

**Clinical
Oncology**

The Royal College of Radiologists

Clinical oncology census report

2021

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Introduction

Oncologists are the cornerstone of cancer care; clinical oncologists (CO) are specialist doctors who treat cancers using non-surgical treatments including radiotherapy and chemotherapy.

Radiotherapy, a component of 50% of cancer treatments and projected to rise to 60% by 2025, can only be prescribed by clinical oncologists. They therefore sit at the heart of cancer treatment. Good patient outcomes, clearing the cancer backlog, and improving cancer care, all depend on the clinical oncology workforce; their work is time-sensitive and critical to a cancer patient's survival.

For over 10 years, The Royal College of Radiologists (RCR) has collected key CO workforce data and insight from cancer centre heads of service, the clinical leads in the 60 UK cancer centres.

These are used to identify trends, issues and make evidence-based recommendations. With a 100% response rate, the results reflect the workforce as it stood on 1 October 2021.

Almost everyone has been affected by cancer, which can devastate the lives of patients and their families. To save more lives and address years of underfunding in clinical oncology, all four UK nations must focus efforts on creating a world-leading oncology workforce which not only improves cancer care but also implements cutting edge innovations.

Foreword

It is a great privilege of my role to oversee the annual RCR workforce census. This is a remarkable piece of work, testament to the dedicated RCR staff who work so hard to compile the census and the heads of service who return the data. Once again, we have achieved an 100% return rate, giving a thorough, accurate and detailed snapshot of the state of the clinical oncology workforce across the UK.

The clinical oncology workforce is central to cancer care, and key to reducing the cancer backlog as well as enabling the 'War on Cancer' that was declared by the Health Secretary in England. Yet the situation in cancer centres across the country, as demonstrated in the 2021 clinical oncology census, shows a very concerning picture.

In the period covering 2021, 67% of cancer centre heads of service were concerned about workforce shortages affecting the quality of patient care. This has leapt from 52% in the previous year, showing that an already bad situation is deteriorating further.

Currently, the CO workforce is short of 189 consultants – a significant number and the same amount as the previous year, in spite of huge increases in activity level, resulting in serious concerns over the quality of care provided to cancer patients.

The national picture masks an even more challenging situation in many regions.

There are areas, such as London, which are better served with 5.4 CO consultants per 100,000 older population. In contrast, there are areas such as the East Midlands and North and West Wales where these figures fall to 2.9 and 1.5 respectively.

“
In 2021, 67% of cancer centre heads of service were concerned about workforce shortages affecting the quality of patient care.



If this wasn't alarming enough, the situation may get worse still. Every single head of service, the clinical leaders of cancer centres, told us they have concerns about workforce morale, stress and burnout amongst their staff, further threatening workforce numbers as doctors are tempted to leave the profession. At the same time, activity is expected to soar further with one cancer charity estimating that there were 50,000 missed cancer diagnoses during the pandemic. Missed diagnoses often result in longer and more complex treatment plans, or, worse, the cancer being beyond curative treatment.

The funding for extra training places allocated in the 2021 Comprehensive Spending Review was welcome and

appreciated. However, it is not enough to tackle the shortfall. The situation is bleak and the warning lights on the dashboard are flashing red; action is required immediately. The RCR is calling for sustained investment in training places to deliver a long-term solution to this workforce crisis, as well as a plan for international recruitment and support with retaining doctors who are thinking of leaving. Without urgent action, patient care will suffer along with patient outcomes. ■



Nicky Thorp,
Medical Director for
Professional Practice,
Clinical Oncology

Key findings

50,000

Patients missed cancer diagnoses due to care backlog during the pandemic



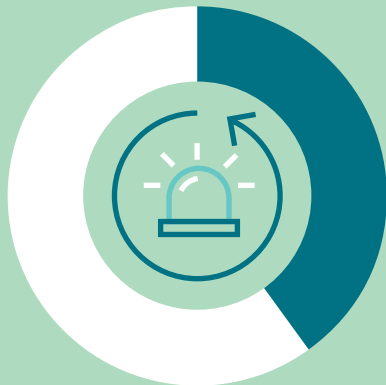
67%

of heads of service are worried that shortages are affecting the quality of patient care



92%

of heads of service are concerned about site specialty shortages



Only **27%**

of cancer centres have a dedicated AOS assessment or admissions unit (Mon to Fri)



West Wales has the lowest ratio of specialists at

1.4
per 100k older population



88%

of heads of service are concerned about delayed treatment for patients

Consultant oncologist workforce shortfall

17%



Current
2021

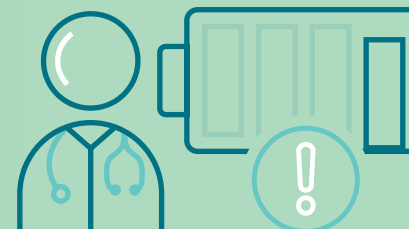
26%



Forecasted
2026

100%

of heads of service are concerned about workforce morale, stress and burnout



1. The backlog of care from the pandemic has resulted in 50,000 patients missing cancer diagnoses and a 12% fall in radiotherapy treatment courses which are vital to cancer patients. Cancer targets were also missed, with only 67% of patients treated within two months of urgent GP referral.
2. Despite the pandemic related drop in patients, the UK continued to have a 17% shortfall of clinical oncologists (CO) in 2021, which translates to 189 clinical oncologists (WTE). Without investment in the CO workforce, the shortfall is estimated to increase to 26% (381) by 2026.
3. In 2021, 67% of cancer centre heads of service were concerned about workforce shortages affecting the quality of patient care compared with 52% in 2020.
4. 88% of cancer centre heads of service say they are concerned about delayed treatment for patients at their centre.
5. 92% of heads of service are concerned about shortages in site specialities at their cancer centre.
6. Only 27% of cancer centres had a dedicated on-site AOS consultant and 35% had an on-call consultant. meaning, acute cancer care across parts of the UK does not meet safe levels.
7. National shortages hide the disparities between oncology numbers around the country. Whilst London has the highest ratio of CO consultants of 5.4 per 100,000 older population, in the East Midlands and North and West Wales these figures fall to 2.9 and 1.5 respectively.
8. 100% of cancer centre heads of service told us they were concerned about workforce morale, stress and burnout amongst their staff, further threatening workforce numbers as doctors are tempted to leave the profession.
9. Whilst cancer incidences are only going to increase, with one in two of us having cancer in our lifetimes, growth of the CO workforce has remained minimal at 3% per annum since 2016.
10. There are now 943 CO whole-time equivalents (WTE) delivering and improving cancer care in the UK, only 30 more in 2021 than 2020.

