

Written evidence submitted by The RCR (RTR0133)

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.

We engage with our Fellows, members and multiple clinical partners, combining the latest research with the development of guidelines to support clinical radiology and clinical oncology patient care. This enables us to effectively educate and support doctors throughout their career by providing practical guidance and supporting individuals and their clinical services to facilitate better patient outcomes.

Radiology is crucial to a functioning health service. Imaging is involved in almost every patient pathway and more than one in three A&E patients have a scan before any test¹. Similarly, it is estimated that 1 in 2 people in the UK will have cancer at some point in their lives², underlining the strategic importance of our clinical oncology and interventional radiology members and Fellows.

After years of underinvestment in the healthcare workforce, the shortage among consultant radiologists and consultant oncologists has grown to be an issue we can no longer ignore. A fully funded and functioning workforce is the number one issue for health service.

The key points of our submission can be summarised in the three following points:

1. To meet existing and growing demand, it is estimated that there is a shortfall of 1,939 whole-time equivalent (WTE) consultant radiologists across the UK (a 33% shortfall). For clinical oncology, this figure stands at 189 WTE consultants (an 17% shortfall³).
2. Recruitment is a vital part of the puzzle, but retention is also an important factor which helps to reduce the shortfall whilst doctors are trained in specialties
3. The most cost effective and long-term solution to workforce shortages is not through international recruitment or locums, but through delivery of sustainable training in specialties.

1. What are the main steps that must be taken to recruit the extra staff that are needed across the health and social care sectors in the short, medium and long-term?

Each year, the RCR conduct a census which provides robust data on the state of the clinical oncology and clinical radiology consultant workforce in the UK. It is an essential tool used by the NHS to assist in workforce planning and helps to identify shortfalls.

When assessing current demand, the RCR estimate there is a shortage of 1,939 whole-time equivalent consultant radiologists for the UK to reach the European average – this equates to a 33% shortage. For consultant oncologists, this figure stands at 189 WTE consultants (a 17% shortfall). If current trends in demand and workforce entries and exits continued to 2030, there would be shortages of close to 6,000 consultant radiologists and 700 consultant oncologists⁴.

¹ Estimates based on RCR analysis of Hospital Episode Statistics (HES) data and Diagnostic Imaging Dataset (DID) data.

² Cancer Research UK

³ RCR 2020 Census: <https://www.rcr.ac.uk/press-and-policy/policy-priorities/workforce/radiology-workforce-census>

⁴ <http://wpieconomics.com/site/wp-content/uploads/2021/10/WPI-Economics-RCR-Final-report-Oct-21.pdf>

In the past two years, there have been an extra 110 Clinical Radiology training places, 20 Interventional Radiology training places and 50 Clinical Oncology places, although not all of these trainees will finish their training in the usual five years due to some training part-time/taking breaks in their learning. RCR data shows clinical oncologists take an average seven years and one month to complete their training whilst clinical radiologists take an average five years and five months.

To address the long-term needs of the NHS, the increased number of clinical radiology and clinical oncology trainees and workforce there needs to be a long-term commitment to increased training numbers year on year. Short term increases and / or temporary fixes for our specialities will not future proof NHS service delivery.

We appreciate that training more doctors is a large investment and would require further funding from HM Treasury, in addition to local decisions on where training investment is made such as Health Education England. However, our research shows that funding more training places is actually a cost saving measure. This is because when we consider current spending on overseas recruitment and costly outsourcing, maintaining an increase in training places would save £420 million by 2030⁵.

Additional support for Trusts in delivering increased training places is also essential. Expanding the workforce at an increased rate would be a challenge, but one that our members stand ready to play a key role and advise on the most efficient ways to progress.

In the medium term, the RCR is working with the Society and College of Radiographers (SCoR) – the professional body of radiographers – the clinical staff that obtain the imaging tests - to actively looking at different ways to train radiographers and expand the whole imaging team.

In terms of training, it takes consultant radiologists five years to train for full entry to the speciality (and an additional year for interventional radiology); diagnostic radiographers can be trained to report imaging studies, which allow consultant radiologists to concentrate on complex, cross-modality imaging and service reform. There is, however, a shortfall of over 10% in diagnostic radiographers⁶ which will also need to be addressed, but more radiographer reporters could be trained quickly if there was more training capacity to rapidly expand the workforce. The result of this would be that diagnostic resource could be used more efficiently.

We are also working with nursing and pharmacy colleagues to standardise training in expanded roles for these groups to augment the workforce prescribing systemic anti-cancer therapy (SACT). And support management of acute toxicities of anti-cancer therapies (AOS).

In the very short term, overseas recruitment can be utilised to expand the all the workforces involved in every cancer pathway but this requires support in the form of immigration policies supporting overseas recruitment as well as local support in terms of enhanced induction.

2. What is the best way to ensure that current plans for recruitment, training and retention are able to adapt as models for providing future care change?

According to Cancer Research UK, incidence rates over the past decade for all cancers combined have increased by 4%.⁷ Furthermore, imaging demand has continued to grow at a rate of 6.4% per

⁵ WPI Economics. Understanding the impacts of investing in training for clinical radiology and clinical oncology. London: WPI Economics, 2021.

