



Clinical Oncology UK Workforce Census Report 2013

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Foreword

Now in its sixth year, The Royal College of Radiologists (RCR) clinical oncology workforce census continues to provide an unparalleled resource for describing and tracking the clinical oncology workforce nationally. This provides the College not only with robust data on consultant numbers and work patterns but also information on how trainees transition into the consultant workforce. These powerful data have been used by the College to provide evidence to national bodies (not just in England) who commission the future workforce in an effort to secure increased resource.

This year, for the first time, we have collected data on routine hours of working for both chemotherapy and radiotherapy services, giving a more rounded view on day-to-day activity. Data on the medical oncology workforce have also been collected, describing the balance of specialties nationally, which does, as one would expect, show some variation.

The data collected through the census is also hugely useful in mapping anticipated changes due to retirement.

My sincere thanks to all those who completed the census. I recognise there are many competing requests for your time and am very grateful that you have supported the College by filling in the census in such a timely fashion. As evidence of your commitment and contribution you are listed in Appendix 1.

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1. Introduction and methodology

The aim of the census is to obtain accurate data on the composition of the national UK clinical oncology workforce for use by the RCR. This enables the RCR to identify opportunities and challenges facing the workforce in the future. It also provides robust evidence which can be shared with national organisations such as the Centre for Workforce Intelligence (CfWI), who influence future commissioning of the workforce.

Now in its sixth year, the 2013 clinical oncology workforce census captures information for all consultant clinical and medical oncologists in substantive posts at 58 of the 59 cancer centres in the UK (and uses data from 2012 to report on all 59 centres).

The full set of questions for the 2013 census is provided in Appendix 2.

The 2013 census was launched slightly later than intended (in February 2014) and sought to capture data as of 1 October 2013. The census date should be borne in mind when reading the results due to the time elapsed between this date and the publication of this report.

The census data were collected online through a secure web portal. A link to the portal was emailed to the workforce lead at each of the 59 UK cancer centres to complete the census.

The census is designed to be simple to complete to maximise the response rate and quality of data captured.

Census completion 2008 to 2013

Census year	Census date	% Census completion
2008	1 July 2008	100%
2009	1 October 2009	100%
2010	1 October 2010	100%
2011	1 October 2011	98% ^a
2012	1 October 2012	100%
2013	1 October 2013	98% ^b

a. Charing Cross Hospital did not complete the 2011 census. For reporting, 2010 data submitted by this centre has been used in place of 2011 data.

b. University Hospitals, Coventry and Warwickshire did not complete the 2013 census. For reporting, 2012 data submitted by this centre has been used in place of 2013 data.

All findings in this report relate to the UK clinical oncology workforce, with the exception of Section 3 which additionally reports on UK medical oncology workforce data.

All data are reported as headcount (HC) unless stated otherwise. Where whole-time equivalent (WTE) is used the calculation conforms to the current NHS convention of excluding programmed activities (PAs) that exceed ten PAs, unless stated otherwise.

2. UK clinical oncology workforce – overview

The number of consultant clinical oncologists in a substantive post in the UK increased from 729 headcount (HC) in 2012 to 749 in 2013. These data are shown in Table 1.

Expressed as whole-time equivalents (WTEs), there are 691 WTE consultant clinical oncologists employed in substantive posts in the UK as of 1 October 2013. This equates to 10.8 WTE consultant clinical oncologists per million population (PMP) in the UK.¹

The number of trainee clinical oncologists in UK training schemes as of 1 October 2013 is 376.

Table 1. UK clinical oncology workforce 2011 to 2013

		2011	2012	2013
Consultant	HC	715	729	749
	WTE ^a	671 ^b	677 ^b	691
Trainee	HC	–	377	376
Other grades	HC	79	88	73

a. WTE data available for consultant grade only

b. Estimated research PAs deducted from previously reported 2011 and 2012 WTE data

As previously stated, where WTE data is shown, the calculation conforms to the current NHS convention of excluding PAs that exceed ten PAs. However, many consultants are contracted to work in excess of ten PAs. If all consultants were limited to a contractual maximum of ten PAs, a further 56 WTE consultants would be required to replace the current excess.

Table 2 shows an overview of the clinical oncology workforce by country.

Table 2. UK clinical oncology workforce by country, 2013

		England	Northern Ireland	Scotland	Wales	UK total
Consultant	HC	619	22	65	43	749
	WTE ^a	569	20	62	39	691
Trainee	HC	307	12	45	12	376
Other grades	HC	60	4	3	6	73

a. WTE data available for consultant grade only

3. UK clinical and medical oncology consultant workforce – overview

The number of clinical and medical oncologists (WTE) holding a substantive post across the UK is shown in Figure 1. The number per million of the population (PMP) is shown in Table 3, opposite.

Figure 1. UK clinical and medical oncology consultant workforce (WTE), by region and country

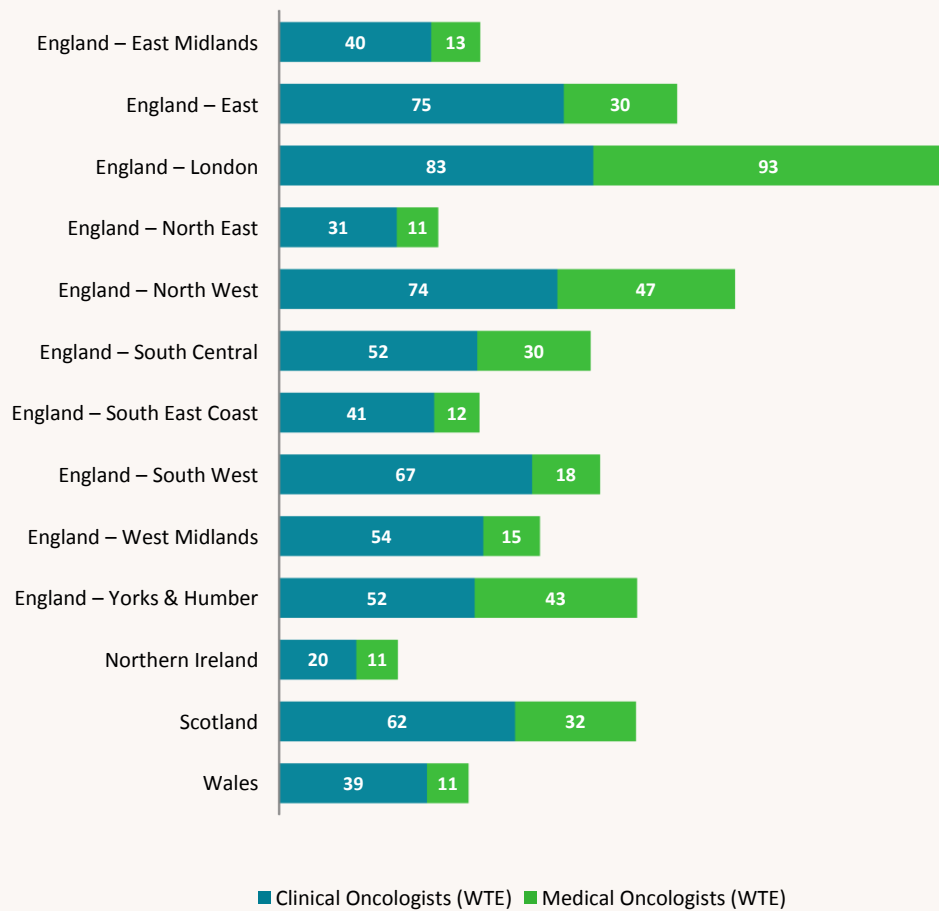


Table 3. UK clinical and medical oncology consultant workforce (WTE), by region and country

