrier. Certain centres, specifically smaller ones, reported issues accessing central funding for training places.

Physical and staff capacity to train

Physical space to accommodate trainees is also an issue – for instance, finding workstations and a suitable space for group teaching. 63% of centres said that physical space was a barrier – 37% said this was a significant barrier.

61% said staff time to train was a barrier, although only 14% said this was a significant barrier.

On average, cancer centres reported having just one consultant with training PAs in their job plan. The average reported number of PAs for training was 0.75, equivalent to just three hours per week. However, only half of cancer centres were able to provide this data, meaning it presents an incomplete picture.

Without action to grow training capacity, and the number of applicants, we will be unable to catch up with persistent workforce shortages, threatening the service.



There is a marked reluctance to move training posts away from larger centres, where there [are] many, to smaller centres, where there is a need for future workforce, even on a rotational basis. Trainees will work where they know so if they don't ever experience the smaller centres they won't work there.



Some consultants
have gone off on
leave due to stress.

Burnout and retention

100%

of Heads of Service reported concerns about morale, stress, and burnout in their workforce

Coupled with rising demand for services, enduring backlogs and a backdrop of industrial action, workforce shortages create an environment of relentless pressure. Doctors say they are feeling unable to do their job to the best of their ability. They are often asked to work longer hours to make up for staff shortfalls, and job planning rarely factors in staff absence or annual leave.

83% of departments relied on goodwill, or unpaid overtime, to manage increasing demand for services.

We are starting to see the impact of burnout and low morale on retention. In 2023, the median age that a clinical oncology consultant left the workforce dropped from 57 to 54. This is lower than the five-year average of 56. Two thirds (66%) of those who left the workforce were under 60.

Without action, more doctors will inevitably leave the service, either retiring early or moving to another country with better working conditions. We need to avoid a 'brain drain' where doctors with considerable experience and expertise are replaced by more junior doctors and trainees, who hold great potential, but once they have been mentored and trained by senior doctors.

Service development

A less well documented consequence of staff shortages is the neglect of service development. As doctors cover additional clinical work, they do not have the time and headspace to develop and introduce innovative ways of working which may ultimately lead to increased quality of care and improved productivity.

Groundbreaking new treatments and technologies have huge potential for streamlining the delivery of care, improving patient outcomes, and expanding workforce capacity. Yet without the workforce to introduce these today, we will fall further behind on outcomes and fail to modernise the system in line with the population's advancing needs.

100%

of Heads of Service said that workforce shortages had led to insufficient time for service improvements. 70% were highly concerned about this.

Allowing sufficient time for service development is critical to the longevity of the service and for the quality of care that patients receive today. New cancer treatments, including radiotherapy techniques and innovative drugs, are not being routinely offered to patients and access to them is unequal across the country.

The potential of AI, data, and other tech investments, which have been earmarked as central to improving productivity in the NHS, will go unrealised if clinical leaders cannot effectively implement these into the service.

A three-point plan for recovering oncology services

1

Recruit

To overcome workforce shortages and prevent patients from receiving suboptimal care, we need to increase the number of clinical oncologists training and working in the NHS. There is a currently a 7% vacancy rate and a lack of qualified candidates available to fill these posts. International recruitment should be used where appropriate and ethical.

Training more doctors will be the most effective way to grow the workforce in the future. We need to at least maintain the increase of specialty training posts and eventually increase the number of training places to keep up with rising demand. In England, the NHS Long Term Workforce Plan commits to increasing the number of medical school students, with funding attached. We look forward to working with the government and NHS England in the next five years to commensurately expand oncology specialty training posts to avoid a bottleneck of qualified graduates.

The lack of applicants to existing clinical oncology training places threatens the future workforce. We now understand the drivers behind low applicant rates, including a lack of exposure on medical syllabuses, and need to take action to address this. Internal Medicine Training (IMT) posts should also have exposure to oncological treatment procedures, such as radiotherapy planning and SACT.

Services should also support the progression of their SAS doctors to specialist roles and include these roles in workforce planning.



Recommendation: The NHS should at least maintain the current number of expansion specialty training posts for clinical oncology to grow the future workforce. As more medical students graduate in 2028, the government should work with the NHS to increase specialty training posts for clinical oncology to increase the number of oncologists.

Recommendation: Hospitals, particularly those with a high shortfall of clinical oncologists, should ensure they have a long-term funding plan for clinical oncology training and consultant posts to grow their workforce.

Recommendation: NHS England should fund a recruitment campaign, in collaboration with the RCR and ACP, to attract trainees to oncology training posts. This should be replicated by the NHS in each nation.

2

Train

We need to expand the number of clinical oncology trainees to grow the workforce. However, currently there are substantial barriers to training enough future doctors.

Local services are also unable to access funding for new training posts due to financial pressures. To address this, the RCR have provided template business cases, produced webinars and spoken at national chief executive or finance director level conferences to explain the importance of investing in the oncology workforce. However, we now need top-level intervention to persuade trusts and health boards to provide this money and to communicate the risks of not doing so.