Treading water

As in 2020, the UK continued to have a 17% shortfall in the clinical oncology (CO) workforce in 2021, meaning the UK is 189 short of the CO consultants needed to provide lifesaving cancer care.¹ Despite recent additional training numbers, without further workforce investment the shortfall is estimated to be 26% by 2026.

This continued shortfall raises concerns that CO workforce growth has been treading water; over the past five years growth has been nominal at around 3% per annum. This is in contrast to the growth of other specialties, such as emergency medicine, which grew 7% over the same period. It is very worrying that one of the largest dedicated cancer treating specialties has grown at effectively less than half that.² The small growth that has occurred means the clinical oncology workforce (WTE) has grown from 913 in 2020 to 943 in 2021, this represents just 30 CO consultants. Similarly, there was only an increase of eight SAS-grade doctors in 2021 (these are doctors with at least four years of postgraduate training, two of which are in a relevant specialty).

Whilst any increase in oncology specialists is welcome, the above is not enough to keep up with increasing demand due to demographic changes as well as the backlog of care caused by COVID-19. Even before the pandemic there was high demand for oncology treatments; nearly 50% of all cancer patients receive radiotherapy as part of their treatment and 40% receive chemotherapy.³

It is estimated that the percentage of cancer patients needing radiotherapy as part of their treatment will rise from 50% to 60% by 2025.⁴ Radiotherapy is an effective treatment that can cure and relieve suffering, it is also substantially cheaper per person compared to many drug treatments.⁵ But if the UK is to experience the full benefits and efficiencies of clinical oncology treatment, we need to have the latest equipment across all 60 cancer centres. Up-to-date equipment plays a vital role in helping treat patients such as more targeted radiotherapy kit which can reduce damage to surrounding areas of a cancer. Demand for oncology will increase in the next ten years because of demographic changes; Cancer Research UK and others indicate that half of cancers occur in the over 70s and 90% are in the over 50s.⁶ By 2030, the forecast number of people aged 65+ will grow to 22% of the UK population, putting huge strain on oncology services.⁷

COVID-19 has had a devastating impact on cancer diagnosis and treatment. The cancer charity Macmillan estimate there were 50,000 missed cancer diagnoses during the pandemic.⁸

A comparison of 2019/20 to 2020/21's radiotherapy episode figures demonstrates a strong correlation between the missed diagnoses and reduced treatment episode figures.⁹

December 2021's figures showed that the 62-day treatment target was still being missed, with only 67% of patients treated within the target timeframe.¹⁰ One of the responding heads of service told us that "new patients are waiting four weeks plus to see an oncologist". Furthermore, for December's figures, it was estimated cancer services in England would have to work at 110% capacity for 16 months just to clear the backlog.¹¹

These missed targets and persistent backlogs are not just figures. Each delay and missed target can increase time for treatment, leading to a higher probability of side-effects going unmanaged and a greater likelihood of a cancer becoming incurable. All resulting in a devastating impact on patients and their loved ones. For doctors, delays and missed diagnoses mean increased workload

and stress to keep up with demand, along with the stress and emotional burnout associated with poor patient outcomes. Considering the above, it is no surprise that our census found an increasingly high level of concern among heads of service about workforce shortages affecting the quality of patient care as it jumped from 52% in 2020 to 67% in 2021. ▶

“ Each delay and missed target can increase time for treatment, leading to a higher probability of side-effects going unmanaged and a greater likelihood of a cancer becoming incurable. All resulting in a devastating impact on patients and their families.

Increase in heads of service concerned about workforce shortages affecting the quality of patient care



