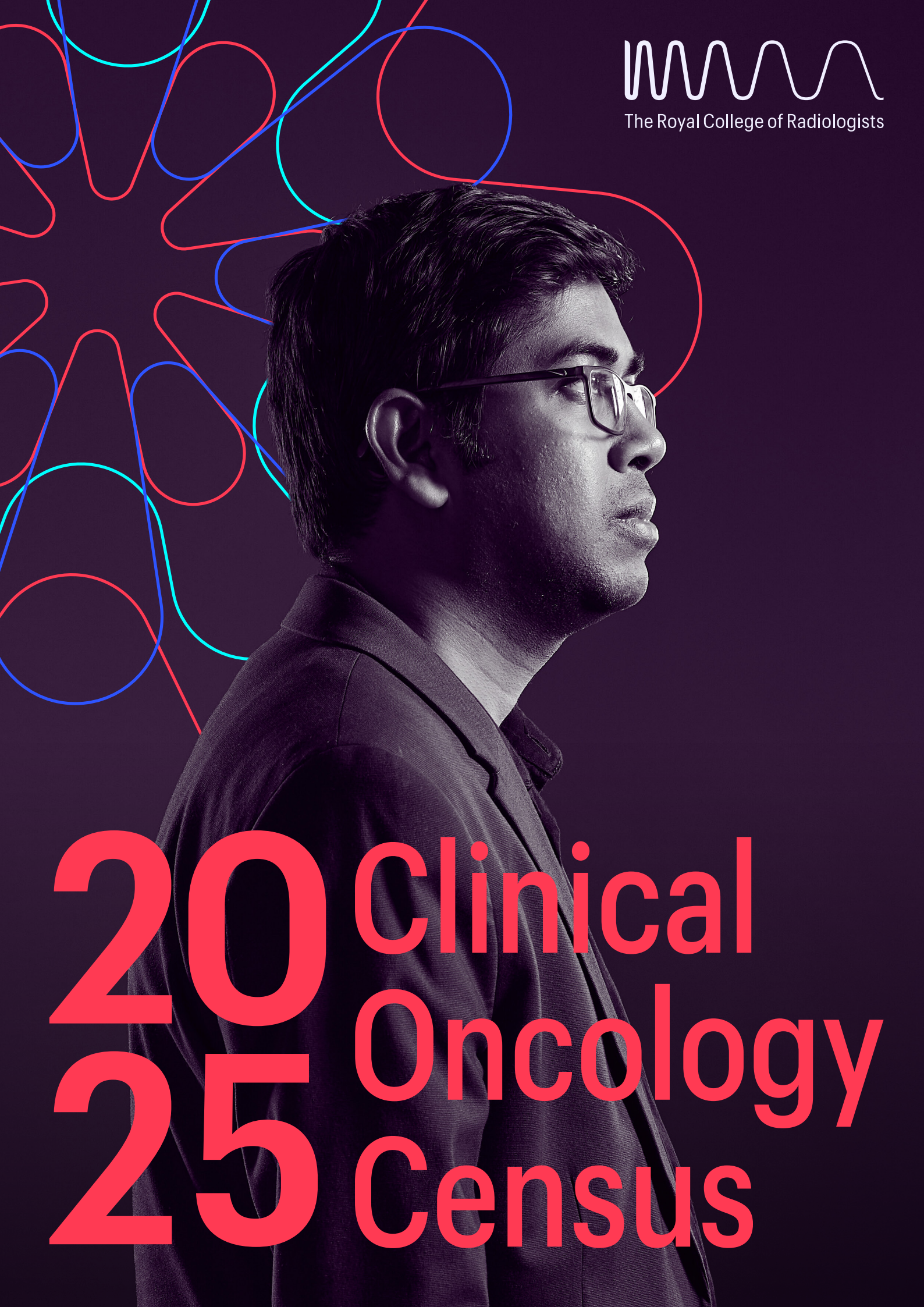




The Royal College of Radiologists

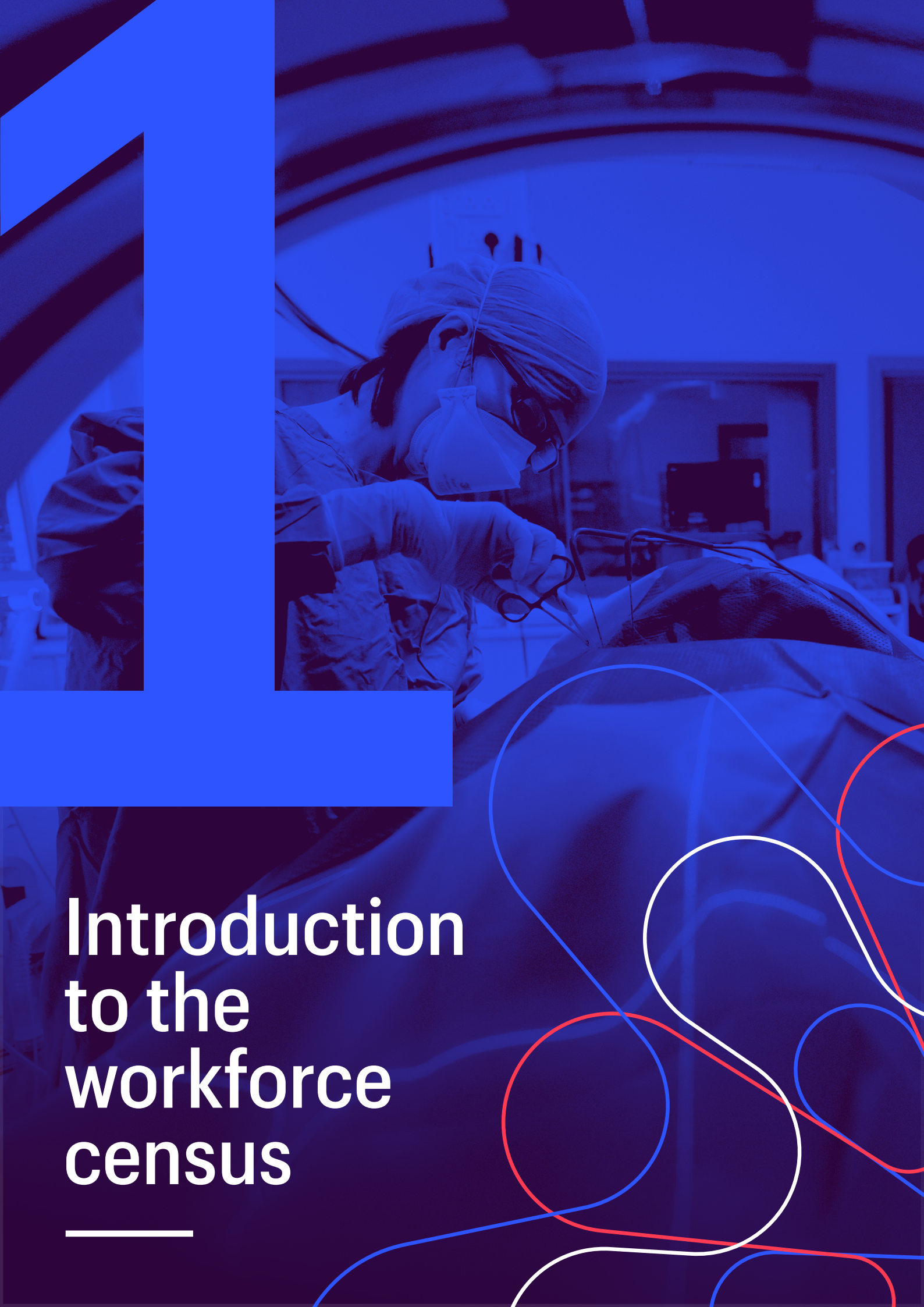


20 Clinical 25 Oncology Census

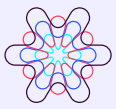


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Introduction to the workforce census



Foreword



Dr Petra Jankowska,
Medical Director
Professional Practice,
Clinical Oncology

The publication of the 2025 clinical oncology workforce census is for me a moment of reflection. Few could disagree with the ambitions laid out in February's National Cancer Plan for England, which was packed full of good ideas for cancer care, including some policies for which the RCR had been specifically advocating. Many of these ideas, such as reform to multidisciplinary team meetings, could apply equally to the whole of the UK and we will look to work with all the devolved governments as they continue to develop their own cancer strategies.

But for all that the National Cancer Plan presented a powerful vision statement, we know that none of it will be possible without the workforce. Yet this crucial topic did not receive the attention it deserved in the Plan. The government in Westminster would prefer the NHS adopt new ways of working than to expand the workforce. I would agree that we need to work smarter. Top of my list would be to have fewer admin tasks, so I have more time for patient care, radiotherapy contouring and service development – in other words, working at the top of my licence. Yet it is naïve to think that the NHS can do without additional clinical oncologists. The data in this report prove the opposite.

In the past year, it feels like things have worsened in many respects. The workforce shortfall has risen, demand continues to outpace capacity and patients are becoming ever more complex to treat, which means we are all working harder than ever simply to keep the ship afloat. There is a widespread feeling of increasing fragility in the system, that we are close to breaking point. This is evident in the extent to which site specialty expertise is becoming dangerously thin on the ground in some areas, and in our ability to maintain a strong training pipeline to produce the next generation of consultants.

As reported by Heads of Service, these difficulties are taking a toll on clinical oncologists across the country. Some of us are struggling to provide or receive the training we need. Some of us are burning out as we strive to deliver the best possible care under near-impossible circumstances. Some of us are struggling to see the light at the end of the tunnel. All of us are grappling with the fact that, too often, we simply cannot provide the level of care we want for patients. None of us joined the NHS to see our patients get worse. We joined the NHS to provide the best care for them.