In the future, the NHS should review funding arrangements for training places with a view to simplifying the process. Centrally funding for the whole training place would avoid the scenario where national initiatives to grow the workforce are hindered by local systems restricting funding.

A lack of capacity to train, both in terms of doctor's time and physical space, also presents challenges. Trusts must prioritise time for senior doctors and other health professionals to train the consultants of the future.

Recommendation: Medical schools should increase exposure to oncology in their syllabuses to attract more trainees into the profession.

Recommendation: As trainee numbers increase, the government should provide dedicated funding for an expansion of clinical and office space.

Recommendation: Doctors should have funded supporting professional activities (SPA) time for training. Retired doctors should be encouraged and enabled to return to support education.

Recommendation: The NHS should explore innovative solutions to expanding training capacity, including with improved use of technology and cross-centre support.



3

Retain

The NHS and individual employers need to consider how to best support staff to work for longer.

One way of keeping the vital expertise of doctors in the system appears to be by offering flexible working patterns, especially as they near retirement. The median age that full time consultants left the service over the past five years was 51, compared to 61 for those working less than full time. Discussing more flexible working patterns with individuals may encourage older staff to stay on for longer.

Similarly, protecting SPA time in job contracts, whereby doctors can spend time on non-clinical work, will support retention and enable service development.

Basic measures such as having up-to-date computer software and hardware, sufficient administrative and clerical staff to avoid consultants undertaking unnecessary administrative tasks, and fostering a collaborative, respectful working culture would all contribute to workforce retention. We need to start assessing how employers are treating their staff, whether they are making these retention and wellbeing measures available, and whether introducing these measures has any tangible impact on staff retention.



Recommendation: Trusts and health boards should ensure basic staff wellbeing measures, including but not limited to, up-to-date computer hardware and software, sufficient administrative and clerical staff, and access to food and drink at all hours of the day.

Recommendation: To hold hospitals to account, the NHS should work with stakeholders to develop metrics that measure how well hospitals are treating their employees.

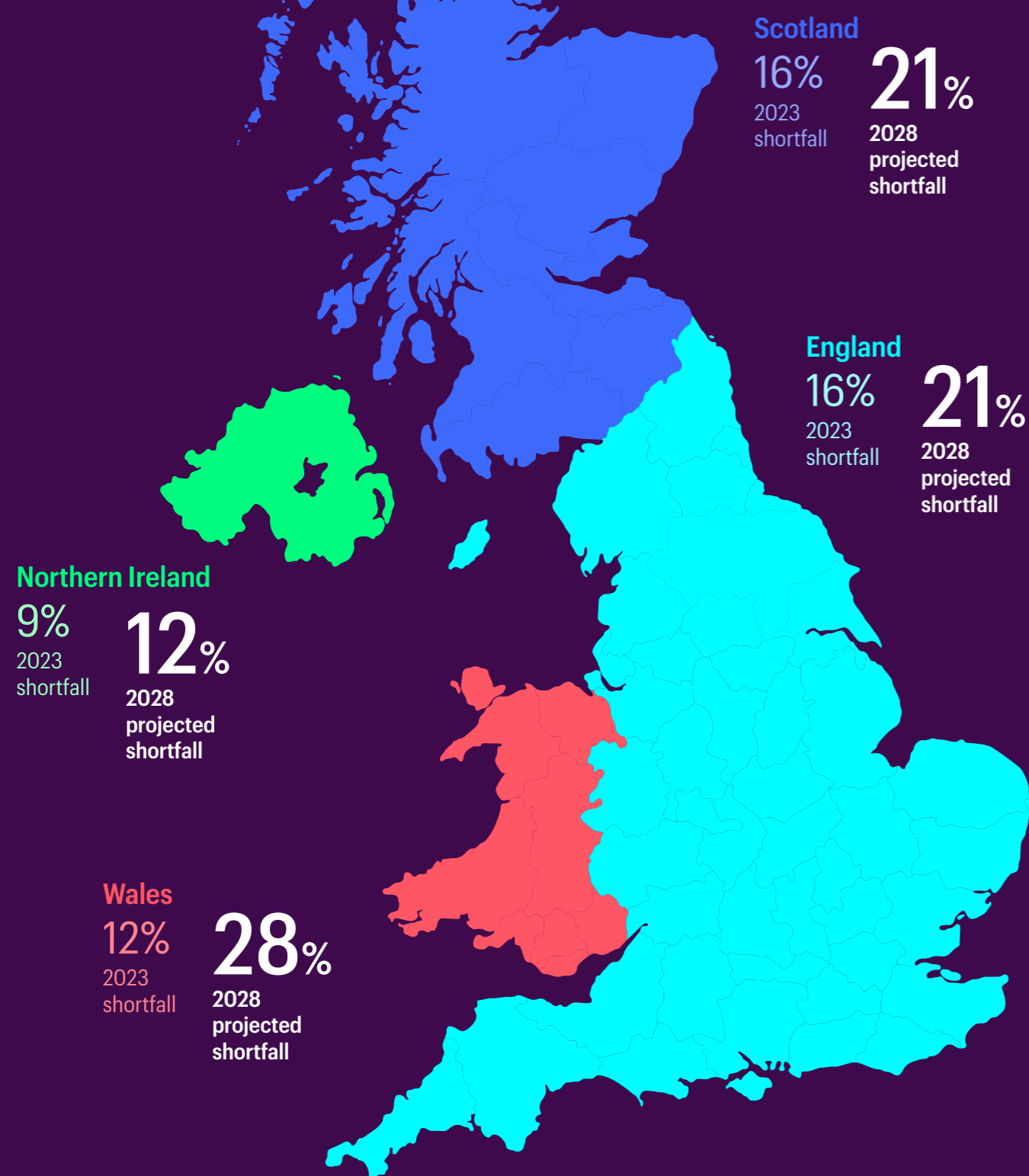
Recommendation: Flexible working patterns should be offered as a default to all existing and new NHS staff. Any associated loss of capacity should be factored into future workforce planning.