52%

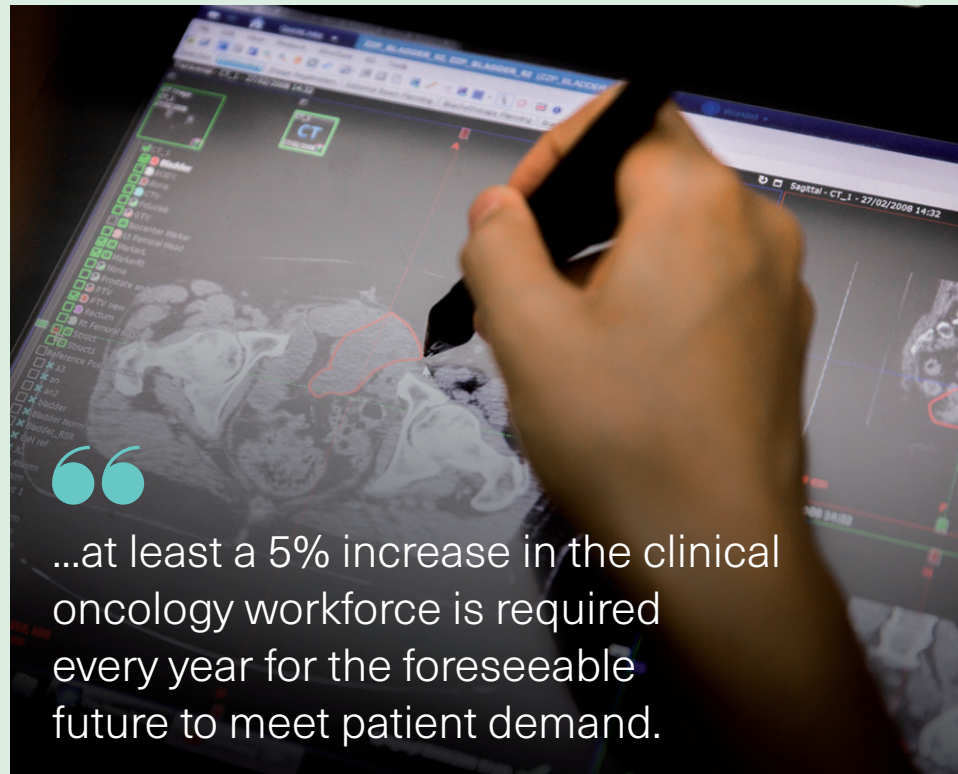
2020

67%

2021

However, the picture is likely to be considerably worse than these figures suggest – as one clinical director told us: *“While there are no vacancies, this is because there is no funding for posts which are needed due to increased workload...”*. There have been welcome announcements regarding additional clinical oncology trainees in England, with 50 additional places in both 2020 and 2021. Meanwhile in Wales, they are funding an additional three clinical oncologists every year for the next five years. Scotland and Northern Ireland have not announced any additional trainee places.¹² We know from our 2021 research that long-term investment in

the clinical oncology workforce creates a more sustainable profession; the cost of extending the 50 additional places in England each year until 2030 is £76 million more than the alternative of increasing overseas recruitment and plugging gaps with other short term fixes.¹³ An increased investment, but a drop in the ocean compared to overall healthcare workforce spending. Whilst all increases are welcome, at least a 5% increase in the clinical oncology workforce is required every year for the foreseeable future to meet patient demand. Without this increase, any strategy to tackle cancer or bring down the backlog simply cannot work. ■

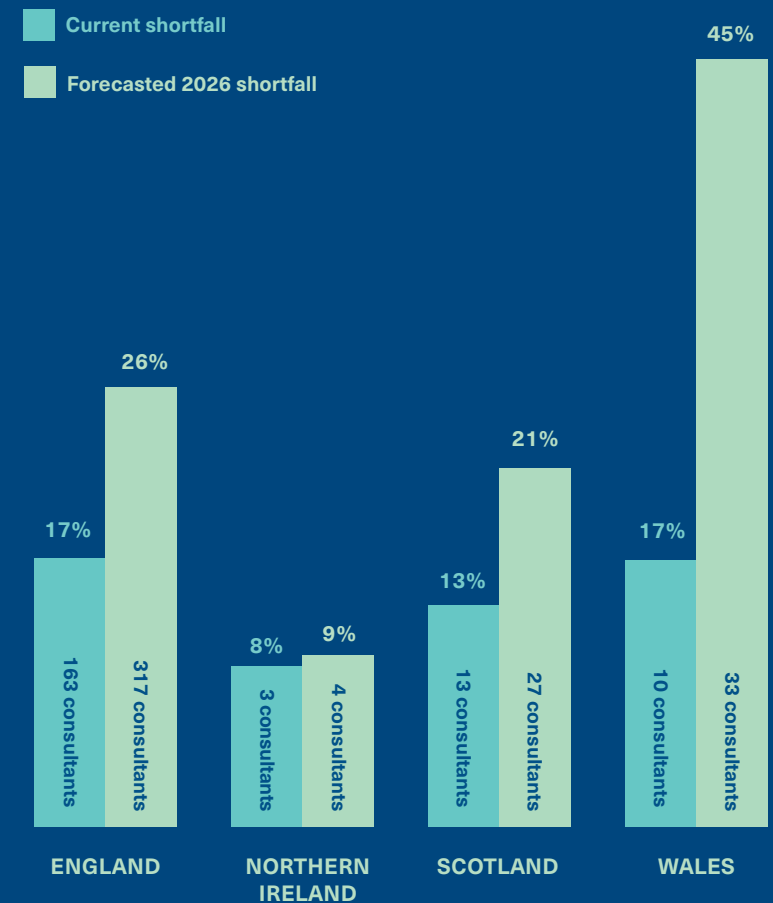


To address the current and future shortfall the RCR recommends:



1

All four nations must develop fully funded long-term workforce plans for clinical oncology. Over the next five years they must begin funding additional training places to address the forecasted shortfall of 381 WTE by 2026. Broken down across the four countries this is:



Threats to patient care

Workforce shortages and wider pressures are impacting patients and their care, with a staggering 88% of cancer centre heads of service saying they are concerned about delayed treatment for patients at their centre.

A global study found that a treatment delay of four weeks is associated with a 6–13% increase in the risk of death, and delays of up to twelve weeks only further increase this risk.¹⁴ These damning figures are set against an already challenging landscape – in 2019 the Organisation for Economic Co-operation and Development (OECD) found that the UK's cancer mortality rate was 13% higher

than the OECD average and when compared to the United States it is 21% higher.¹⁵ The Health and Social Care Select Committee (HSCC) cited a '*lack of serious effort...to tackle gaps in the cancer workforce*'.¹⁶ This is a key issue impacting survival rates; quite simply, the clinical oncology workforce is critical. Drilling into these figures, we find that a startling 92% of heads of service

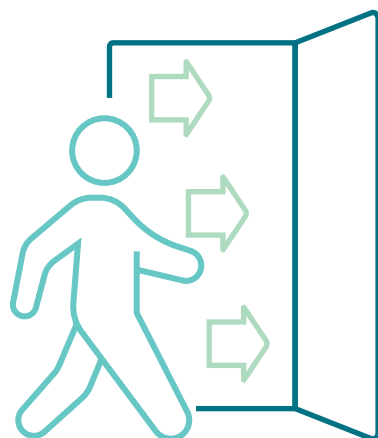
Within the next 10 years:

46% of breast COs

36% of paediatric COs

32% of lung COs

are due to retire.