The census data proves that proper workforce investment is essential for patients and for the country. We are only able to quantify the problem and to articulate clearly what must be done about it by having this data to hand. Therefore, I offer my most sincere thanks to all the Heads of Service and their colleagues who completed the census this year.

The RCR uses the census both to influence change on the national level, but also to support cancer centres to advocate locally, such as with data to support business cases for additional workforce. I strongly encourage you to reach out to us if you have any questions or would like further data for your cancer centre. The 100% response rate makes our data difficult to dismiss and extremely hard to ignore – rest assured we will be using it week in, week out, to represent your views to those that need to hear them.



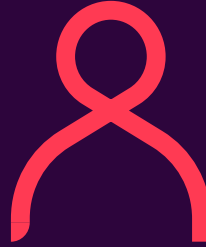
All of us are grappling with the fact that, too often, we simply cannot provide the level of care we want for patients.



Key findings at a glance

17%

2025 clinical oncology consultant shortfall



26% 2030 forecast CO consultant shortfall

Nearly 2x average cancer centre shortfall in rural or deprived areas (22%) than in urban or less deprived areas



90%

cancer centres report delays to patients starting radiotherapy or SACT



51%

Heads of Service say that patients' conditions have worsened due to staff shortages



51%

cancer centres experienced a recruitment freeze in 2025, twice the number in 2024

75%

Heads of Service are concerned that workforce shortages are adversely affecting training quality for resident doctors

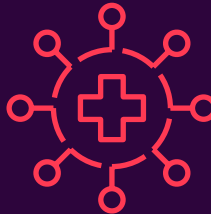
46%

small cancer centres without adequate consultant cover for two or more cancer types



42%

CO consultants working less than full time, forecast to rise to 52% by 2030



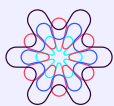
4 in 5

cancer centres using artificial intelligence in 2025



1 in 5

CO consultants forecast to retire by 2030



Executive summary

The Royal College of Radiologists' 18th annual clinical oncology (CO) workforce census presents a comprehensive, in-depth look at the state of the specialty across the entire UK. Data collection began in October 2025 and once again, the completion rate was 100%.

Clinical oncologists provide expert, pioneering cancer care, overseeing patient treatment with both systemic therapies and radiotherapy. The RCR uses the census to understand the challenges facing CO and to offer clear recommendations to governments and the NHS.