	Clin onc WTE	Med onc WTE ^{2,a}	Med & clin onc WTE	Pop'n ^{1,3,b}	Onc WTE PMP
England – East Midlands	40	13	53	4,410,612	12.1
England – East	75	30	105	5,787,144	18.2
England – London	83	93	176	7,832,487	22.5
England – North East	31	11	42	2,600,233	16.2
England – North West	74	47	121	6,962,848	17.3
England – South Central	52	30	82	4,112,460	20.0
England – South East Coast	41	12	53	4,347,587	12.2
England – South West	67	18	85	5,221,895	16.3
England – West Midlands	54	15	69	5,445,991	12.7
England – Yorks & Humber	52	43	95	5,289,015	17.9
<i>England total</i>	<i>569</i>	<i>312</i>	<i>881</i>	<i>53,865,817</i>	<i>16.4</i>
Northern Ireland	20	11	31	1,829,725	17.2
Scotland	62	32	94	5,327,700	17.7
Wales	39	11	50	3,082,412	16.2
UK total	691	367	1058	64,105,654	16.5

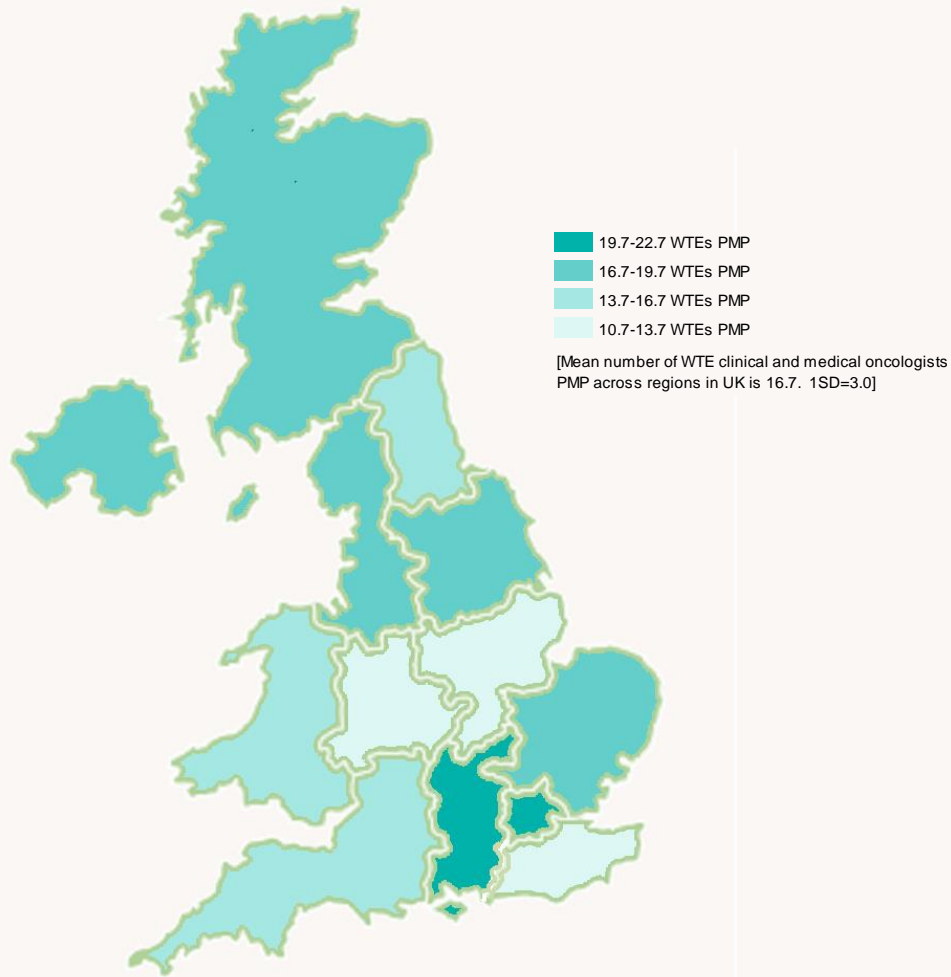
a. When calculating WTE, all those with PAs greater than ten were assumed to be 1.0 WTE in line with current NHS convention. Research SPAs were removed from SPA total individually prior to calculating WTE.

b. The dates of the most recently published population figures at region and country level (for England) are different therefore the sum of region populations does not equal the England total.

As of 1 October 2013, there are 16.5 WTE clinical and medical oncologists per million of the population in the UK. Figure 2 overleaf shows the combined ratio of clinical and medical oncologists across the four countries in the UK.

Nationally, non-surgical oncology services are delivered by a mixture of clinical and medical oncologists working together in teams. There is often significant variation in the composition of those teams. By combining the number of WTE clinical and medical oncologists for the first time we have tried to show the full oncology provision nationally. Regional and national data on solely clinical oncology provision are shown on pages 14 and 15 of this report.

Figure 2. UK clinical and medical oncology consultant workforce (WTE), by region and country¹⁻³



The number of medical oncologists working in cancer centres was supplied by the census. A number of medical oncologists are employed nationally with no link to a cancer centres and those numbers have been found from the Royal College of Physicians (RCP) census data. (A number of assumptions have been made about the medical oncology WTE. The number and gender of consultants were obtained from the RCR and RCP census. The participation rate was applied pro rata across the whole medical oncology consultant workforce where data were unobtainable.)

4. UK clinical oncology consultant workforce

The number of consultant clinical oncologists in a substantive post in the UK as of 1 October 2013 is 749. These figures include NHS consultants, those described as holding mixed NHS/academic posts (on NHS contracts) and those holding wholly academic posts (on university contracts). The split across these groups is shown in Table 4.

Table 4. Type of consultant

Type	Count	% of total
NHS consultant	668	89%
Mixed NHS/Academic	47	6%
Academic	33	4%
Other	1	0%
UK total	749	100%

Predominant workload

The proportion of the consultant workforce reported to have a predominantly radiotherapy workload is unchanged from 2012 at 14%. The data show that 85% of clinical oncologists undertake a balance of both radiotherapy and chemotherapy. The results are shown in Figure 3.

