

## Written evidence submitted by Royal College of Radiologists

### About the RCR

1. The Royal College of Radiologists (RCR) is the professional membership body for doctors specialising in the fields of clinical radiology (including interventional radiology) and clinical oncology. We provide leadership to improve the standard of medical practice and training across both disciplines.
2. We engage with our Fellows, members, and multiple clinical partners, combining the latest research with the development of guidelines to support patient care in clinical radiology and clinical oncology. This enables us to effectively educate and support doctors throughout their career by providing practical guidance as well as supporting them in their clinical services to facilitate better patient outcomes. The RCR welcomes this opportunity to contribute to an important conversation.

### Current backlog in Cancer and Imaging services

3. Cancer and imaging services in England were already overstretched pre-Covid-19. However, the pandemic has added significant pressure on these services, resulting in more people waiting longer for diagnosis and therefore for subsequent treatment.
4. When Covid-19 struck, many services were paused as changes were needed to ensure that they could be delivered in a Covid-secure manner. These changes meant that imaging machines especially were not able to accommodate the same number of patients as before due to the time needed to clean facilities in between appointments. Elective imaging work decreased significantly during the first wave. This allowed the backlog of scans already acquired to be cleared and the reduced demand matched available departmental reporting capacity, allowing imaging services to streamline patient pathways, facilitating decision on admission or discharge in real time, improving patient movement through ED. In oncology, work continued throughout the pandemic, with innovation, including remote consent for treatment, limiting patient attendances to cancer centres to the bare minimum required to deliver treatment. Chronic understaffing has been exacerbated by staff sickness absence due to COVID-19, leading to increased pressure on staff, decreasing staff wellbeing and increasing risk of burnout leading to worsening staff retention. As elective recovery continues, despite scanning capacity exceeding prepandemic levels, we are now seeing the effects of chronic underfunding of imaging especially with rising waiting lists that are causing delays to diagnosis and treatment, including for patients with cancer.
  - a. As of September 2021, **281,275 patients** were waiting for an MRI scan, an increase from August's **265,858**. **64,395 of those** were waiting more than 6 weeks - **this is 75.6% higher** than the number of patients waiting more than six weeks in March 2020 (pre-pandemic)<sup>1</sup>.
  - b. **175,824 patients** were waiting for an CT scan and **31,223** were waiting more than 6 weeks – **72% higher** than March figures<sup>2</sup>.

<sup>1</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2020-21/>

- c. In September more than **64,000 people had to wait more than 4 weeks** to find out whether or not they had cancer from their initial urgent referral<sup>3</sup>. This has a major impact of commencing anti-cancer treatment, be it surgery, radiotherapy, or chemotherapy.
- d. Macmillan Cancer Charity estimates that the NHS in England would need to work at **110% capacity for 15 months to catch up** on missing cancer diagnoses, and for **13 months to clear the cancer treatment backlog**<sup>4</sup>.
- e. **More than 4,750 people were waiting** more than 2 months before starting treatment after an urgent GP referral – this is a new record high (the previous record high was August at 4,000)<sup>5</sup>. There is evidence that delayed diagnosis directly results in poorer cancer survival<sup>6</sup>.  
The number of people starting treatment for cancer in September 2021 was **27,342**. While this figure is back to pre-pandemic levels, it indicates that backlogs are not being adequately addressed as figures should be higher. Indeed, it is believed the number of people who have seen a specialist for suspected cancer since the pandemic began is still more than 190,000 lower than expected<sup>7</sup>.