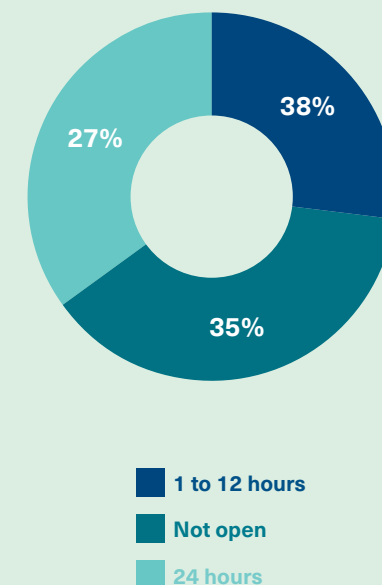
are concerned about shortages in site-specialities (specific area of the body e.g. breast, lung) expertise at their cancer centre. Having expert staff and specialist knowledge to treat all forms of cancer improves cancer care. Yet many site-specialities are struggling: there has been no growth in paediatric CO consultant headcount since 2016; breast and lung site specialists have increased by only one and four respectively in the same period. Very worryingly, a third of paediatric specialists, 46% of breast and a third of lung are all set to retire in the next ten years. With breast and lung cancer being two of the most common cancers in the UK, this is jeopardising patient access to expert cancer specialists.¹⁷ Which may only get worse if screening programmes are rolled out further to support targets around the early detection of cancer.

Another area of concern is Acute Oncology Services (AOS), which provide multidisciplinary clinical expertise to support the care of acutely unwell cancer patients, helping to reduce the burden on accident and emergency (A&E) staff and departments. AOS is a critical area of care which works to ensure cancer patients receive specialised treatment early on and plays a role in reducing patients' time in hospital or avoiding being admitted altogether, which in turn saves money and bed capacity.

Unfortunately, 35% of cancer centres in the UK do not have a dedicated AOS assessment or admissions unit. Furthermore, only 27% of centres offer AOS 24/7, meaning that acute cancer patients in other centres either don't have AOS at all or must hope their need for care aligns with the opening hours of the service.

Many try to mitigate the lack of a 24/7 service by having a telephone based advice service. Indeed, 100% of centres use one, but this is not the same level of care as having dedicated staff on-site. In terms of actual consultants, 27% had a dedicated on-site AOS consultant and 35% have an on-call consultant. These AOS figures mean that acute cancer care across parts of the UK does not meet safe levels which are there to ensure patients receive the timely treatment they deserve. Without a greater number of oncology consultants who can help provide this service, we will not see improvement. ▶

Opening hours for acute oncology assessment/admissions units (Mon–Fri)





“Oncologists are now working to tackle the backlog of care that’s built up, meaning service improvements are taking a backseat

Advances in patient treatment and the implementation of new methods, innovative pathways and new technologies have always been an integral part of patient care and improving outcomes. However, this year 98% of heads of service told us there is insufficient time for clinical trial recruitment and 100% told us they are concerned there is not enough time for embedding technological advances.

A lack of time to implement service improvements and new treatments has a profound effect on patient outcomes. This is because doctors and other clinicians need time in their day to carry out research, innovate within their hospitals and specialties and implement improvements. Without the time to consider such things as speeding up patient pathways, the patient experience is worse and risks losing out on improved care and the lack of better processes prevent the

doctor from treating more patients in the same amount of time. As cancer treatment is so time sensitive, this slowing down of the process of improvement has a large impact. New treatments have continued to be reviewed and approved for cancer by regulators such as NICE (National Institute for Health and Care Excellence) throughout the pandemic as they were working remotely. However, oncologists are now working to tackle the backlog of care that has built up, meaning service improvements are taking a backseat.

To ensure efficient patient pathways, address concerns about delayed patient treatment, reduce shortages in site-specialities and provide improved Acute Oncology Services, the current 3% annual growth rate in the oncology workforce would need to increase to at least 5% per annum for the foreseeable future. ■

To improve patient care and prevent life threatening delays, the RCR recommends:



1

All four nations must develop fully funded, long-term plans for the clinical oncology workforce, increasing it from 3% to at least 5% per annum.

2

There should be:

- Defined national frameworks for AOS to support quality assurance.
- Departmental governance processes (including reviews of outcomes and critical events) to ensure high standards.
- Formalised AOS roles with dedicated time to lead on service development in job plans.¹⁸

Regional disparities

There have long been concerns about a postcode lottery and inequalities in our health care system. For the cancer treatment workforce, this concern seems to be a reality.