Figure 3. Predominant workload

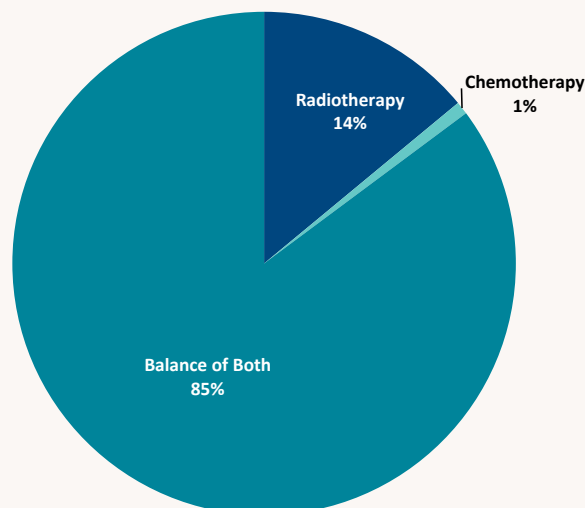
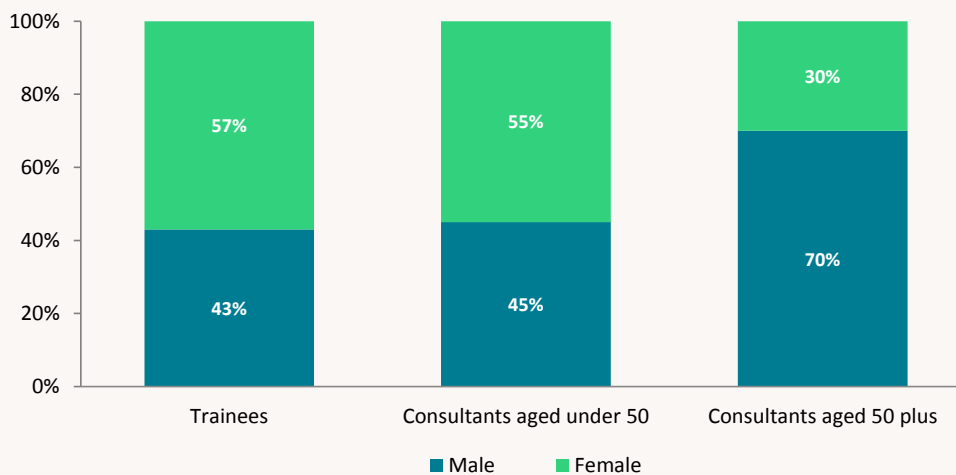


Table 5. Workforce by age and gender

Age group	Male	Female	Total	% of total
<36	5	14	19	3%
36–40	58	69	127	17%
41–45	99	115	214	29%
46–50	60	75	135	18%
51–55	68	40	108	14%
56–60	55	19	74	10%
61–65	38	9	47	6%
66+	6	0	6	1%
Not known	8	4	19 ^a	3%
Total	397	345	749	100%

a. Gender not known for seven clinical oncologists

Overall, almost half (46%) of the consultant clinical oncology workforce is female. The number of female oncologists exceeds the number of male oncologists up to the age of 50. Figure 4 illustrates the changing profile and feminisation of the clinical oncology workforce.

Figure 4. Feminisation of the workforce

Less than full-time (LTFT) working

The 2013 census data shows that just over one-in-five consultant clinical oncologists now work less than full-time. This is a two percentage point increase on two years earlier. For LTFT consultants, the median number of contracted PAs is 8.0 and the mean is 7.4.

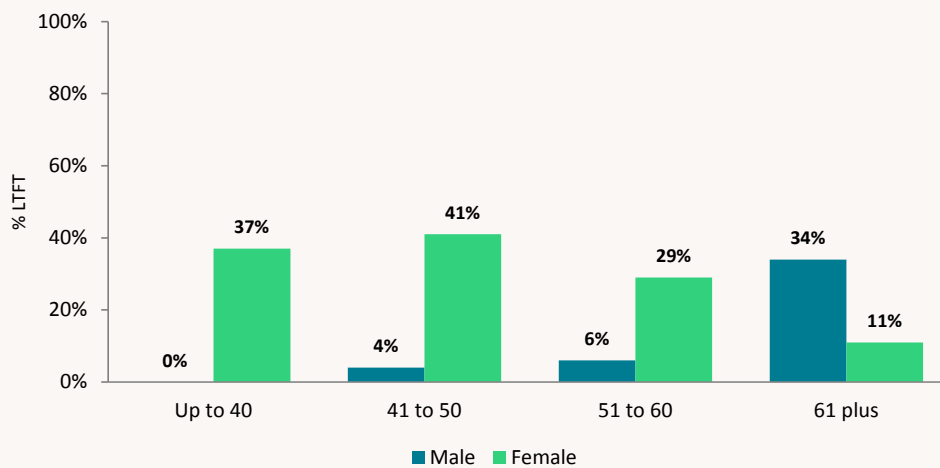
A key implication of the feminisation of the workforce is the greater propensity for women to work less than full-time. According to the 2013 census over a third of female consultant clinical oncologists now work less than full-time. A breakdown across age groups is provided in Table 6 and illustrated in Figure 5, opposite.

The extent of part-time working among women currently peaks in the age group 41–50, at 41%. Given the increasing numbers of women entering the consultant workforce (57% of current trainees are female compared with 46% of consultants) the extent of part-time working is highly likely to continue to increase in coming years.

Table 6. Number working LTFT, by age and gender

Age group	Male	Female
<40	0	31
41–50	7	77
51–60	7	17
61+	15	1
Total	30 ^a	126

a. Age not known for one clinical oncologist

Figure 5. Percentage LTFT working, by age and gender

Programmed activities

The census collected data on the number of PAs of each consultant clinical oncologist subdivided into direct clinical care (DCC) PAs and supporting professional activities (SPA) PAs.

Table 7. Mean contracted PAs by country (full-time NHS consultants only)

Country	DCC PAs	SPA PAs	Total PAs
England	8.81	2.18	10.99
Northern Ireland	10.16	1.93	12.09
Scotland	8.98	2.12	11.10
Wales	8.17	2.81	10.98
UK total	8.82	2.21	11.03

Table 7 shows the mean number of contracted PAs of full-time consultants across the four countries. The mean number of contracted SPAs for full-time consultant NHS clinical oncologists in the UK in 2013 was reported as 2.21. In Wales, the number is higher at 2.81, assumed to be a reflection of the Welsh national contract of '7+3'. Across the UK, a quarter of full-time consultants are reported as having fewer than two SPAs in their job plan.

The 2013 census did not collect additional responsibilities (AR) PAs, for example, management PAs, so these may have been included in the SPA count in Table 7. The 2014 census will collect AR PAs separately.

Tumour site specialisation

Tumour site-specialisation data are collected through the census. The census allows for more than one site specialty to be entered against each consultant. The findings are shown in Table 8 and in Figure 6, page 13.

The sum of consultants reported against each site specialty exceeds the total number of consultants as the majority of consultant job plans encompass two or more site specialties. For example, it should not be interpreted that there are 211 consultants solely specialising in breast cancer, rather that there are 211 consultants whose job plans include breast.

Table 8. Consultant site specialties (multi-response), by country

	England		Northern Ireland		Scotland		Wales		UK overall	
	Count	%	Count	%	Count	%	Count	%	Count	%
Acute oncology	70	11%	0	0%	0	0%	0	0%	70	9%
Breast	211	34%	7	32%	16	25%	11	26%	245	33%
CNS/Neuro	81	13%	2	9%	9	14%	5	12%	97	13%
Colo-rectal	148	24%	7	32%	13	20%	7	16%	175	23%
Genito-urinary	188	30%	10	45%	13	20%	5	12%	216	29%
Gynaecology	92	15%	2	9%	10	15%	4	9%	108	14%
Head and Neck	94	15%	3	14%	11	17%	7	16%	115	15%
Lung	168	27%	6	27%	21	32%	12	28%	207	28%
Haematological malignancy	79	13%	2	9%	8	12%	5	12%	94	13%
Paediatric	26	4%	2	9%	3	5%	1	2%	32	4%
Sarcomas	48	8%	2	9%	4	6%	3	7%	57	8%
Skin	76	12%	3	14%	6	9%	2	5%	87	12%
Teen and Young Adult	10	2%	3	14%	0	0%	0	0%	13	2%
Thyroid	44	7%	1	5%	3	5%	3	7%	51	7%
Upper GI (incl HPB)	92	15%	4	18%	11	17%	9	21%	116	15%
Other	33	5%	2	9%	0	0%	7	16%	42	6%
Total	619	100%	22	100%	65	100%	43	100%	749	100%

Acute oncology is a new site specialty. Although it was perceived that the majority of acute oncology posts would be held by medical oncologists, the number of clinical oncologists declaring an acute oncology interest is 89% greater in 2013 than in 2012.