### Workforce issues compounded by Covid-19 backlog

5. Increasing workforce shortages amongst radiologists and clinical oncologists is the number one issue affecting our doctors and the Covid-19 pandemic has exacerbated this problem. Having a well-trained, supported and adequately staffed workforce, including clinical radiologists and clinical oncologists, is the key building block to the NHS delivering safe and effective diagnostic and cancer care, including the ambitions of the long-term plan. However, the pandemic has made these targets even harder to achieve, with clinicians seeing significant delays in cancer referrals, diagnosis, and treatment. For instance:
  - The NHS radiologist workforce is now short-staffed by 33% and needs at least another 1,939 consultants just to keep up with pre-coronavirus levels of demand for scans and surgery.
  - More than half (58%) of radiology leaders say they do not have enough diagnostic and interventional radiologists to keep patients safe.
  - Patients are potentially missing out on cutting-edge, lifesaving, minimally invasive procedures as half of trusts and health boards (47%) do not have the staff or transfer arrangements needed to run safe 24/7 interventional radiology services.
  - Without more consultants in training, investment in new models of care and better staff retention and recruitment, the UK's radiologist shortfall is forecast to hit 44% (3,613 consultants) by 2025<sup>8</sup>.
  - The NHS needs at least another 189 (17% of the workforce) clinical oncologists to meet current demand, which is growing due to population demographics.
  - More than half of UK cancer centre clinical directors (52%) say oncologist shortages are negatively impacting patient care.
  
6. Overall, increases in training numbers present a cost-effective strategy for tackling the workforce shortfall in the long-term. Compared to an alternative approach of increasing

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<sup>2</sup> Ibid.

<sup>3</sup> [Cancer Waiting Times — National Time Series Oct 2009 — September 2021 with Revisions](#)

<sup>4</sup> <https://medium.com/macmillan-press-releases-and-statements/macmillan-responds-to-the-nhs-england-cancer-waiting-times-september-2021-statistics-a45a6a414625>.

<sup>5</sup> [Cancer Waiting Times — National Time Series Oct 2009 — September 2021 with Revisions](#)

<sup>6</sup> The Lancet Oncology. The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study. August 2020.

<sup>7</sup> <https://medium.com/macmillan-press-releases-and-statements/macmillan-responds-to-the-nhs-england-cancer-waiting-times-september-2021-statistics-a45a6a414625>

<sup>8</sup> The Royal College of Radiologists. Clinical radiology UK workforce census 2020 report. London: The Royal College of Radiologists, 2021.

overseas recruitment and outsourcing, maintaining the increase of 110 clinical radiology trainees and 50 clinical oncology trainees would provide cost savings of £420 million by 2030<sup>9</sup>. The approach would also provide a sustainable long-term solution to the workforce crisis. With pressures already on overseas recruitment and outsourcing, it is unlikely that these routes could feasibly deliver such a large increase in whole-time equivalent (WTE) workforce. Investment in the clinical oncology and clinical radiology workforce will be crucial to tackling the cancer backlog and improving cancer survival rates.

## Working with worn out tools

7. In addition to the workforce considerations, a significant barrier to reducing the cancer and imaging backlog is outdated and insufficient equipment required to deliver world-class diagnostic and cancer care. However, this challenge can be overcome by significant investment in modern technology to support early detection and treatment.
8. Radiotherapy is a highly effective cancer treatment. Around 4 in 10 people whose cancer is cured receive radiotherapy as part of that cure and 16% of all cancer cures can be attributed to radiotherapy entirely<sup>10</sup>. Furthermore, it is estimated that between 40 and 50% of people diagnosed with cancer should receive radiotherapy as part of their treatment<sup>11</sup>. By 2025, the percentage of cancer patients needing radiotherapy as part of their treatment will have risen from the current 50% to 60% (many as part of a curative treatment)<sup>12</sup>. Moreover, the Covid-19 pandemic has shone a light on radiotherapy as it is one of the few cancer treatments which can be given relatively safely during the pandemic and is a curative alternative to surgery in many cases<sup>13</sup>. Funding equipment for radiotherapy delivery will reduce waiting times for patients, improve patient experience of treatment and reduce regional variation in patient access to the latest advanced radiotherapy techniques.
9. In the same vein, investment in equipment for diagnostic imaging is also needed. Any equipment that is more than ten years old can be considered obsolete or inadequate for conducting certain procedures and must be replaced; yet previous industry surveys have shown one in ten CT scanners and nearly a third of MRI scanners in UK hospitals exceed this threshold and hence pose a risk to patients<sup>14</sup>. The UK also has fewer scanners than the majority of comparable OECD countries – 8.8 CT scanners per million population compared to an OECD average of 25.9 and 7.4 MRI scanners per million population compared to an OECD average of 16.9<sup>15</sup>. The UK is more efficient in the use of imaging equipment, but the shortfall cannot be bridged by sweating the assets alone. Adequate funding for diagnostic imaging will support ambitions for early diagnosis by improving access and in turn help tackle the current waiting times and backlog crisis.