The UK has too few clinical oncologists – and the problem is getting worse.

As of 2025, the country has a 17% shortage of consultant clinical oncologists, up from 15% in 2024. This means we are over 200 CO consultants short of being able to provide safe and effective care to all cancer patients that need it.

The shortage will rise to 26% by 2030 if nothing is done. This is because demand for care is already outpacing capacity, measured by the average rate of growth in radiotherapy and chemotherapy treatments (4% and 5.2% per annum respectively) against the average rate of workforce growth (3.6% p.a.) over the past five years. Moreover, one in five consultants are set to retire between now and 2030. This situation is compounded by recruitment freezes, with trusts and health boards feeling forced to adopt an incoherent policy of preventing workforce investment because of severe financial constraints. These recruitment freezes have doubled in the past year, from 23% in 2024 to 51% in 2025. They are a direct blocker to timely and effective patient care.

Patients are at risk, with geographical inequities in access to care arising from workforce issues.

Patients are increasingly at risk because of workforce shortfalls. Delays to cancer treatment can be ruinous for patient outcomes, and even in best case scenarios result in unnecessary distress. For the first time, over half of all Heads of Service report that they have seen patients' conditions worsen because of workforce shortages causing delays to treatment. Data also show that delays to radiotherapy and other cancer treatments are widespread and common.

Equally worrying are the geographical disparities in access to care. Rural and coastal areas, as well as more deprived areas of the country, face particular challenges. Workforce shortages are notably more severe in these areas, with the average workforce shortfall in a cancer centre in a rural or more deprived area nearly twice that of a cancer centre in an urban or less deprived area. Also concerning is the provision of cross-cover for common cancer types in certain regions. Nearly half of small cancer centres lack adequate consultant cover for two or more cancer types. Lone practitioners in these areas are at risk of burnout, and patients are at risk of delays if the one doctor in their area who can treat their cancer is unavailable.

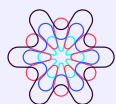
We are failing to recruit and train enough clinical oncologists.

In the face of these stark challenges, it is vital that the NHS attract more doctors to clinical oncology and provide expert training to produce the next generation of CO consultants. However, demand for care is such that most consultants are experiencing an erosion of their non-clinical time, reducing the time that they can dedicate to training or supervision. Other consultants are concerned that the quality of the training they can provide is suffering.

As well as a lack of trainer time, cancer centre leaders report a lack of physical space to accommodate residents and growing complexities around the funding of training posts. Recruitment freezes are adding a complicating factor: more people are 'stuck' in their grace period after completing training whilst they wait for consultant posts to be advertised. All this puts the training pipeline in a perilous state, which risks the future CO consultant workforce and hence the health of future patients.

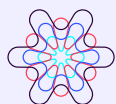
Technology could help clinical oncologists dedicate their time to caring for their patients, provided support is in place.

Despite the systemic challenges, every single cancer centre is doing what it can to work in more effective ways that will help them to meet rising demand. For example, artificial intelligence for radiotherapy treatment planning is now used in nearly 80% of cancer centres. Heads of Service are largely positive about its effects, with three-quarters saying it has reduced their workload. However, AI use for other purposes remains uncommon. Tools to reduce oncologists' administrative burden would be especially welcome. Cancer centres will require more support to complete the national rollout of AI for treatment planning and to ensure AI meaningfully releases capacity back into the system.



Recommendations

-
- A** **Grow the clinical oncology workforce**
- + The NHS in each nation should increase the baseline number of specialty training places for clinical oncology to progressively eliminate the workforce shortfall.
 - + Trusts/health boards will require adequate financial support to enable them to take up additional training posts.
 - + An additional ten CO specialty training posts each year would, after ten years, be sufficient to close the workforce shortfall and deliver ~£20 million in cost savings.¹
-
- B** **Eliminate recruitment freezes**
- + Trusts/health boards should not impose recruitment freezes on cancer centres. All ongoing recruitment freezes should be lifted.
 - + National NHS leadership must intervene where recruitment freezes are identified.
-
- C** **Allocate training posts by WTE to maximise training capacity**
- + The NHS should allocate funding for specialty training posts by whole time equivalence (WTE), rather than simple headcount, to facilitate greater use of slot sharing and maximise existing capacity in the system.
 - + The NHS should provide timely confirmation of funding for training posts, including any additional posts, to allow trusts/health boards to take advantage of the offer.
-
- D** **Tackle workforce shortages in rural, coastal and high deprivation regions**
- + The NHS should introduce measures to attract doctors to under-resourced areas, such as those rural or coastal regions, and to small cancer centres.
 - + The NHS should consider providing further incentives to attract staff to traditionally under-resourced areas.
-
- E** **Attract graduates and medical students to clinical oncology**
- + To attract more people to the specialty, medical schools should increase students' exposure to clinical oncology during their undergraduate degree. Statutory education bodies and local deaneries should increase doctors' exposure to clinical oncology during foundation and internal medicine training.
 - + The NHS should work with the RCR to provide those IMT residents who express an interest in oncology with tailored rotations.
 - + Phase Two of the Medical Training Review should assess whether foundation training residents could be given the ability to preference certain rotations, with weighting given to nationally important and/or under-subscribed specialties.



F Provide and protect doctors' leadership, training and governance time

- + Trusts/health boards should ensure all doctors have a minimum of 1.5 SPAs in their job plans to enable revalidation.
- + Job plans should be sufficiently detailed and transparent, such that the activity is achievable without the erosion of allocated SPA time.
- + Doctors with additional responsibilities, such as training or clinical leadership, should have additional SPAs (i.e. more than the minimum of 1.5) that realistically reflect the time required for those roles and responsibilities.
- + Trusts/health boards should ensure that clinic templates in cancer centres include sufficient outpatient work that falls within standard working hours, so that resident doctors are able to gain experience of this aspect of oncology.