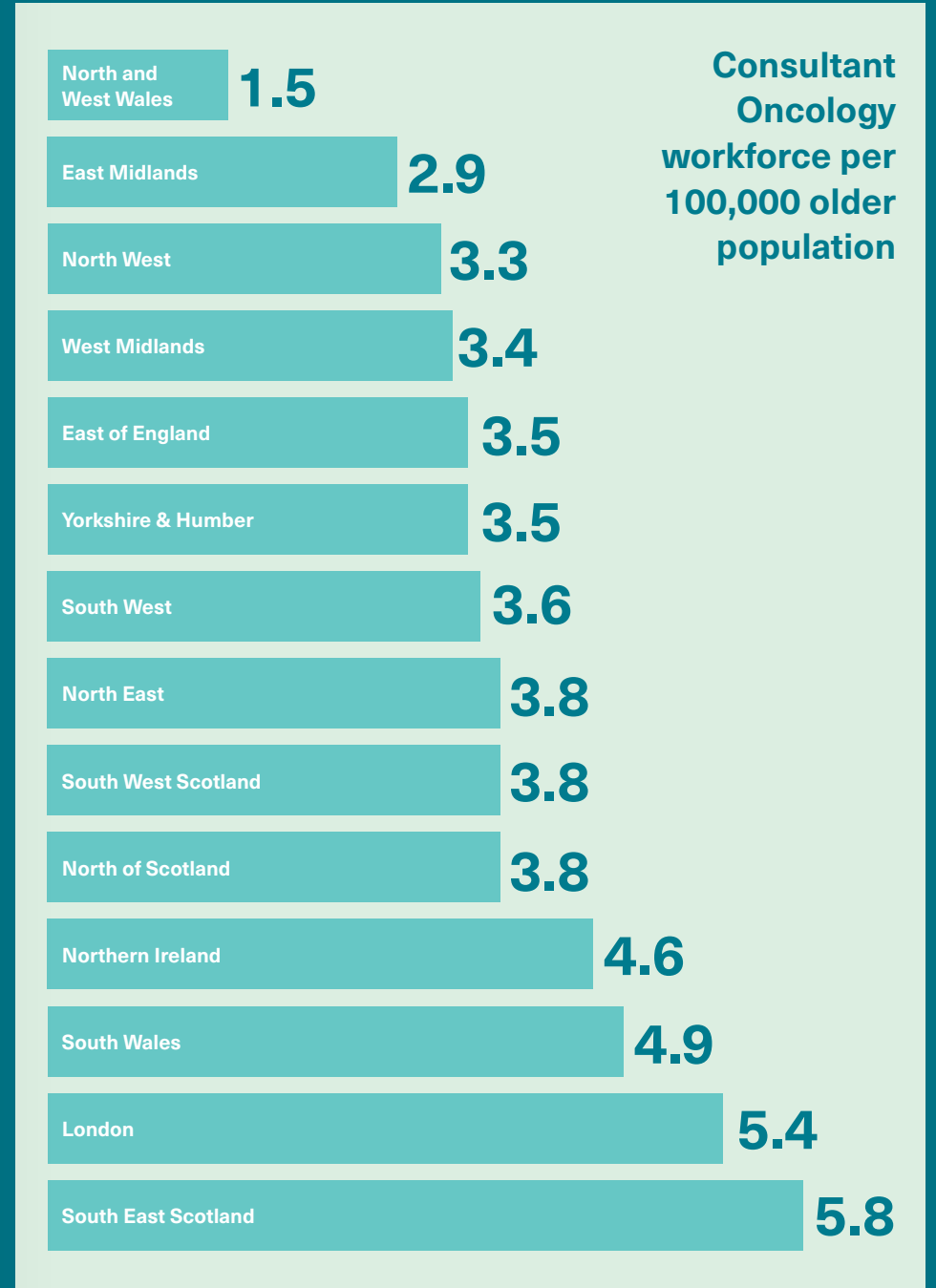
In London, census data does not show any shortfall of WTE clinical oncologists. In stark comparison, North and West Wales has a 54% shortfall and the East Midlands's has a 28% shortfall. The same picture can also be seen when we look at clinical oncologists per 100,000 older population.¹⁹ London is one of the most well-served regions with 5.4 clinical oncologists per 100,000. In contrast, it is once again North and West Wales and the East Midlands that lag far behind the capital with 1.5 and 2.9 respectively. It is not just oncology where this divide is clear. It has been found that London has twice as many doctors specialising in geriatric medicine than in any other English region, despite having the lowest number of over-65s.²⁰

It must be noted that London is home to some of the UK's leading cancer centres and multiple teaching hospitals. Despite this, the figures show there are clear inequalities between the UK's regions' ability to deliver cancer care. These inequalities mean that oncologists in certain regions, such as the East Midlands and North and West Wales, are under more strain to fill gaps in the workforce.

Some cancer centres are turning to locums and short-term agreements to plug holes, one Head of Service told us; *"Other cancer centres in the region have been supplying emergency cover primarily through remote consultations and virtual consultations"*. Workarounds such as these show the dedication that the oncology workforce has towards delivering patient care, but they aren't a long-term solution to the concerning regional disparities. ▶



Each delay and missed target can increase time for treatment, higher probability of side-effects going unmanaged and a greater likelihood of a cancer becoming incurable.



The census figures also show that there are difficulties in recruiting to certain areas of the UK. In England, the South East, South West and Yorkshire and Humber all had high numbers of vacancies at 25, 16 and 11 respectively. The East Midlands and the East of England have very high proportions of vacancies unfilled for over a year with both at 75%. The North East and North West of England were also high with 52% and 43% respectively.

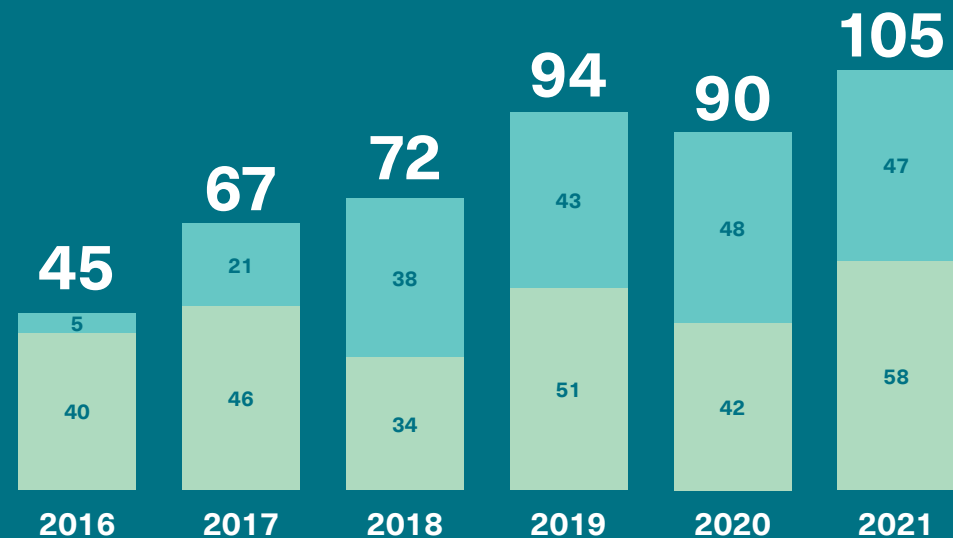
The figures show the regions have different issues in terms of vacancies, but the reality is that every vacancy in the UK is wasted potential in that region's cancer centre. This is because the funding is available to fund a clinical oncologist to deliver patient care, but unfortunately there is no one to take up the opportunity.