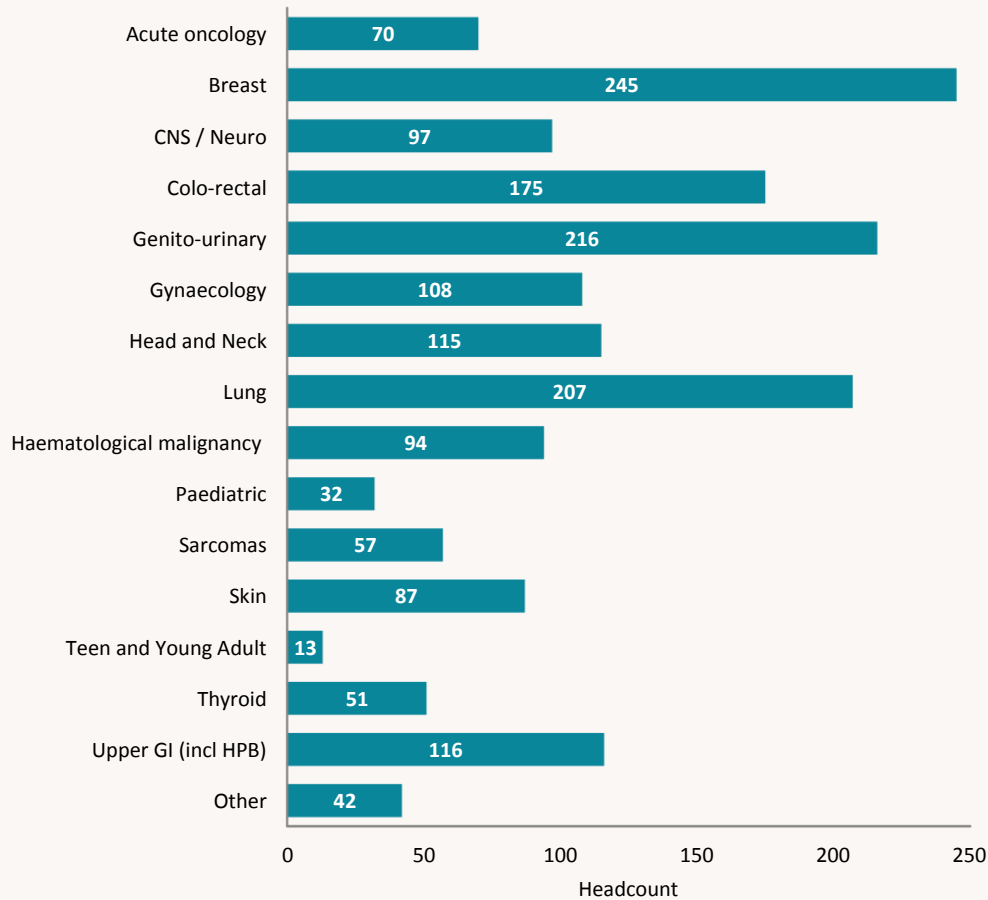
Figure 6. Consultant site specialties (multi-response), UK overall

Table 9 shows the number of tumour site specialties reported against each consultant.

Table 9. Number of site specialties per consultant

Site specialties	Headcount	Percentage
1	129	17%
2	364	49%
3	184	25%
4 or more	72	10%
Total	749	100%

Two-thirds of consultants specialise in one or two tumour sites, as per RCR guidance.⁴ The rapidly emerging evidence base and operational commitments such as multidisciplinary teams (MDTs) and cross-site travelling make it increasingly difficult for those with more site specialties to maintain adequate continuing professional development (CPD) in all areas.

Regional patterns

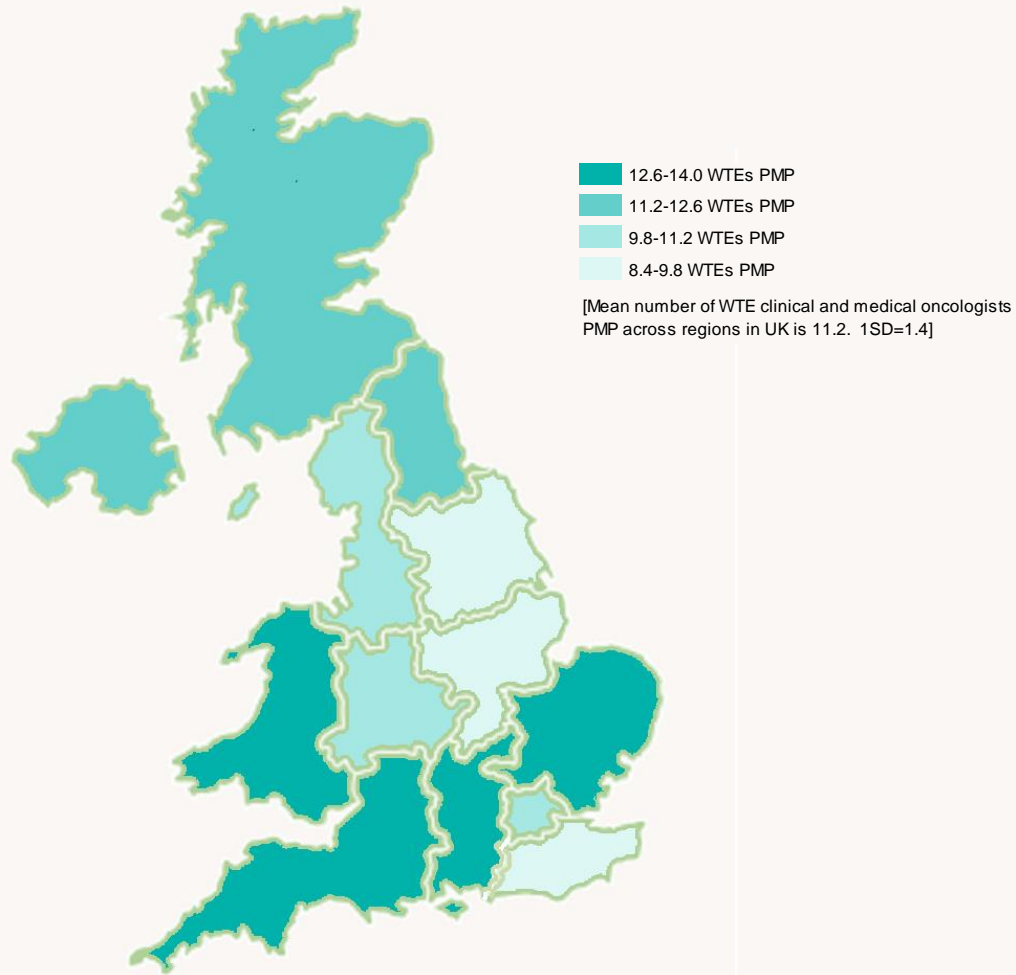
The number of WTE consultant clinical oncologists per million population in the UK as a whole is 10.8, however there is significant variation across the UK. The figure ranges from 9.1 per million in the East Midlands at the lowest end of the scale, to 13.0 in the East of England. These data are shown in Table 10.