G Provide AI tools to every cancer centre

- + The NHS should provide additional investment to complete the rollout of artificial intelligence in auto-contouring to every cancer centre in the UK, given the evidence of its capacity to free up clinicians' time for use in providing direct patient care.
- + The NHS should also consider wider rollout of AI-powered administrative tools to cancer centres, such as ambient voice technologies.
- + Trusts/health boards should be encouraged and supported via deployment guidance to select the best AI tools for a given task, rather than a cheaper but less effective option.

H Ensure cross-cover care for all cancer types

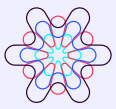
- + NHS national workforce planning must include measures to preserve expertise for all cancer types, such that patients across the UK have equitable access to quality care.
- + All cancer centres should ensure there is time in at least two consultants' job plans to cover each tumour site for which the centre provides treatment.
- + Where a centre does not provide treatment for a given cancer type, it must have in place robust and sustainable solutions for patient transfer. Other services, such as those for very rare cancers, may need to be centralised, depending on provision of workforce and facilities.

I Provide funding for additional workstations

- + Funding for expansion posts in clinical oncology must include a component to cover the provision of additional workstations so that all residents can contribute effectively to the service.
- + Clinic room capacity in cancer centres must likewise be commensurate to the number of clinical oncologists – consultant, SAS, and resident – working there.



Consultants and SAS doctors



Size of the shortfall in 2025

The UK has a 17% shortfall of clinical oncology consultants.

This means that the country is short of an additional 234 whole time equivalent (WTE) doctors needed to provide the level of safe, effective care that is required.² The shortfall has risen from 8% in 2015, and has been largely static, despite workforce growth, since 2022.³

England currently has a 17% shortfall, Northern Ireland a 9% shortfall, Wales a 17% shortfall, and Scotland an 18% shortfall. There are regional variations. The national shortfall in Wales belies the gaping chasm between South Wales' shortfall of 11% and North Wales' shortfall of 39%. Similarly, the shortfall in South East Scotland is 13%, but the shortfall in the North of Scotland is 21%. Some English

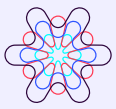
regions likewise have large shortfalls, such as the East Midlands (27%) and Yorkshire and the Humber (22%).

Small cancer centres have an average shortfall of 26%, versus 13% amongst large centres.⁴ Similarly, centres in rural or more deprived areas have an average shortfall of 22%, compared to 12% amongst those in urban or less deprived areas.⁵ Cancer centres in these areas have historically been under-resourced in terms of healthcare staff.⁶ The UK shortfall is forecast to rise to 26% by 2030, should current trends persist. This is an increase from 2024's forecast shortfall of 19% by 2029, which suggests that the gap between capacity and demand is widening. Action to address workforce shortages must be taken before they become worse.



[Patient] delays are a direct consequence of insufficient capacity, workforce shortages and an absence of timely senior clinical decision-making. This is not an operational failure at the frontline, but a policy failure.

CLINICAL ONCOLOGIST

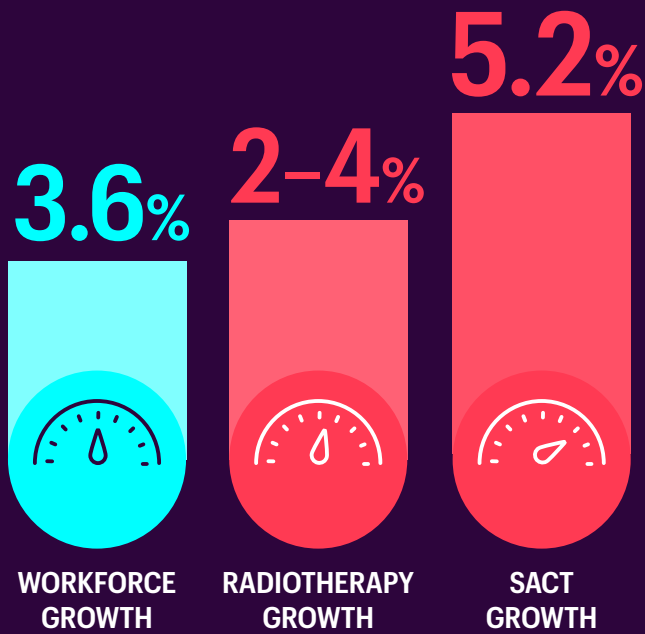


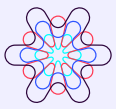
Workforce growth – substantive staff

As of the end of 2025, there are 1,138 WTE substantive consultant and SAS clinical oncologists in the NHS. Of these, 1,049 WTE are consultants. In the past year, the NHS gained a net 45 WTE CO consultants. This is good news – though it falls short of the 234 required to eliminate the workforce shortfall. The substantive CO consultant workforce grew by 4.5% in 2025 and has grown by an average of 3.6% over the past five years.

The average annual growth rate of CO consultants in small cancer centres over the past five years was 0.4%. This compares to 3.6% per year in medium centres and 4.4% per year in large centres. Likewise, growth rates vary across UK nations. The five-year average annual growth rates in Northern Ireland, Scotland and Wales were 2.5%, 3% and 2.6%, respectively – all below the equivalent figure in England: 3.7%.

Demand is outpacing growth





Rising demand for cancer care

Demand for cancer care has risen sharply in recent decades. More people require care, and that care is becoming more complex, with a greater number of advanced treatments now available. Over the past five years, the number of SACT regimens grew by 5.2% per year and the number of radiotherapy episodes grew by 1.8% per year. Radiotherapy activity was significantly impacted by the Covid-19 pandemic; if we consider just the financial years from 2021–22 onwards, average annual growth in radiotherapy episodes was 4%.⁷ These figures show that demand for cancer care is outpacing workforce growth (compared to 3.6% average annual consultant workforce growth).

Recent analyses have shown that most of the rise in activity can be explained by 'non-demographic factors', which include medical advances, changes in care pathways and funding flows.⁸

However, demographic change is also playing a role, with the UK population now disproportionately older than in decades past. Not only is cancer incidence higher in older cohorts, but people are now spending a greater proportion of their lives in ill health, many with multiple chronic or major illnesses.⁹ Estimates suggest there will be over 5 million people living with cancer in the UK by 2040.¹⁰



[We are seeing] increasing patient numbers and complexity of treatment, but [we do not have a] commissioned service, therefore [there is] no mechanism to increase the workforce, other than ad hoc business cases.

