Workforce Crisis:
The Extent of Consultant Hiring Freezes in UK Imaging and Cancer Departments

The Royal College of Radiologists

Short term budget deficits are leading trusts to freeze or cut consultant posts. Indicative[1] data from our annual 'state of the workforce' census shows that in 2024...

1 in 4 (24%) cancer departments

1 in 5 (19%) radiology departments

... are freezing the expansion of their workforce.

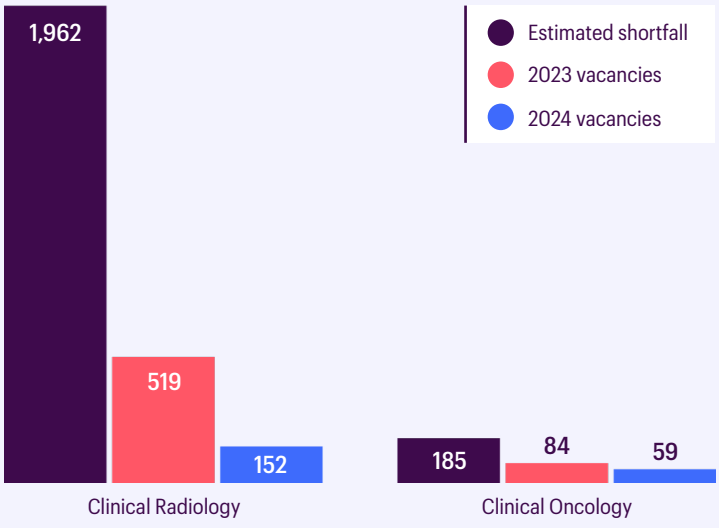
Certain trusts have been placed under recruitment freezes – where they are not permitted to take on new trainees, consultants, or specialty and specialist (SAS) doctors, meaning workforce expansion is taken out of their control.

Reduction in consultant posts threatens workforce stability and patient care

Failing to create new consultant posts means that trainees may complete their medical training without a job to progress into. Pausing the growth of the workforce while demand continues to escalate means more patients will face potentially dangerous delays.

Our preliminary 2024 census data shows that the number of advertised posts has dropped considerably over the past year, risking newly qualified doctors not having jobs on completion of training. In 2024, 264 radiologists and 54 oncologists completed their specialist training.

ADVERTISED CONSULTANT POSTS, UK



As the data shows, the number of vacancies was insufficient even before these hiring freezes – with vacancies based on funding available, rather than the number of posts truly needed to meet demand and to meet workforce shortfalls. However, this year the number of posts has dropped sharply, particularly for radiology. This does not mean the posts have been filled or the consultants hired – it means the funding has been taken away for departments to recruit.

These freezes are particularly frustrating since they undermine recent, much-needed efforts to boost capacity in diagnostics and cancer by expanding the number of specialty training posts.

This mismatch has left newly trained consultants without jobs, even as the healthcare system faces persistent reporting backlogs and rising patient demand. Not only is this a blatant waste of the costs of training a doctor in the NHS but limits any improvements to patient care and any attempts to bring down waiting lists. These freezes have also resulted in escalating costs associated with the increasing use of locums and outsourcing, long waits for patients, and persistent failure to meet cancer and diagnostic targets.

> **We are unable to attract and employ our ex-trainees who wish to work with us - in a national shortage of oncologists this is highly demoralising.**
>
> Cancer Centre Head of Service

[1] Based on 94% return rate from Radiology Clinical Directors and 92% return rate from Cancer Centre Heads of Service

Widening health inequalities

In oncology, training places have been weighted in areas which are traditionally difficult to recruit to – since doctors often take up consultant posts where they trained – and which often experience worse health outcomes. In the wake of the Covid-19 pandemic, specialty posts in both radiology and oncology were redistributed away from London to meet regional need. The first of this cohort will CCT (complete specialty training) in 2026 . Without the consultant posts now being made available, these inequalities will worsen. This is particularly pertinent in oncology; it's estimated that there are 20,000 extra cancer cases each year in more deprived areas of the UK.[2]

Where possible, regions should offer resident doctors a post where they trained given that they know the systems, teams and local area.

Impact on consultants

Doctors are being expected to do more clinical work, within the same workforce resource. Our members are overworked and burnt out, unable to commit time to teaching, service development and other non-patient facing tasks which provide value and are essential for the future. Increasingly, they are having to cover the workload of colleagues who have taken sick leave or reduced their hours because of burnout. The average age that both clinical oncologists and radiologists left the NHS was just 54 in 2023.

Consultants are working overtime to catch up imaging reporting backlogs, often at a high cost to the NHS. Funding more consultants would be a more cost-effective and safe way of dealing with excessive reporting demand.