Cancer centres are trying to fill vacancies but are hindered by a lack of appropriate candidates, caused by not enough trainees and the slow international recruitment process. One Head of Service commented that *"Multiple posts are needed but [the] Registrars [are] not yet at a point in training to apply"*. Whilst this is an issue where a longer-term strategy is needed to address persistent vacancies, a strong pipeline of trainees to all regions of the UK would help address the issue.

The unequal playing field in cancer care means there are patients in some regions who may not receive the specialised tailored care they need, which in turn can affect mortality rates and as many of the comments we've received from heads of service show, only increases pressure on oncologists. ■

Number of vacancies

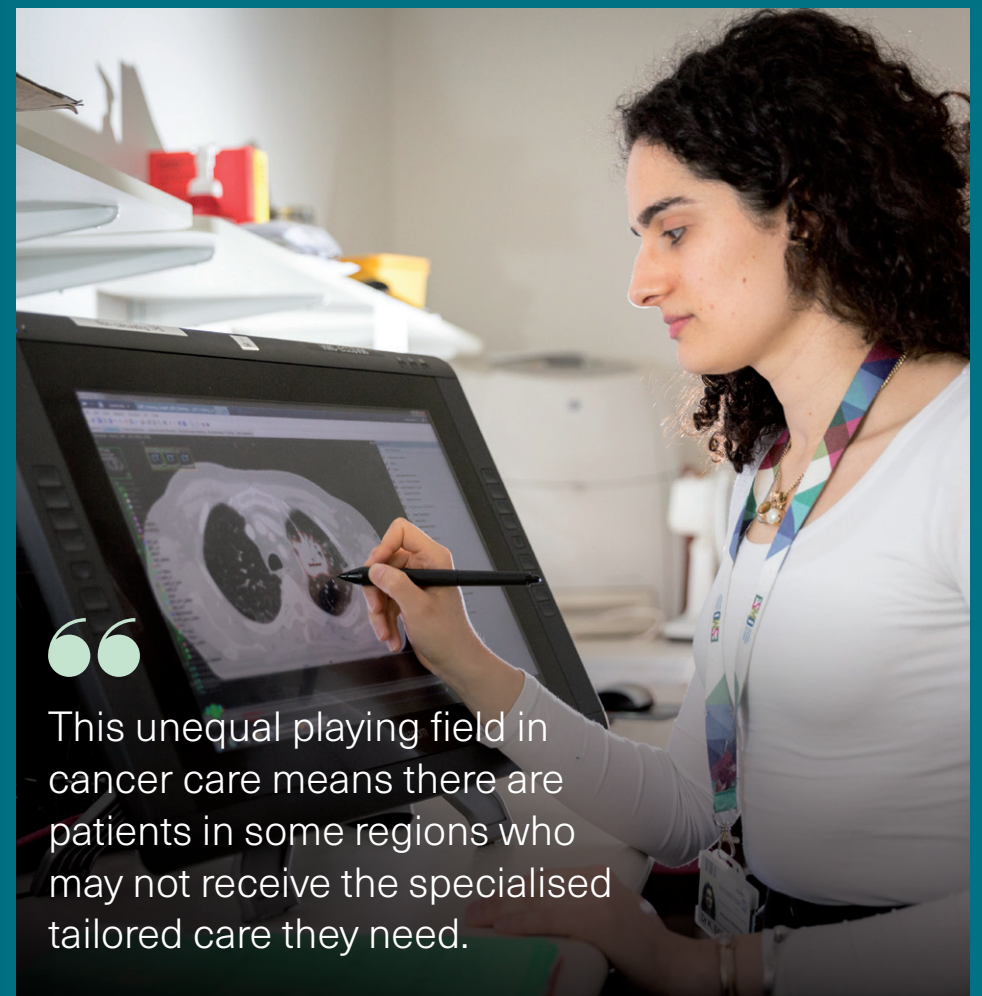
■ 0 to 11 months ■ 12 months or more



To address regional disparities, the RCR recommends:



- 1 That all four nations and their respective health education bodies must ensure funding supports regional recruitment and that they address regional disparities in long-term funding strategies.



“ This unequal playing field in cancer care means there are patients in some regions who may not receive the specialised tailored care they need.

Demoralised workforce

Stress and burnout are perhaps some of the biggest challenges facing UK cancer centres. A staggering 100% of cancer centre heads of service told us they were concerned about workforce morale, stress and burnout, and 90% of these were highly or moderately concerned.

As one head of service told us “*Pressures are felt in most, if not all, site-specialty areas, and there is some fear about the future, contributing to low morale and planned early retirements*”. Another told us: “*Recent example of a colleague experiencing burnout and needing to go off sick for 3 months. The complete inability to cover his full clinical workload meant patients in pre-existing clinics having to be put on a waiting list while a locum is sought*”. Doctor representative bodies such as the British Medical Association (BMA) have long raised similar concerns about stress and burnout, but in 2021 a survey of their members found that 25% of those surveyed were considering a career break and 21% said they were considering leaving the NHS altogether.²¹

The sector has made strides towards improving the mental health and wellbeing of the health and social care workforce in recent years, indeed NHS England

launched its People Plan in 2020 with the other devolved nations following suit. However, as we can see from the sheer level of concern about stress and burnout within the oncology workforce, this work is not being felt on the ground.