CO HEAD OF SERVICE



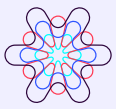
We break ourselves overbooking patients so [their] care is not compromised.

CLINICAL ONCOLOGIST

Medical oncologists

Whereas clinical oncologists are specialist doctors who are trained in both radiotherapy and Systemic Anti-Cancer Therapies (SACT), medical oncologists (MO) are specialist doctors who focus on delivering cancer drug treatments. The UK has 691 WTE MO consultants, which is 38% of all oncology consultants in the UK. Cancer centres in rural or more deprived areas employ more MOs as a proportion of all oncologists than those in urban or less deprived areas (41% MOs versus 36% MOs).

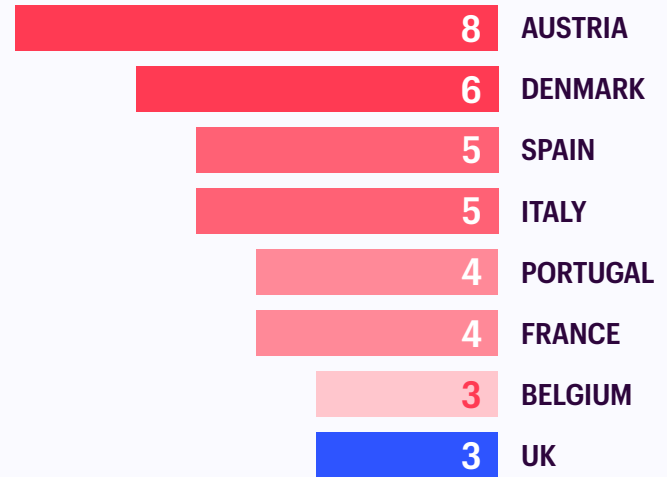




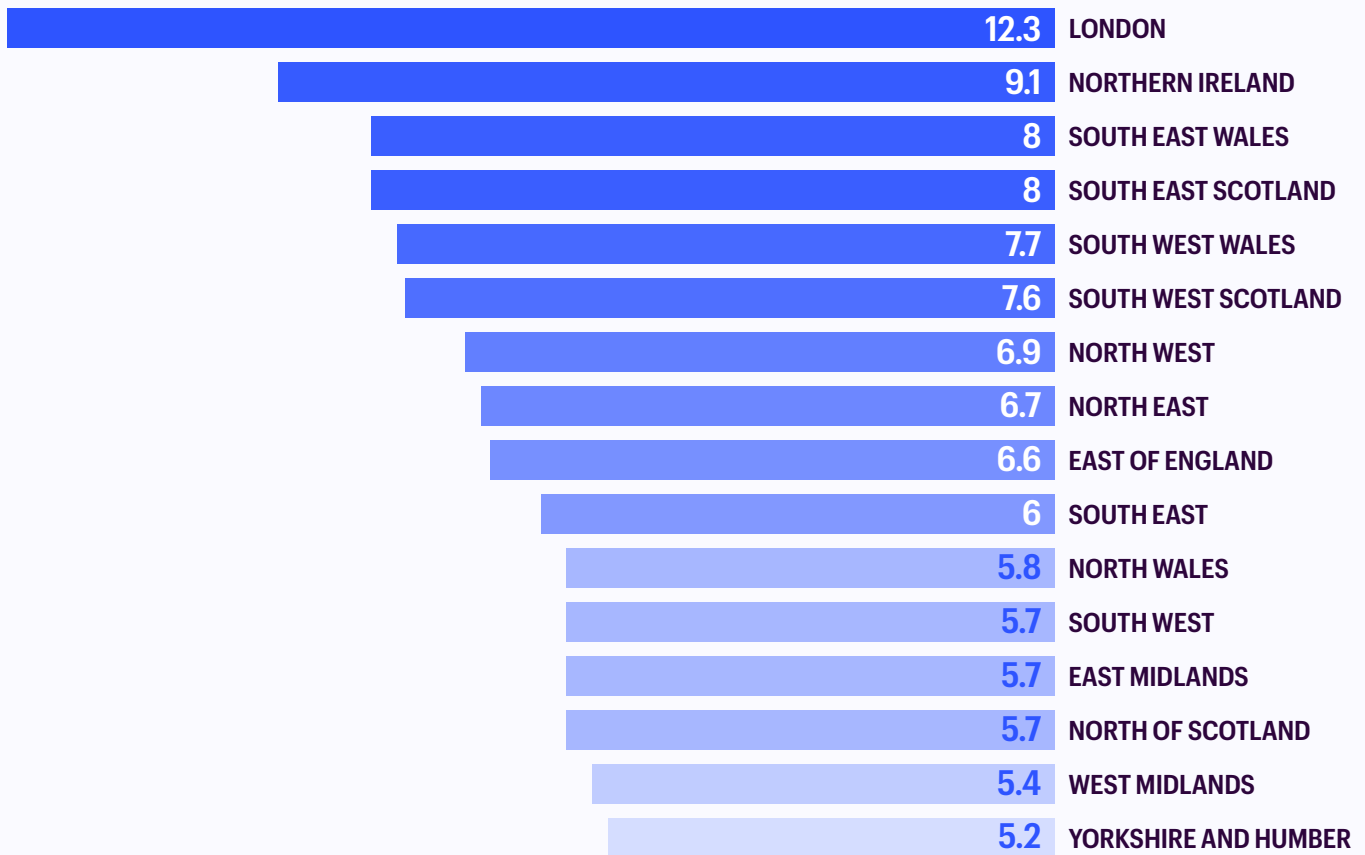
Workforce distribution

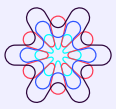
The cancer workforce is not evenly distributed across the country. 90% of people diagnosed with cancer are aged 50+, so it is useful to compare numbers of oncologists against region's 50+ populations.¹¹ For every 100,000 people aged 50+, the UK has 6.9 WTE oncology consultants (CO and MO). England has 6.8, Northern Ireland 9.1, Scotland has 7.2 and Wales has 7.4 per 100,000 aged 50+. Amongst the regions, London has 12.3, but Yorkshire and the Humber has just 5.2 oncology consultants. Regions with fewer oncologists per capita often experience greater pressure on patient waiting times. However, how quickly patients receive a cancer diagnosis and start treatment also depends on diagnostic capacity, availability of radiotherapy equipment, staffing across the wider cancer workforce (e.g. radiographers, nurses) and a range of other factors across the cancer pathway. International comparisons show that the UK has fewer oncologists than comparable European nations. It has the fewest consultant oncologists per 100,000 population (all ages) than many countries including France, Italy, and Spain.¹²