Table 10. UK clinical oncology consultant workforce (WTE) PMP, by region and country

Region/country	WTEs	Population ^{1,3}	WTEs PMP
England – East Midlands	40	4,410,612	9.1
England – East	75	5,787,144	13.0
England – London	83	7,832,487	10.6
England – North East	31	2,600,233	12.0
England – North West	74	6,962,848	10.6
England – South Central	52	4,112,460	12.7
England – South East Coast	41	4,347,587	9.4
England – South West	67	5,221,895	12.8
England – West Midlands	54	5,445,991	9.9
England – Yorks & Humber	52	5,289,015	9.8
<i>England total</i>	<i>569</i>	<i>53,865,817</i>	<i>10.6</i>
Northern Ireland	20	1,829,725	11.2
Scotland	62	5,327,700	11.7
Wales	39	3,082,412	12.7
UK total	691	64,105,654	10.8

Figure 7, opposite, shows the ratio of clinical oncologists per million population across the four countries in the UK. (Appendix 3 additionally shows the number of WTE consultant clinical oncologists per million population within the catchment of each individual cancer centre.)

Figure 7. UK clinical oncology consultant workforce (WTE) PMP, by region and country¹⁻³



Cross-site working patterns

The proportion of consultants working cross site is shown in Table 11. More than half of consultants in the UK deliver care at more than one site on a regular basis; over a third (36%) doing so with a split day, travelling to more than one site in a working day on a regular basis. In England, nearly a quarter of consultants are employed at more than one trust. In Wales, more than half of consultants are required to travel to more than one site in a working day on a regular basis.

Table 11. Cross-site working patterns

	England	Northern Ireland	Scotland	Wales	UK total
Consultants	619	22	65	43	749
Employed at more than one trust	24%	0%	0%	5%	20%
Deliver care at more than one site on a regular basis	52%	68%	66%	63%	54%
Required to travel to more than one site in a working day on a regular basis	36%	32%	23%	53%	36%

Attrition

The census gathered data on those leaving the workforce. Eight consultants, equalling 1% of the consultant workforce, left clinical oncology in the UK during 2013. This compares with 20 leaving in 2012 and ten in 2011. Table 12 shows the reasons given for leaving.

Table 12. Workforce attrition, 2013

Attrition type	Count
Retired	7
Resigned from NHS	1
Total	8

Of the eight who left their post in 2013, seven were retirements. The median age at retirement was 60. This is unchanged since 2010. Of the seven, all but one worked on a full-time basis immediately prior to retirement.

The census collects data on who has retired in the previous 12 months. A number of colleagues are 'retiring and resuming'. On tracking the data over the past four years it has been found that no person entered as retired who appears in the following years' returns implying that this question has been interpreted as finally stopping work rather than 'retiring and resuming'. In addition, in the two years prior to stopping work no person has appeared to reduce PAs implying that consultants reduce work more than three years in advance of retirement (if at all).

To gain an understanding of the clinical oncology posts likely to become vacant, each workforce lead was asked to state if any of the consultants in their department were expected to retire in the next 12 months. These data, combined with the known median retirement age of 60, are used as a basis for estimating likely retirements in the next five and ten years – see Table 13 and 14 opposite. A fifth of the consultant workforce is expected to retire in the next five years; a third is expected to retire in the next ten years.

Table 13. Estimated retirements next five and ten years, by region and country

Region/country	Next five years	Next ten years
England – East Midlands	33%	40%
England – East	21%	34%
England – London	20%	36%
England – North East	22%	41%
England – North West	26%	36%
England – South Central	24%	35%
England – South East Coast	9%	33%
England – South West	20%	27%
England – West Midlands	20%	38%
England – Yorks & Humber	16%	33%
Northern Ireland	18%	32%
Scotland	15%	31%
Wales	9%	28%
UK total	20%	34%

In the next ten years, the areas most likely to be impacted by forthcoming retirements are the North East (41% expected to retire) and the East Midlands (40%). In addition, the East Midlands has one of the lowest clinical oncologists WTE PMP. These facts in combination are a cause of potential concern.

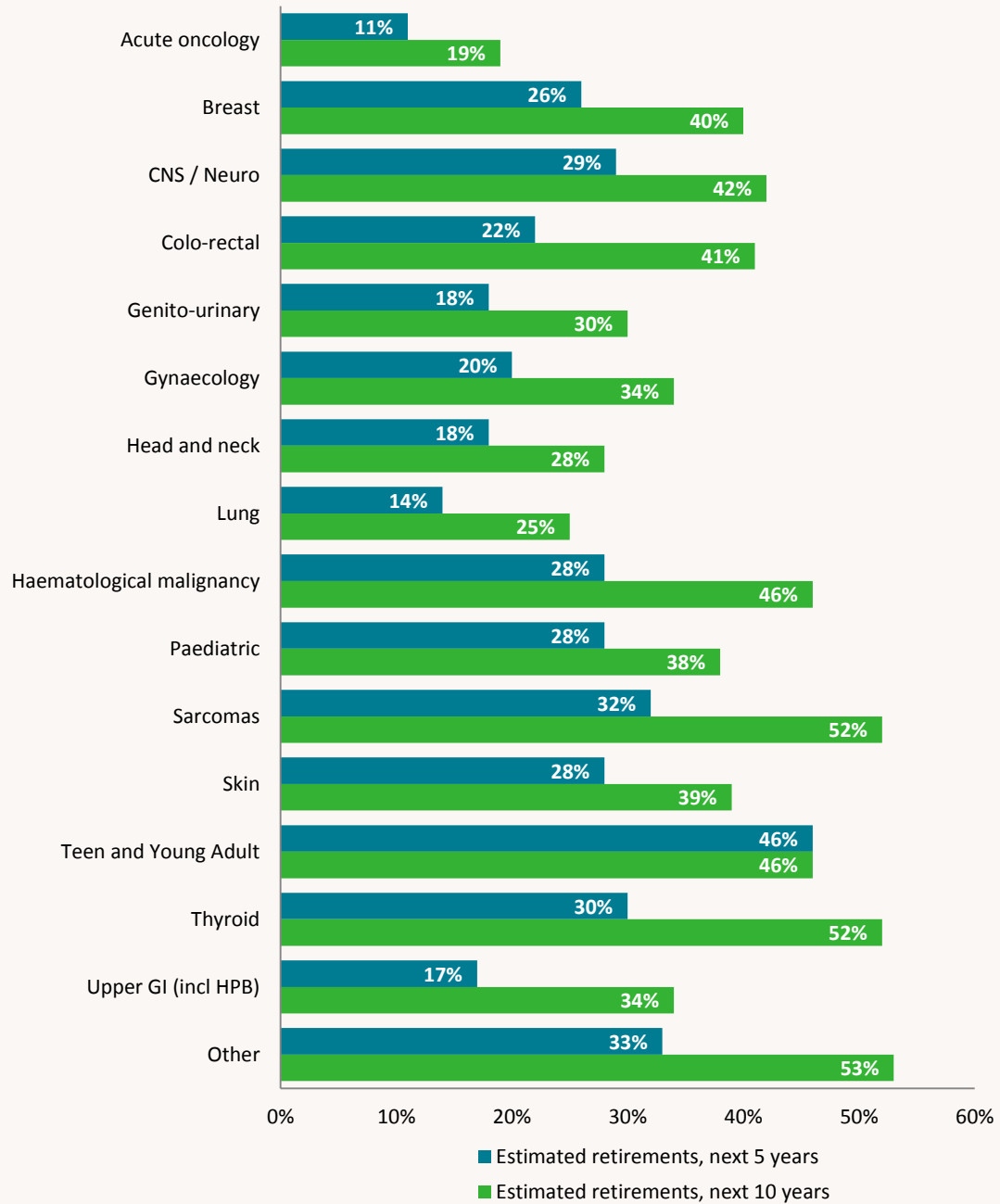
Based on the median retirement age of 60 it is possible to predict the site specialties where there are likely to be future training needs. For example, the census data shows that 46% of the 13 consultants specialising in teen and young adult conditions are predicted to retire in the next five years and 52% of the 51 consultants specialising in sarcomas and thyroid conditions are predicted to retire in the next ten years – see Table 14.