⁶ <https://www.sor.org/news/government-nhs/radiographer-reporting-grows-as-nhs-struggles-with>

⁷ <https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/>

year for CT and for 4.8% per year for MRI⁸. Complexity of imaging and radiotherapy treatments are increasing at the same pace as demand.

Recruitment and training need to emphasise team working, ‘team’ supervision (rather than “individual”) of patient care, assessing the evidence base and adopting new proven techniques rapidly, flexibility and leadership across professional silos. Recruitment and training need to emphasise the high-level capabilities of consultant practice as laid out in the new curricula, rather than focus on the granular approach to knowledge and practices that are subject to constant change.

This growth in demand means that by 2025, the clinical radiology workforce shortfall will be 44%⁹. This underlines the need to take action now to avoid further issues in the future.

One way that the NHS has sought to find efficiency with imaging amid a year-on-year increased demand for diagnostics is through Community Diagnostic Centres (CDCs). These aim to bring diagnostic services under one roof where a patient can, for example, undergo all the diagnostic tests they need in one visit. They also aim to bring diagnostic services closer to patient's homes and outside of hospital settings – something which has proved helpful during the pandemic.

Whilst CDCs have an increased role to play, it is important to note that these centres need to be staffed in a way that does not take clinicians from other care settings or departments as it could exasperate patient demand issues. CDCs should offer an opportunity for staff to rotate to deal with different working environments which are less pressurised, improving retention.

Many of the flexible working practices that would support staff retention are available currently, but are often not used or used very infrequently. There is geographical variation in this. Employers and HR departments, as well as clinical managers need to be encouraged to use all possible measures to retain staff, perhaps with exemplars shared e.g. through the hospital futures / model hospital platform.

3. What is the correct balance between domestic and international recruitment of health and social care workers in the short, medium and long term?

International recruitment can help alleviate some of the workforce shortage issues, however it is not a panacea to the problem. Research by the RCR and policy experts WPI Economics¹⁰, shows the NHS could waste £420m by 2030 if it continues with outsourcing and overseas recruitment to plug the UK’s shortage of consultant radiologists and consultant oncologists, instead of investing in homegrown consultants. Sustained investment in the two medical specialties would cost £652m by 2030 and provide nearly all the consultant oncologists the NHS will need and around half the forecasted shortfall of consultant radiologists.

In contrast, existing strategies to manage clinical consultant radiologist and consultant oncologist shortfalls – even helped by savings from artificial intelligence (AI) programmes and smarter working – would cost just over £1b by 2030¹¹. Status quo funding would provide a similar amount of

8 <https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/>

9 RCR Workforce Census 2020 – Page 4 - https://www.rcr.ac.uk/system/files/publication/field_publication_files/clinical-radiology-uk-workforce-census-2020-report.pdf

10 <http://wpieconomics.com/site/wp-content/uploads/2021/10/WPI-Economics-RCR-Final-report-Oct-21.pdf>

11 <https://www.rcr.ac.uk/posts/nhs-will-waste-over-%C2%A3400m-2030-if-government-fails-invest-imaging-and-cancer->

consultant radiologist cover as workforce investment, but only a-fifth of the extra consultant oncologists the NHS will need to meet even basic demands for cancer care.

When designing a strategy featuring international recruitment, care must be taken to be mindful of 'asset stripping' from other nations, whilst also recognising that UK is destination of choice for many.

Our WPI report shows that even if overseas recruitment were increased by 50%, outsourcing doubled (for clinical consultant radiologists) and improved working practices led to very significant efficiency gains, just 56% (clinical consultant radiologists) and 18% (consultant oncologists) of the WTE shortfall would be met by 2030.

At the RCR, we do have a dedicated member of staff responsible for assisting with overseas recruitment. This support includes help with the Certificate of Eligibility for Specialist Registration (CESR) application. One point to note is recruitment is often those doctors that are already here in the UK, rather than those that are living overseas, although we do have outreach programmes to assist here too.

International recruitment is a good way for UK staff to learn from other health care systems and the diversity or healthcare solutions that are used by other nations. In the same way, those coming to the UK can benefit from direct experience in the UK system. The UK has long relied on international recruitment. Whilst there is a benefit to continuing this, true sustainability should have reliance on and need for only a low level of overseas recruitment. This would mean less shortfall in times of international emergency.

4. What can the Government do to make it easier for staff to be recruited from countries from which it is ethically acceptable to recruit, with trusted training programmes?

Regulatory reform to GMC CESR processes, making them more proportionate and streamlined would assist in ethical overseas recruitment.

**5. What changes could be made to the initial and ongoing training of staff in the health and social care sectors in order to help increase the number of staff working in these sectors?
In particular:**

- **To what extent is there an adequate system for determining how many doctors, nurses and allied health professionals should be trained to meet long-term need?**

As mentioned in our answer to question 1, the RCR conduct a census each year which provides robust data on the state of the clinical oncology and clinical radiology consultant workforce in the UK.