Oncologists per 100,000 population by nation



Consultant oncologists (CO and MO) per 100,000 older population, 2025





Vacancies

There is currently a 7% vacancy rate amongst CO consultant posts. This is relatively low, and has not changed since 2022. It should be noted, however, that the increasing prevalence of recruitment freezes (see page 25) has depressed vacancy rates.

Vacancy rates are slightly higher in cancer centres in rural or more deprived areas (8%) and significantly higher amongst small cancer centres (21%). This same discrepancy is also the case for SAS post vacancies.



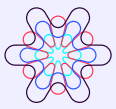
One post in my team has been vacant for more than a year now and remaining colleagues have just been expected to step up and fill the gap. This is becoming unsustainable.

CLINICAL ONCOLOGIST

Demographics

In recent years, the CO workforce has achieved gender parity. 52% of CO consultants in the NHS are now women – up from 45% in 2015. CO compares favourably to other medical specialties in this regard, with the gender ratio for the whole GMC specialist register being 60:40 men:women. Amongst SAS doctors, women comprise 56% of the workforce. The median age of a CO consultant is 48 years (versus 45 years in 2015). SAS doctors also tend to be slightly younger, with a median age of 46 years.



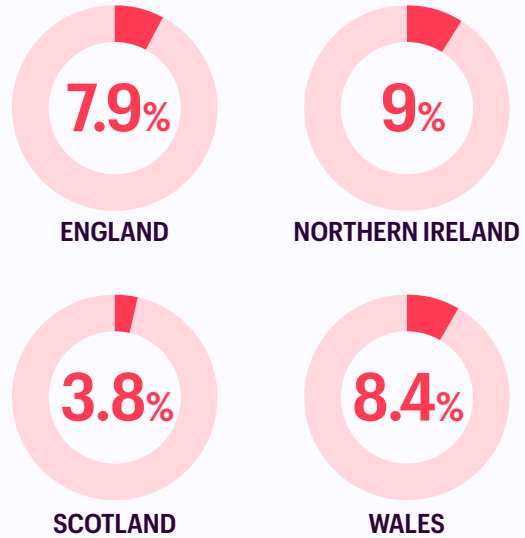


Spotlight: SAS doctors

SAS doctors are a diverse group of postgraduate clinicians, who have chosen to specialise in an area of medicine but have not completed specialty training to become a consultant. They are a hugely valued part of the workforce. There are 94 WTE SAS doctors in clinical oncology (including locums). This equates to 8% of the total CO workforce (consultant and SAS combined). Since 2020, there has been an average annual increase of 6% in CO SAS doctors. 79% of CO SAS doctors are international medical graduates (IMGs) who gained their primary medical qualification (PMQ) overseas; 4.6% gained their PMQ in the European Economic Area (EEA).

Scotland is an outlier, with SAS doctors comprising just 3.8% of its CO workforce. The equivalent figures for England, Northern Ireland and Wales are 7.9%, 9% and 8.4%. Across the board, small cancer centres rely most heavily on SAS doctors, where they comprise 11.6% of the CO workforce, compared to just 3.2% in large centres.

SAS doctors as a percentage of the CO workforce (consultant + SAS) by nation, 2025



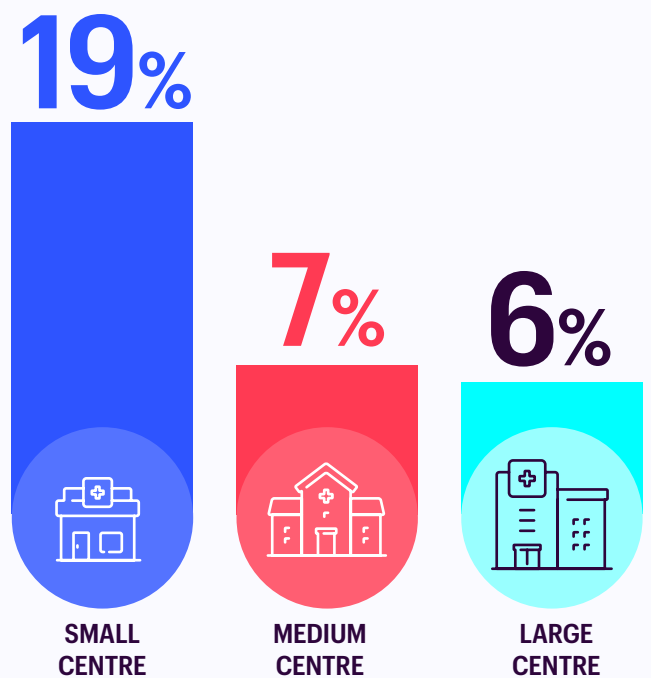
Locum doctors

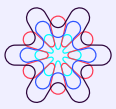
Locum doctors are employed on a fixed-term basis, typically to plug a gap in the workforce in the event of absence (for reasons such as parental leave or sickness). Individuals may choose locum posts for the greater flexibility they offer, or because substantive consultant posts are not available.