Recent example of a colleague experiencing burnout and needing to go off sick for 3 months. The complete inability to cover his full clinical workload meant patients in pre-existing clinics having to be put on a waiting list while a locum is sought.

It is also the case that workstreams to support doctors and staff have been affected by the pandemic and not received the attention they deserve. If we are to tackle stress and burnout, we must reinvigorate these efforts. However, it is hard to see any initiatives making real impact while the underlying issues – overwork due to rising demand and the workforce crisis – remain unresolved. Cancer centre heads of service have also told us that clinical oncologists do not have enough time for ‘Supporting Professional

Activities’ (SPA), indeed 25% were short of the recommended time in 2021, this is much higher than 2016’s 17%.²² SPAs are essential to a doctors working life as it is time spent training the next generation of COs and others. SPA activities contribute to improved patient care, audit and quality improvement and appraisal activities. A strong pipeline of trainees entering clinical oncology will be key to alleviating stress and burnout in the longer term, but in the short term, doctors need to be listened to, supported and offered flexibility. ■

To address issues around staff morale, stress and burnout the RCR recommends:



1

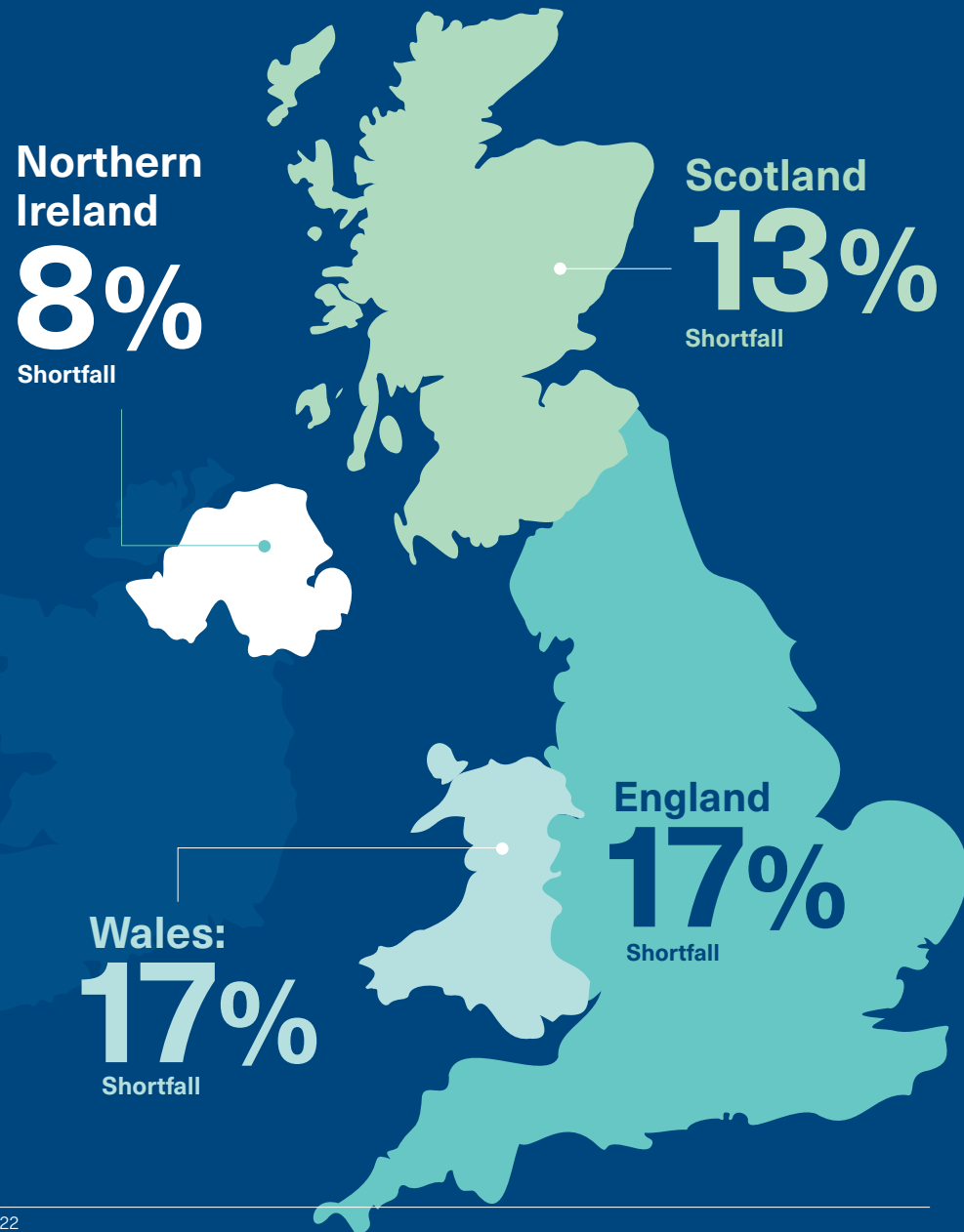
All trusts and health boards increase time available in work plans for service improvements. Guidance in the model contract states full-time consultants should have 2.5 Supporting Professional Activities (10 hours) per week, the bare minimum needed is 1.5. This allows sufficient time for all vital supporting professional activities, including service improvements.²³

2

Enact the RCR’s ‘Care is not just for the patient’ recommendations, most notably:

- Monitor oncologists’ workloads and restructure job plans accordingly where they are overworked.
- Develop strong clinical leadership to ensure effective team working, autonomy and participation in decision-making.
- Use quality improvement and process improvement techniques to improve systems and pathways incrementally for the benefit of both doctors and patients.
- Work towards a supportive environment with a culture of supportive leadership and positive change.^{24, 25}

The four nations



Northern Ireland

Northern Ireland has the lowest shortfall of clinical oncologists in the UK, at 8%, significantly lower than the 17% shortfalls in England and Wales.