The report monitors key workforce trends, forecast future numbers of consultant radiologists, and highlights any gaps between the workforce supply and the demand for diagnostic and interventional radiology. It is an essential tool which augments internal NHS workforce planning and helps to identify shortfalls.

However, the collection and identification of other health professionals working in cancer is poor and confusing. Advanced practitioner roles are rarely identified and nurses working within cancer

are not distinguished on the NMC register. Certain integral roles such as health technologists and sonographers are not regulated so collecting accurate data is almost impossible. If data is unavailable, modelling of future needs is poor. Full collection of roles on ESR and regulation of certain critical professions would allow much better informed workforce planning. Collecting data on future intended working patterns is also poor. Less than full time (LTFT) training and working significantly impacts on modelling but a robust evidence based insight into future working trends would improve workforce planning.

- **Do the curriculums for training doctors, nurses, and allied health professionals need updating to ensure that staff have the right mix of skills?**

Please see answer to question 1.

- **Could the training period for doctors be reduced?**

We believe that the system we have in the UK is the gold-standard and is world-renown. Diluting the training doctors receive would not be in the best interests of patient care.

- **Should the cap on the number of medical places offered to international and domestic students be removed?**

We do not believe that the cap is a hinderance to the recruitment of consultant oncologists and consultant radiologists and believe a greater focus should be given to domestic recruitment through training. The number of medical school places in the UK need to be expanded. High quality clinical placements need to be provided for any medical school expansion. Ideally the places should be filled by those who are likely continue to work in the UK post registration.

6. What are the principal factors driving staff to leave the health and social care sectors and what could be done to address them?

It's important to note that as well as recruitment, reducing the loss of workforce is also an important consideration; one member used the metaphor that "it's not just about filling the bathtub up, it's about stopping it emptying too".

We have listed some areas which might improve retention below. Some of these are more difficult than others, but the themes of 'flexibility' and "feeling valued" runs through them. Some may have a cost attached to them, but compared to the cost of training a new doctor, the costs are significantly lower:

1. Address doctor's pensions concerns, and remove financial disincentives to continue working.
2. Ensure "retire and return" policies are used and implemented flexibly on the ground – especially not exclusively using 12 month renewable contracts
3. Enable access to flexible working patterns, especially after retirement, including
 - a. coming off on-call rota as you get older
 - b. annualised contracts allowing term time working – (grand)child caring responsibilities
 - c. working non-standard hours (e.g. 6 – 9am routinely)
 - d. facilitating remote working where possible (or wanted)
 - e. tailoring employment to consultant skillset e.g. allowing reduced DCCs and increased SPA for appraisal and training or accommodating those who only want to do clinical work with no extra responsibility
 - f. ensure that training time is protected, even at the expense of service delivery

4. Free car parking and designated spaces especially for those travelling between sites
5. Fully tailored mandatory training aligned to job role
6. IT that is rapid to boot up with single sign on that works
7. Interconnected IT with all legacy systems and between hospitals
8. Reinstatement of administrative support so that routine tasks can be delegated
9. Ability to access study leave during the normal working day, especially after retiring
10. Being allowed to take professional leave, especially after retiring, to engage in the work for the wider benefit of the NHS including MRC, NICE etc during the normal working day
11. Ensure all GP surgeries have a hospital only access phone number that is manned
12. Ensure all hospitals have a GP access only phone number that is manned
13. Passporting of skills / training / stat/man training in those who rotate between sites / Trusts
14. No financial penalty after retiring – maintaining level on pay scale and consideration of retaining CEAs.

7. Are there specific roles, and/or geographical locations, where recruitment and retention are a particular problem and what could be done to address this?

Clinical radiology workforce shortages are highest in the East Midlands and the North East, both of which stand at 43%. The East Midlands also has the lowest number of consultant radiologists (whole-time equivalent) per 100,000 population, currently at 6.8 – the European average is 12.8 consultant radiologists per 100,000.

Investment in training places and training infrastructure can help to level up all regions across England and ensure that patients receive the best possible care, regardless of where they live. Furthermore, there are large shortages in the interventional radiology workforce. Interventional radiologists use image-guided techniques to carry out minimally-invasive - and often life-saving – procedures, including treatments for stroke and severe bleeding due to trauma. Patients are potentially missing out on these life-saving 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.

There are also large regional variations in workforce shortages for the clinical oncology workforce across England, especially in the East Midlands and North East. While a quarter of cancer centres reported average annual workforce growth of 6% or more per year, another quarter reported no gain or a decline in their workforce. Regional variation in workforce has a direct impact on the care that patients receive. In areas that have severe staff shortages, access to services is likely to be more difficult and there is no time to implement treatment innovations, potentially adversely affecting patient outcomes.

8. What should be in the next iteration of the NHS People Plan, and a people plan for the social care sector, to address the recruitment, training and retention of staff?

We have chosen not to answer this question.

9. To what extent are the contractual and employment models used in the health and social care sectors fit for the purpose of attracting, training, and retaining the right numbers of staff with the right skills?

In terms of retaining staff, we reference our answer to Question 6.

10. What is the role of integrated care systems in ensuring that local health and care organisations attract and retain staff with the right mix of skills?

We have chosen not to answer this question.

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