The UK has 85 WTE CO locum consultants. This equates to approximately 8% of the total consultant workforce. There are fewer locums in the workforce than the 2024 peak of 98 WTE. This shift may relate to the government's recent cuts to agency spending.¹³ However, the 2025 figure is nonetheless more than double that in 2020 (32 WTE). Since then, the average annual growth rate for locums was 22%, approximately six times that of substantive consultants. Reliance on locums varies by cancer centre size and between the nations.

Generally, locums deliver service (e.g. outpatient clinics, radiotherapy/SACT prescribing, ward reviews) but do not contribute to service development, audit, research and other similar activities. It is these that can make a cancer centre an attractive place to work – so centres employing many locums can see their recruitment challenges compounded.

Locums as a percentage of consultant workforce by cancer centre size, 2025





Attrition

In 2025, the attrition rate for CO consultants was 3.1% (excluding locums). Those leaving the NHS have various destinations: some are retirees, some leave to practise medicine abroad, and some pursue work in other sectors. Approximately three-fifths of leavers were under the age of 60. The median age of a CO consultant who left in 2025 was 58 years.

For consultants who completed CO specialty training in the UK, the average annual attrition rate over the past five years was 1%. For those who completed specialty training overseas (or via the portfolio pathway), it was 4.2%. Doctors who trained overseas are likely to have stronger connections with the country in which they trained and may return to that country after working in the UK; others join the NHS on a fixed-term basis.¹⁴

Similarly, locum consultants left the NHS at over five times the rate of substantive consultants over the past five years. These effects must be factored into workforce planning. For SAS doctors, average annual attrition is 15.5%, nearly five times that of consultants. They also leave at a younger age, with an average age of 38 years in 2025, and 81% of leavers being under 50 years of age. Within the past five years, half

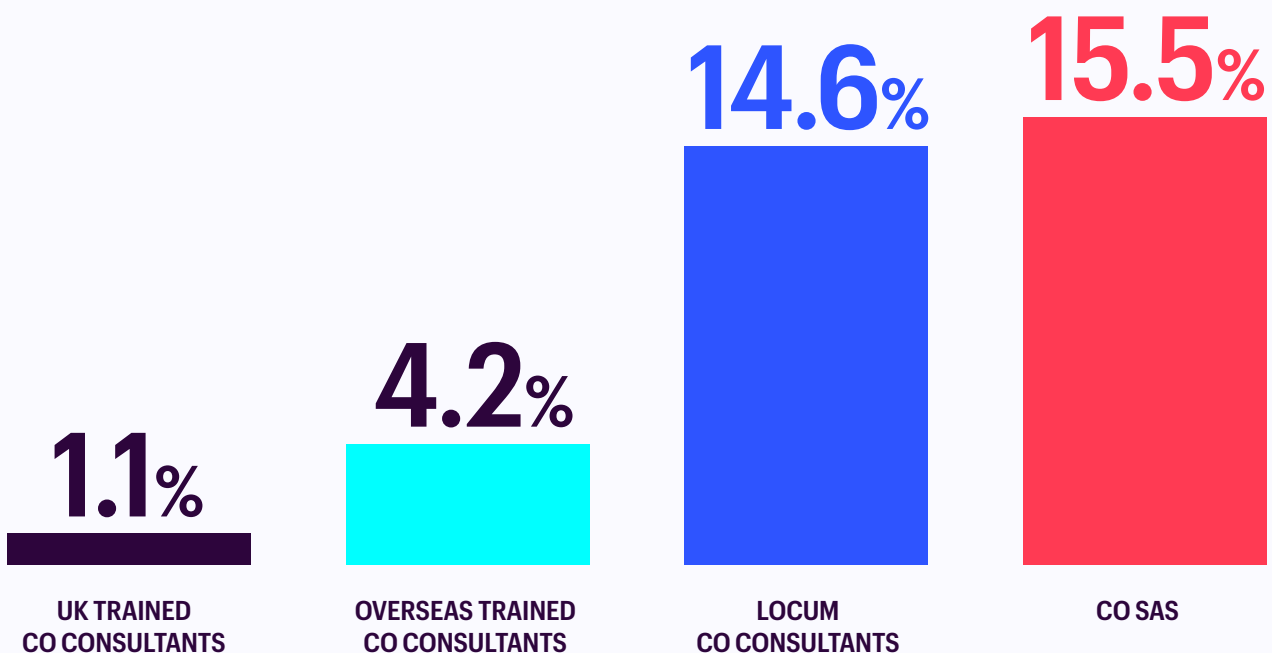
of SAS leavers had served up to two years' service, compared to just 10% of consultant leavers. This discrepancy is not due to a change of grade from SAS to consultant. Rather, higher turnover in SAS posts has been observed across specialties and is associated with fewer continuous development (CPD) opportunities, less chance of progression, and a feeling of exclusion from the multidisciplinary team.¹⁵ The fact that most SAS doctors are IMGs may also contribute to this effect.

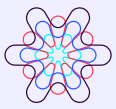


We have continued to deliver [the] service but with significant impact on existing staff. This will lead to stress, burnout and people leaving.

HEAD OF SERVICE

Clinical oncology attrition rates (5-year average)





Forecast retirements

Around a fifth (22%) of CO consultants are forecast to retire by 2030 (based on a median retirement age of 60 years). Moreover, 44% are expected to retire by 2035. As a younger cohort, fewer SAS doctors are expected to retire in this time: 15% by 2030 and 35% by 2035.



20% of our consultants are due to retire in the next two years, which presents a significant concern with staffing.

HEAD OF SERVICE

Five- and ten-year forecast retirements, CO consultants



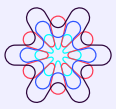
Site specialties

Clinical oncologists specialise their practice to specific cancer types, owing to the huge complexity and increasing treatment options available for each type. The RCR recommends that each CO consultant has at most two areas of expertise, or 'site specialties'.¹⁶ The average consultant currently has 1.9 site specialties. However, 30% of consultants have more than the RCR recommended number (i.e. they have three or more site specialties). This is a particular issue in small cancer centres, where 48% of consultants have more than two site specialties (versus 18% of those in large centres). This is a concern because consultants may struggle to keep up with advancing clinical practice across so many areas of cancer care.