Table 14. Estimated retirements next five and ten years, by site-specialty

	<i>Consultants</i>	<i>Next five years</i>	<i>Next ten years</i>
Acute oncology	70	11%	19%
Breast	245	26%	40%
CNS/Neuro	97	29%	42%
Colo-rectal	175	22%	41%
Genito-urinary	216	18%	30%
Gynaecology	108	20%	34%
Head and neck	115	18%	28%
Lung	207	14%	25%
Haematological malignancy	94	28%	46%
Paediatric	32	28%	38%
Sarcomas	57	32%	52%
Skin	87	28%	39%
Teen and young adult	13	46%	46%
Thyroid	51	30%	52%
Upper GI (including HPB)	116	17%	34%
Other	42	33%	53%

Figure 8 illustrates the data shown in Table 14.

Figure 8. Estimated retirements next five and ten years, by site specialty



Unfilled posts

In addition to consultant clinical oncologists **in post**, the workforce census also captured information on unfilled posts as of 1 October 2013. As the census is a snapshot at a given point in time, other posts may have been appointed to during the remainder of the year.

A total of 33 unfilled consultant posts were identified across the UK clinical oncology workforce as of 1 October 2013. This translates to 4% of all consultant clinical oncology posts unfilled at the census date. Of the unfilled posts, 45% are currently filled by locums.

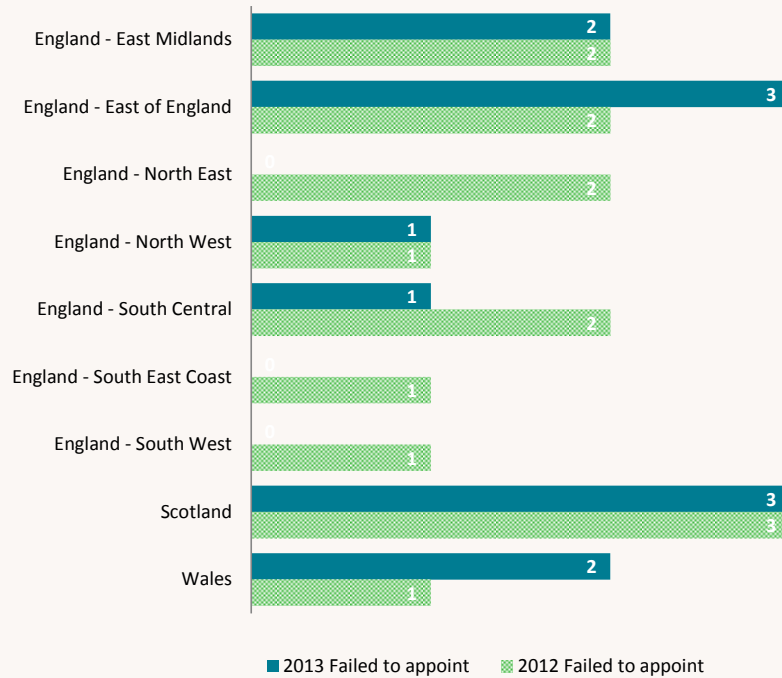
Compared with the previous year's census in 2012, the data suggest that finding suitable candidates to fill vacant posts may be becoming more difficult. In 2012, 29% of unfilled posts were not appointed to. This figure rose to 36% in the 2013 census, with particular difficulties experienced in Scotland, Wales and the East of England. However, the absolute number of posts 'failing to appoint' fell slightly. These data are shown in Table 15 and Figure 9, overleaf.

Table 15. Unfilled posts by region and country, 2013 (and 2012 for comparison)

Region/country	2013 total posts ^a	2013 unfilled posts	2013 failed to appoint ^b	2012 failed to appoint ^b
England – East Midlands	46	4	2	2
England – East of England	89	7	3	2
England – London	94	2	0	0
England – North East	32	0	0	2
England – North West	85	5	1	1
England – South Central	67	4	1	2
England – South East Coast	47	2	0	1
England – South West	70	0	0	1
England – West Midlands	56	0	0	0
England – Yorks & Humber	57	0	0	0
<i>England total</i>	<i>643</i>	<i>24</i>	<i>7</i>	<i>11</i>
Northern Ireland	23	1	0	0
Scotland	71	6	3	3
Wales	45	2	2	1
UK total	782	33	12	15

a. Total substantive posts, including unfilled.

b. 'Failed to appoint' posts have either been advertised with no applicants or interviewed with no suitable 'appointable' applicant.

Figure 9. 'Failed to appoint' by region, 2012 and 2013^a

a. Regions and countries with zero posts failing to appoint in 2012 or 2013 not shown.

5. Routine-hours working

Many services are feeling increased pressure due to lack of capacity. In 2013, for the first time, questions were included in the census about routine length of working days and seven-day working.

The majority of UK cancer centres are routinely open for between 8–10 hours on weekdays for the delivery of radiotherapy and chemotherapy services. The full breakdown of opening hours is shown in Tables 16 and 17. Additional information, overleaf, provided by cancer centres suggests that, in many cases, opening hours may have been extended since the census date of October 2013.

Table 16. Number of hours radiotherapy services are routinely open on weekdays

	England	Northern Ireland	Scotland	Wales	UK total
<8 hours	5	0	3	0	8
8–10 hours	29	1	2	3	35
10+ hours	12	0	0	0	12
Varies depending on weekday	3	0	0	0	3
Not known	1	0	0	0	1
Total	50	1	5	3	59

Table 17. Number of hours chemotherapy services are routinely open on weekdays

	England	Northern Ireland	Scotland	Wales	UK total
<8 hours	12	0	2	1	15
8–10 hours	29	1	2	1	33
10+ hours	4	0	0	1	5
Varies depending on weekday	4	0	1	0	5
Not known	1	0	0	0	1
Total	50	1	5	3	59

Almost a quarter of cancer centres (24%) routinely offer non-emergency radiotherapy on Saturdays, compared with 14% offering non-emergency chemotherapy – see Table 18, overleaf.