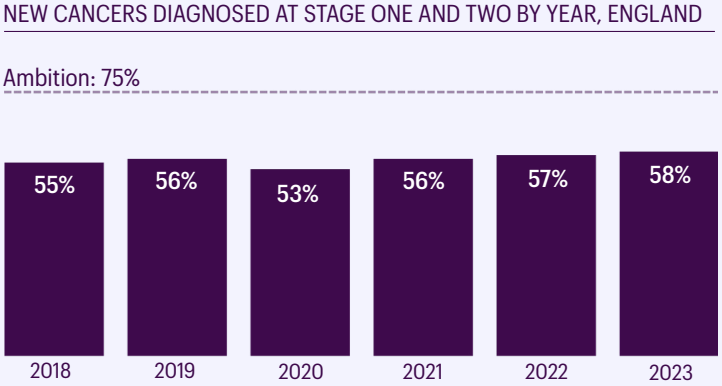
Long term workforce planning

As a result of hiring freezes, many hospitals are also being prevented from taking on new resident doctors since there are too few educators to train, hindering current and future growth. To meaningfully support the workforce, we need a long-term approach to workforce planning.

This has been recognised and acted upon by the Government who are delivering the first NHS Long Term Workforce Plan. However, these new consultant recruitment freezes limit the Government's s ability to achieve its ambitions, and means we are reverting to a short-term approach. Without a sufficient rise in consultants, residents cannot be trained, and we will not see the anticipated growth in the workforce.

Cancer and diagnostics are a national priority. We need the workforce in place to manage rising demand.

NEW CANCERS DIAGNOSED AT STAGE ONE AND TWO BY YEAR, ENGLAND



While we recognise the tough financial pressures that the Government and NHS are operating under, we strongly believe that cancer and diagnostics should be exempt from cost-cutting mechanisms to support patient outcomes.

Every ICB continuously fails to meet its cancer and diagnostic waiting time targets. Despite NHS England's ambition to diagnose 75% of cancers at stage 1 or 2 in four years' time, we have seen minimal progress in recent years.

There is insufficient capacity in departments to manage the current level of demand, let alone the increased demand we will continue to see, especially in the context of the Government's drive for earlier diagnosis.

It is difficult to understand how the Government will meet its ambitions to cut waiting lists without investment in the workforce responsible for diagnosing and treating patients.

[2] Cancer Research UK. UK health inequalities: 20,000 more cancer cases a year in the most deprived areas. 2020. Available at: https://news.cancerresearchuk.org/2020/09/30/uk-health-inequalities-20000-more-cancer-cases-a-year-in-the-most-deprived-areas/

Radiologists

Diagnostics, and particularly the radiology workforce, underpin every other specialty and is central to boosting productivity in the NHS.

The recent Autumn budget allocated £1.5bn to cutting waiting lists, including by investing in new diagnostic scanners and centres. While we welcome the Government's commitment to fund more scanners in the Budget, a two-pronged approach is essential. To meaningfully bring down waiting lists, the workforce must be in place to report the increased level of scans.

Clinical Oncologists

Cancer is a national priority. 1 in 2 people will now get cancer in their lifetime and incidence has risen 19% in the last decade.

Recognising poor performance against waiting times, particularly in radiotherapy, the Government have invested £70 million into Linac machines. While we welcome this investment, there is limited evidence to suggest this will help outcomes without additional staff to supervise care. Clinical oncologists are the only workforce group able to manage radiotherapy, as well as chemotherapy (SACT). SACT treatment delivery is rising by around 6% annually, compared to a 3.5% growth in the workforce.

Shortages in this workforce group are limiting the efficacy and timeliness of cancer treatment delivery. Without investment in staff, certain oncology departments may be forced to limit access to treatment, risking patient outcomes and reintroducing a postcode lottery of care.

What do we need to happen?

We are calling on the Government to enable NHS trusts to protect the stability and long-term future of their cancer and diagnostics workforce. In particular:

1. Trusts who have been placed under funding freezes should be allowed to continue to invest in their cancer and diagnostics workforce.
2. All hospitals should be required to develop a long-term funding plan for the cancer and diagnostics workforce, which covers both training and consultant posts.
3. The Government should prioritise the radiology and oncology workforce in the Spending Review 2025, by growing the number of specialty training places to meet rising demand.

Case Study

"After I completed my medical training, I undertook a fellowship at an external cancer centre to help develop my knowledge and skills with the aim of making me a more experienced and well-rounded consultant. Following this, I returned to my local cancer centre to start my consultant-career, but there were no consultant posts available.

To keep working, I took up a locum post. This was extremely busy covering three disease sites. Not only was I providing service provision for known consultant gaps but also covering colleagues' sickness. Despite multiple promises of a substantive post being advertised, a post was not advertised for 18 months. Eventually, two years after my return to my local centre, a full-time consultant post was made available.

"Living with this uncertainty, as well as managing the excessive workload of the locum post, has not only affected my professional career, in terms of self-development, but it has also impacted my personal life."

RCR member