## New models of delivery

10. Following the COVID-19 pandemic, recent developments in diagnostic and cancer care could be utilised to improve patient access to services outside of an acute hospital and in turn reduce delays for patients and relieve pressure on emergency/acute diagnostic services. For example, the new Community Diagnostic Centres (CDCs) and Rapid Diagnostic Centres (RDCs) models are designed to expedite diagnoses and improve early access to testing across a range of services, including imaging, endoscopy, and cardiology. If fully functional, they will relieve pressure on acute hospital departments, and provide a platform for

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<sup>9</sup> WPI Economics. Understanding the impacts of investing in training for clinical radiology and clinical oncology. London: WPI Economics, 2021.

<sup>10</sup> Cancer Research UK: [Vision for Radiotherapy 2014-24](#)

<sup>11</sup> Cancer Research UK: [Response to the APPG on Radiotherapy's Inquiry \(June 2019\)](#)

<sup>12</sup> <https://www.axrem.org.uk/radiotherapy/>

<sup>13</sup> The APPG for Radiology. Transforming Radiotherapy: A six-point Covid-19 recovery plan to save lives and save money within the NHS. July 2020.

<sup>14</sup> COCIR. Medical imaging equipment: age and profile density, 2019 edition. Brussels: COCIR, 2019.

<sup>15</sup> OECD (2021), *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris, <https://doi.org/10.1787/ae3016b9-en>.

streamlined patient pathways. However, the successful development depends on having the sufficient workforce and IT infrastructure in place to deliver services. The Government has announced an investment of £2.3bn to transform diagnostic services in this year's Comprehensive Spending review announcement. This funding must be used to deliver the required equipment and IT connectivity for CDCs and RDCs and reduce patient waiting times.

11. Furthermore, to facilitate quicker diagnosis of patients and reduce patient waiting times, it is crucial that patient pathways are streamlined to ensure that patients are referred for the most appropriate scan as quickly as possible. To support this the RCR has developed the iRefer tool which supports referring GPs, clinicians, and other healthcare professionals to determine the most appropriate imaging investigation(s) or intervention for patients. It provides practical guidance based on the best available evidence and the guidelines are accredited by National Institute for Health and Care Excellence (NICE). Use of the guidelines minimises the risk of a patient being exposed to potentially unwarranted ionising radiation through incorrect investigations. The Department of Health and Social Care has recently announced its funding of iRefer as part of a £248m investment to improve diagnostics over the next year. This funding will allow for quicker and more accurate referrals for diagnostic tests, checks and scans to help provide faster diagnosis of a health condition, earlier treatment and reduce waiting lists.

## Conclusion

12. This submission clearly details the ongoing impact that the Covid-19 pandemic has had on patient care and also offers some real and lasting solutions to help address this issue. To mitigate these challenges, the government needs to support and invest in the workforce to continue to deliver the highest quality cancer and diagnostic care, invest in modern equipment and IT infrastructure to support early detection and treatment, and support new models of delivering services to improve patient care and access to care. This will ensure that the NHS is on a solid footing and has the equipment, processes, and support it needs to reduce waiting times and continue to provide world leading care to patients.

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