Table 18. Proportion of cancer centres routinely offering non-emergency radiotherapy/ chemotherapy on Saturdays

	England	Northern Ireland	Scotland	Wales	UK total
Number of cancer centres	50	1	5	3	59
% routinely offering non-emergency radiotherapy on Saturdays	22%	0%	20%	67%	24%
% routinely offering non-emergency chemotherapy on Saturdays	14%	0%	20%	0%	14%

In addition to the data provided above, the following comments were provided by workforce leads regarding working hours.

- *Chemo day unit constantly overstretched leading to delays in starting chemotherapy. Ad hoc Saturdays are sometimes done to catch up especially after bank holidays. Centre provides a supraregional continuous hyperfractionated accelerated radiotherapy (CHART) service, thus open Saturday/Sunday on clinical grounds.*
- *Hours have been extended in 2014.*
- *Due to equipment replacement and national targets, it has been necessary to work extended days on a planned basis.*
- *Extending radiotherapy or chemotherapy is limited because of the constraints of the private finance initiative (PFI) contract.*
- *Extended hours are generally at times of greatest clinical need but we are scoping extending the working day at present.*
- *Extra days at weekends are sometimes used such as over bank holidays to accommodate patient needs.*
- *In 2013 we implemented Saturday and Sunday working and occasional weekend working at weekends around bank holidays.*
- *Our radiotherapy service is under extreme stress – we run an extended working day and we work as many Saturdays as we need to in addition for breakdowns and bank holidays.*
- *Very variable, dependent on staffing levels and machine breakdown.*
- *We are considering moving to routine treatments being delivered seven days per week.*
- *We are currently planning to offer extended working for routine chemotherapy on Saturdays.*
- *We are starting routine radiotherapy delivery on Saturdays. We are looking at extending the regular working day beyond 8–10 hours.*
- *We do not routinely work Saturday, but have worked more than half over recent months due to capacity and breakdown issues.*
- *No routine chemo at weekends.*
- *We do offer radiotherapy on Saturdays to compensate for some weekends and did run on some Saturdays to cope with capacity.*
- *Will be delivering chemotherapy on Saturdays once pharmacy cover arranged which will then mitigate current capacity issues in department.*
- *Working from 8 am to 8 pm is not really considered extended hours.*
- *Working towards opening chemotherapy unit on weekend.*

6. Conclusion

The 2013 clinical oncology workforce census provides a snapshot of the workforce and, for the first time, service delivery in the UK. The data show several trends, some of which are merely interesting but some of which are a potential cause of anxiety if they play out as expected over the next five to ten years.

The vast majority of consultants continue to deliver a mixture of chemotherapy and radiotherapy, and these data are reinforced by initial releases from the newly established systemic anti-cancer therapy (SACT) dataset.⁵ SPA activity remains close to two PAs, hopefully meaning colleagues have enough time to participate in revalidation. There is a significant national variation in the oncology workforce available to serve the population. There is also significant geographical variation in where the workforce is likely to retire. This information should hopefully be of use both to those managing the service but also to trainees interested in future career prospects.

The consultant workforce continues to expand, but there is an increasing gap between headcount and WTE. This gap looks set to increase given the demographics of our trainees. A significant number of consultant colleagues have job plans either covering higher than the recommended number of tumour sites or with more travelling than the ideal.

The data on routine hours of work demonstrates that there have been significant changes in the past few years in service delivery in many centres. Coupled with the free-text quotes, this indicates a workforce that is working hard to deliver a quality service.

Approved by the Clinical Oncology Faculty Board: 15 September 2014

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Appendix 1. 2013 census completions

Thank you to all the people below for completing the 2013 census – your input is greatly appreciated.

Aberdeen Royal Infirmary, Dr Leslie Samuel
 Addenbrooke's Hospital (Cambridge), Dr Richard Benson
 Beatson West of Scotland Cancer Centre (Glasgow), Dr David Dunlop
 Belfast City Hospital, Dr Seamus McAleer
 Bristol Haematology & Oncology Centre, Dr Matthew Beasley
 Castle Hill Hospital (East Riding of Yorkshire), Dr Rajarshi Roy
 Cheltenham General Hospital, Dr Jo Bowen
 Christie Hospital (Manchester), Dr John Logue
 Clatterbridge Cancer Centre (Wirral), Susan Birch
 Cumberland Infirmary (Carlisle), Mr Jim Methven
 Derriford Hospital (Plymouth), Dr Sarah Pascoe
 Dorset Cancer Centre, Poole Hospital, Dr Maxine Flubacher
 Edinburgh Cancer Centre, Western General Hospital, Dr Sara Erridge/Professor David Cameron
 Essex County Hospital (Colchester), Dr Philip Murray
 Glan Clwyd Hospital (North Wales), Dr Win Soe
 Guy's & St Thomas' Cancer Centre (London), Dr Shahreen Ahmad
 Imperial College Cancer Centre (London), Dr Danielle Power
 Ipswich Hospital, Dr Christopher Scrase
 James Cook University Foundation Hospital (Middlesbrough), Dr Adrian Rathmell
 Kent Oncology Centre (Maidstone & Canterbury), Dr Sharon Beesley
 Leicester Royal Infirmary, Dr David Peel
 Lincoln County Hospital, Dr Miguel Panades
 Mount Vernon Cancer Centre (Middlesex), Dr Mark Harrison
 Musgrove Park Hospital (Taunton), Dr Petra Jankowska
 NCCC, the Freeman Hospital (Newcastle), Dr Ian Pedley
 New Cross Hospital (Wolverhampton), Dr Caroline Brammer
 Ninewells Hospital & Medical School (Dundee), Dr Richard Casasola
 Norfolk and Norwich University Hospital, Dr Thomas Roques
 North Middlesex University Hospital (London), Dr Sian Davies
 Northampton General Hospital, Dr Amanda Bisset
 Nottingham University Hospital, City Hospital Campus, Dr Daniel Saunders
 Oxford Cancer Centre, Churchill Hospital, Oxford, Dr Claire Blesing
 Peterborough City Hospital, Dr Catherine Jephcott
 Portsmouth Oncology Centre, Queen Alexandra's Hospital, Dr Daniel Dubois
 Queen Elizabeth Hospital (Birmingham), Dr Andrea Stevens
 Queen's Hospital, Romford (Essex), Dr Eliot Sims
 Raigmore Hospital (Inverness), Dr David Whillis
 Royal Berkshire Hospital (Reading), Dr James Gildersleve
 Royal Cornwall Hospital (Truro), Dr Toby Talbot
 Royal Derby Hospital, Dr Mojca Persic
 Royal Devon & Exeter Hospital, Dr Elizabeth Toy
 Royal Free Hospital (London), Dr Katharine Pigott
 Royal Marsden Hospital (London), Dr Imogen Locke
 Royal Preston Hospital, Dr Geraldine Skailes
 Royal Shrewsbury Hospital, Dr Sheena Khanduri
 Royal Surrey County Hospital (Guildford), Charlotte Freeman
 Royal Sussex County Hospital (Brighton), Dr Fiona Mckinna
 Royal United Hospital (Bath), Dr Mark Beresford
 Singleton Hospital (Swansea), Dr Delia Pudney
 South Devon Hospital (Torbay), Dr Anna Lydon
 Southampton General Hospital, Dr Andrew Bates
 Southend Hospital, Dr Imtiaz Ahmed
 St Bartholomew's Hospital (London), Dr Paula Wells
 St James's Institute of Oncology (Leeds), Professor David Dodwell
 University College Hospital (London), Dr Katharine Pigott
 University Hospital of North Staffordshire (Stoke), Dr Selvaraj Giridharan
 * University Hospitals, Coventry and Warwickshire
 Velindre Hospital (Cardiff), Dr Tom Crosby
 Weston Park Hospital (Sheffield), Dr Patricia Fisher

* University Hospitals, Coventry and Warwickshire did not complete the 2013 census. 2012 data submitted by this centre was used in place of 2013 data.