Recommendation: Trusts and health boards should ensure that all doctors have sufficient SPA time protected in their job plans. This must include those working less than full time (LTFT) and specialty and specialist (SAS) doctors. Future workforce planning should accommodate this.

Recommendation: Exit interviews should be conducted with all doctors leaving the service to understand the reasons for their departure.

The national picture

Map of shortfalls



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.

- There is a 16% shortfall of CO consultants – the joint highest of the four nations – equivalent to 159 additional consultants.
- There was a net growth of 29 CO consultants in 2023, meaning the workforce grew by 3.5%.
- England has 65 vacancies (WTE) open. 58% of these have been unfilled for over six months.
- Nearly 9 in 10 (88%) Heads of Service reported workforce shortages affecting patient care – higher than the UK average of 84%.

Wales

- Wales's CO consultant workforce grew by 6 WTEs, equivalent to 12%, by far the largest percentage growth of the four nations.
- However, five of the six new consultants (WTE) are locums, which potentially threatens the stability of the country's oncology services.
- Regional inequalities persist. While there are 7.4 clinical oncologists per 100,000 older population in South West Wales and 6.6 in South East Wales (both above the UK average), this reduces to 5.3 in North Wales.
- Despite strong growth, there is still a 12% shortfall of clinical oncologists, equivalent to 7 consultants.
- This is expected to rise to 28% by 2028 – the largest shortfall of all four nations. The workforce is predicted to grow by just 0.7% a year for the next five years.
- In part, this is because 24% of CO consultants in Wales are forecast to retire over the next five years, higher than the UK average of 18%, and in part due to Wales having fewer trainees. Trainees make up 29% of Wales's CO workforce compared to the UK average of 32%.
- 44% of the workforce are on less than full time contracts equivalent to an almost 20% loss in capacity. This increases to 53% for those aged over 50.
- In all three cancer centres, workforce shortages had led to radiotherapy and SACT treatment being delayed.
- All centres were unable to manage demand within the existing workforce and relied on goodwill, insourcing, and locums to cope.

Scotland

- While the number of SACT appointments has grown by 7% over the past year, the clinical oncology workforce (WTE) saw no growth in 2023.³ Scotland has had slow annual growth over the past five years, growing by a yearly average of 2.3% compared to 3.5% across the UK.
- Scotland faces a 15% shortfall of clinical oncologists. While the South East region has a 7% shortfall, both the North and South West regions have 20% shortfalls.
- 7 substantive consultants left the workforce last year, with an average age of 50.
- The medical oncology workforce also decreased by four doctors (WTE).
- Scotland has a 9% CO consultant vacancy rate, higher than the 7% UK average, although just over 60% of the vacancies have been open less than six months.
- 100% of Heads of Service were worried about workforce shortages resulting in decreased quality of patient care. 80% were concerned about the impact on patient safety.
- In 60% of Scottish cancer centres, patients were sent elsewhere for treatment, compared to 27% in the UK. In Scotland, this can be particularly difficult given the significant distances to travel.
- Every centre relied on goodwill and insourcing to manage rising demand.

Northern Ireland

- Northern Ireland was the only country whose clinical oncology WTE workforce shrunk in 2023.
- Cancer centres are very reliant on locums, which make up 21% of its workforce, compared to 9% across the UK.
- It also has the lowest trainee ratio, making up 24% of the CO workforce, compared to the UK average of 32%.
- 39% of the workforce are on less than full time contracts, compared to 27% in 2022.
- There is a 9% shortfall in clinical oncologists, equivalent to 3 consultants. This is the lowest of the four UK nations.
- Northern Ireland is the only country where every cancer centre operates an AOS on the weekend.
- Both cancer centres relied on goodwill, insourcing, and locums to manage clinical demand.

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