NI also has the highest number of COs per 100,000 older population at 4.6, much higher than the 3.7 UK average. However, despite these positive figures there is cause for future concern, NI has experienced lower (per annum) workforce growth than the UK's 3% average since 2016 at 2%. In 2021, there was 0% growth with no additional consultants recruited.

Furthermore, whilst the current shortfall is the lowest, without investment in training places and measures to mitigate retirements, this will rise significantly over the next five years as 25% of the CO consultant workforce, the highest proportion in the UK, is set to retire over that time.

There are also signs that the workforce is under increasing pressure as COs only have 69% of the time they need for Supporting Professional Activities (SPAs), which results in professional development and quality improvement work being done in their own time or not at all.

England

England makes up over 85% of data submitted in the RCR census; for that reason, the majority of England trends closely mirror the UK's summary.

There are, however, some specific issues to highlight. In England, workforce growth has remained steady at 3% since 2016 which, as already noted, is barely enough to deliver basic cancer care and not enough to improve services.

Unfortunately when we drill down into England's figures, we see huge disparities in that growth with the North West having 0% growth in 2021 whereas London had 5%. England is also joint bottom in the UK for clinical oncologists per 100,000 older people at 3.6.

It is no surprise then that England, along with Wales, had the highest workforce shortfall at 17%. Again there are further concerns for the nation as some areas have much higher shortfalls than others, the shortfall in the East Midlands is 11% higher than England's overall at 28%. Within England there are also worries about recruitment as it has the highest vacancy rate at 10%. There may be further issues with retirements over the coming years as areas such as the North East has 30% of its oncology workforce set to retire by 2026. ▶

Scotland

Scotland has enjoyed the highest workforce growth rate in the UK at 6% per annum (average) since 2016, double the UK average of 3%.

On the face of it this looks impressive, however the growth was not across the whole nation as the North of Scotland had 1% growth in 2021 while South East Scotland had 10%. Despite there being growth in some areas, Scotland had a 30% increase in cancer centre heads of service being concerned that workforce shortages were impacting on patient care as it rose from 50% in 2020 to 80% in 2021, some of the highest levels of concern in the UK. Similarly to England, there are concerns regarding recruitment with half of vacancies unfilled for over a year.

Wales

In 2021 there was no increase in CO consultants in Wales; the workforce remained at 47 (WTE). The lack of growth meant that Wales had the joint lowest number of clinical oncologists per 100,000 older population at 3.6.

These issues with workforce growth meant that Wales was joint top with England in having the highest workforce shortfalls at 17%, but most disturbingly North and West Wales have a 54% shortfall. This region also has the highest number of consultants approaching retirement in the UK, 57% of its workforce.

Despite these workforce pressures, Wales continued to lead the UK in time for Supporting Professional Activities (SPA) as they received the full recommended SPA time, compared to England's 74% of recommended levels. This means that cancer centres in Wales are providing staff with dedicated time for personal and clinical improvement. ■

Conclusion

The figures and views in this census represent an oncology workforce that is under extreme pressure.

The issues were already stark before the pandemic, but the backlog of care and pressure of the pandemic have exacerbated the workforce issue further. Cancer centre heads of service have laid bare their real concerns about patient safety, their treatment and the worrying levels of stress and burnout of staff. In the coming years,

the UK as a whole must work to grow the clinical oncology workforce and also improve their working environments.

The recommendations in this report are crucial to ensuring that patients receive the treatment they need, when they need it – improving outcomes and saving lives.

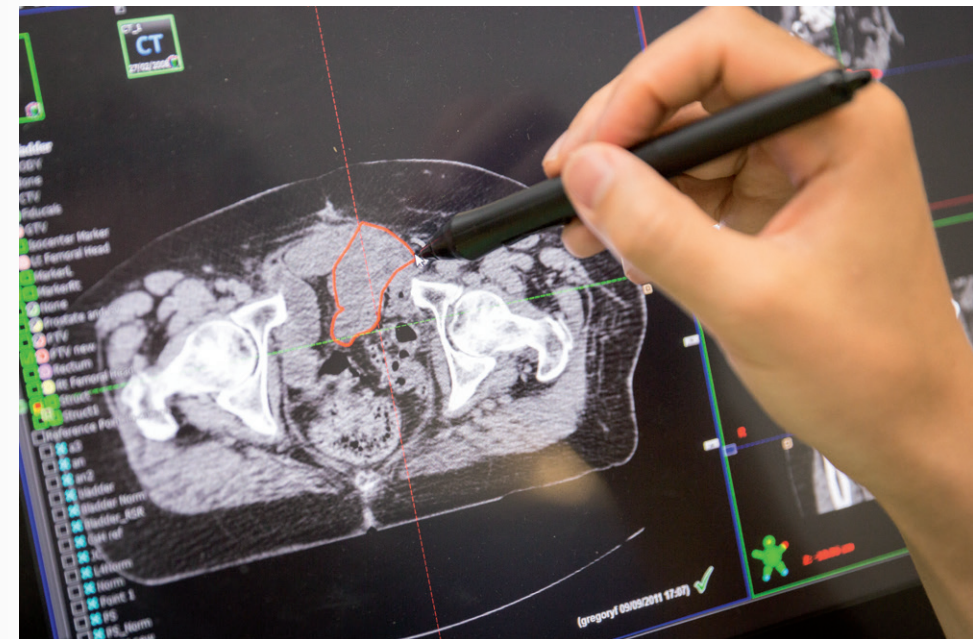


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