Appendix 2. 2013 census questions

Part 1. Your organisation details

Cancer centre name

Region/country

Workforce lead full name

Part 2. Staff details – clinical oncology

Full name

Grade

- Consultant
- Associate specialist
- Clinical assistant
- Specialty doctor
- Trust grade
- Other

Contracted DCC PAs (Consultants only)

Contracted SPA PAs (Consultants only)

Contracted Total PAs (Consultants only)

SPAs allocated to research?

Full-time/part-time (All grades)

Type of post

- NHS
- Academic
- NHS and academic

Predominant workload

- Chemotherapy
- Radiotherapy
- Balance of both

Site specialties

- Option list

Employed at multiple trusts

- Yes/no

Cared at multiple sites

- Yes/no

Travels to multiple sites

- Yes/no

Expected to retire by 1 October 2014

- Yes/no

Left since 1 October 2012

- Yes/no

Reason for leaving

- Moved to another NHS post
- Resigned from the NHS
- Retired from the NHS
- Died
- Other

Part 3. Staff details – medical oncology

Consultant medical oncologists

Full name

Grade

- Consultant
- Associate specialist
- Clinical assistant
- Specialty doctor
- Trust grade
- Other

Full-time/part-time

Type of post

- NHS
- Academic
- NHS and academic

Site specialties

- Option list

Left since 1 October 2012

- Yes/no

Part 4. Unfilled posts

Unfilled post status

- Advertised but failed to appoint
- Appointed but not yet taken up
- Funded but not yet appointed

Grade

Contracted total PAs

Full-time/part-time

Specialty

- Clinical oncology
- Medical oncology

Site specialties

- Option list

Locum filled?

- Yes/no

Part 5. Routine-hours working

No. weekdays radiotherapy service currently routinely open

Routinely offer non-emergency radiotherapy on Saturdays?

No. weekdays chemo- service currently routinely open

Routinely offer non-emergency chemo on Saturdays?

Comments

Appendix 3. Clinical oncologists by UK cancer centre

Cancer centre	Consultant WTEs	Catchment population ⁶	Consultant WTEs PMCP
Aberdeen Royal Infirmary	5.8	606,402	9.6
Addenbrooke's Hospital (Cambridge)	20.9	1,408,835	14.8
Beatson West of Scotland Cancer Centre (Glasgow)	29.0	2,526,190	11.5
Belfast City Hospital	20.4	1,823,600	11.2
Bristol Haematology & Oncology Centre	12.4	1,069,735	11.6
Castle Hill Hospital (East Riding of Yorkshire)	11.0	1,016,331	10.8
Cheltenham General Hospital	11.0	1,079,211	10.2
Christie Hospital (Manchester)	32.2	3,250,272	9.9
Clatterbridge Cancer Centre (Wirral)	22.9	2,219,372	10.3
Cumberland Infirmary (Carlisle)	3.0	300,549	10.0
Derriford Hospital (Plymouth)	8.0	453,046	17.7
Dorset Cancer Centre, Poole Hospital	6.7	713,802	9.4
Edinburgh Cancer Centre, Western General Hospital	17.3	1,371,736	12.6
Essex County Hospital (Colchester)	9.3	699,489	13.3
Glan Clwyd Hospital (North Wales)	6.0	700,000	8.6
Guy's & St Thomas' Cancer Centre (London)	16.2	1,695,277	9.6
Imperial College Cancer Centre (London)	11.1	1,172,283	9.4
Ipswich Hospital	6.0	352,977	17.0
James Cook University Foundation Hospital (Middlesbrough)	12.0	1,011,710	11.9
Kent Oncology Centre (Maidstone & Canterbury)	17.9	1,776,720	10.0
Leicester Royal Infirmary	7.3	915,820	8.0
Lincoln County Hospital	7.0	564,952	12.4
Mount Vernon Cancer Centre (Middlesex)	20.3	1,937,737	10.5
Musgrove Park Hospital (Taunton)	6.3	384,846	16.4
NCCC, the Freeman Hospital (Newcastle)	19.1	1,755,837	10.9
New Cross Hospital (Wolverhampton)	7.6	847,433	8.9
Ninewells Hospital & Medical School (Dundee)	6.4	500,000	12.7
Norfolk and Norwich University Hospital	8.0	842,360	9.4
North Middlesex University Hospital (London)	6.6	573,653	11.5
Northampton General Hospital	8.0	855,325	9.4
Nottingham University Hospital, City Hospital Campus	10.9	1,101,230	9.9
Oxford Cancer Centre, Churchill Hospital, Oxford	21.2	1,334,512	15.9
Peterborough City Hospital	2.5	268,508	9.3
Portsmouth Oncology Centre, Queen Alexandra's Hospital	8.0	787,346	10.1
Queen Elizabeth Hospital (Birmingham)	14.7	1,931,339	7.6
Queen's Hospital, Romford (Essex)	7.9	586,746	13.5
Raigmore Hospital (Inverness)	4.0	353,204	11.3
Royal Berkshire Hospital (Reading)	7.6	715,497	10.6
Royal Cornwall Hospital (Truro)	5.0	403,014	12.4
Royal Derby Hospital	7.0	704,817	9.9
Royal Devon & Exeter Hospital	10.3	572,489	18.0
Royal Free Hospital (London)	4.4	384,387	11.3
Royal Marsden Hospital (London)	19.4	2,135,001	9.1
Royal Preston Hospital	15.5	1,443,305	10.7
Royal Shrewsbury Hospital	8.0	452,790	17.7
Royal Surrey County Hospital (Guildford)	11.5	1,245,057	9.2
Royal Sussex County Hospital (Brighton)	11.7	923,398	12.6
Royal United Hospital (Bath)	5.4	431,841	12.5
Singleton Hospital (Swansea)	10.5	900,000	11.6
South Devon Hospital (Torbay)	1.8	243,574	7.2
Southampton General Hospital	15.7	1,265,099	12.4
Southend Hospital	8.3	660,285	12.6
St Bartholomew's Hospital (London)	6.0	1,078,722	5.5
St James's Institute of Oncology (Leeds)	24.8	2,800,766	8.8
University College Hospital (London)	11.6	868,771	13.4
University Hospital of North Staffordshire (Stoke)	10.0	657,233	15.2
University Hospitals, Coventry and Warwickshire	13.8	1,037,004	13.3
Velindre Hospital (Cardiff)	22.6	1,500,000	15.1
Weston Park Hospital (Sheffield)	16.0	1,759,015	9.1

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