Forecast retirements over the next five years vary significantly between site specialties. Areas with the highest forecast retirement rates include breast (28%), gynaecology (26%), haematological malignancy (34%), thyroid (31%), paediatrics (22%) and sarcoma (23%).

Thyroid, sarcoma and haematological malignancy are rare tumours that are treated with radiotherapy relatively infrequently. Higher forecast retirement rates may reflect natural attrition and may be less cause for concern so long as the cancer centres in question are aware and are actively planning to replace those staff (though it can be challenging to replace expertise in these less common cancers).

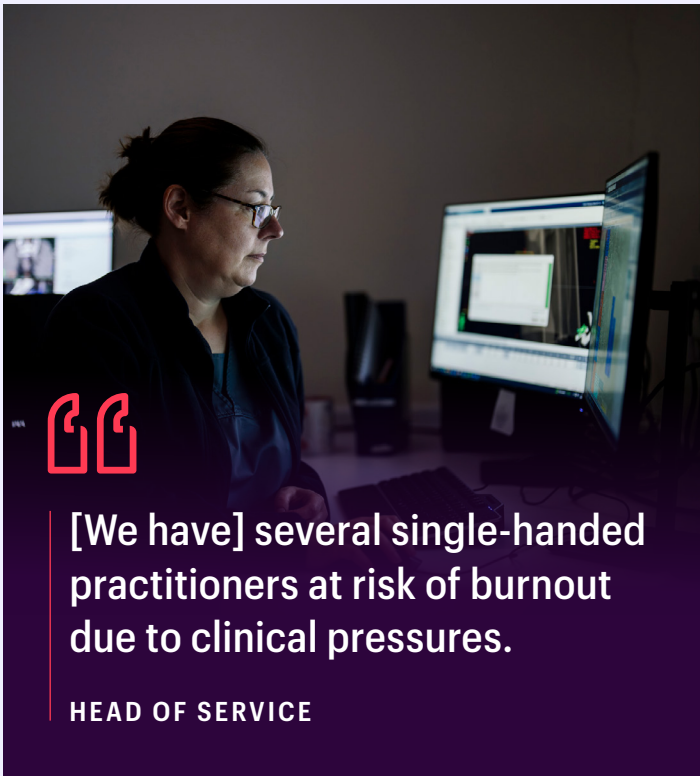
Areas such as breast are more concerning. Patient volumes for breast cancer are high. Many patients are predominantly treated with SACT, rather than radiotherapy, but radiotherapy expertise for breast cancers is nonetheless required in every cancer centre. The higher forecast retirement rate for this site specialty may reflect this being a relatively unattractive and/or high burnout area, due to the intensity of the work. Breast and gynaecological cancers primarily affect women; workforce planning must ensure that inequities in women's access to cancer care are avoided.



Lone practitioners

RCR recommends that there should be at least two consultants per cancer type per cancer centre, such that unplanned absences can be accommodated.¹⁷ A lack of adequate consultant cover refers to a cancer centre having either a lone practitioner or no consultants whatsoever capable of treating a certain tumour type. Some cancer centres may have networked arrangements for certain cancer types, and care for some cancer types may be led by medical oncologists. In the following analysis, where a cancer centre has no consultants for a given tumour type, it is assumed they do not treat patients for that type of cancer, and they are excluded.

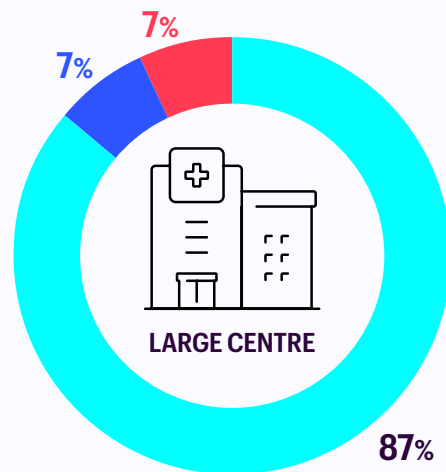
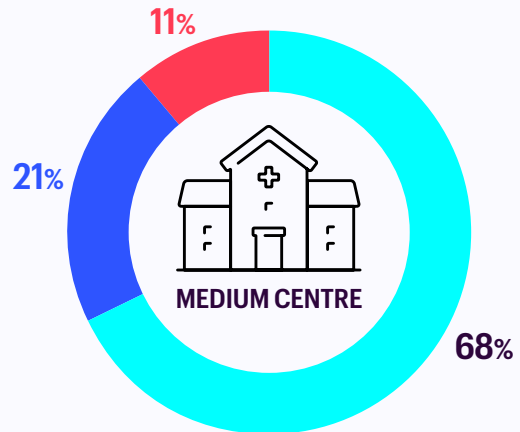
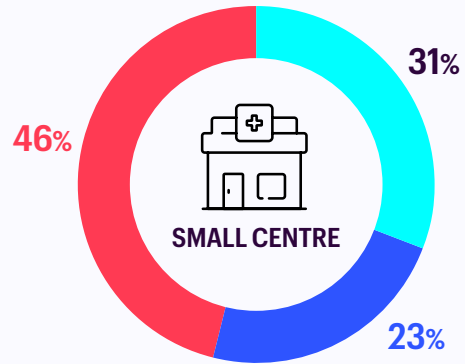
Approximately one-fifth of cancer centres report having no consultant cover for two or more cancer types. This indicates a significant risk to timely and safe patient care and also to the wellbeing of these lone practitioners, who may suffer greater risk of burnout. Twenty-one cancer centres have no cover for haematological malignancy, thirteen have no cover for sarcoma, and ten have no cover for central nervous system cancers. Nearly half of small centres (46%) have no cover for two or more cancer types. By contrast, 87% of large centres have cover for all cancer types. It is not known which of these cancer centres have networking arrangements in place for these cancer types.



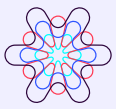
[We have] several single-handed practitioners at risk of burnout due to clinical pressures.

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Proportion of cancer centres lacking tumour site cover by cancer centre size, 2025



- Two or more tumour sites without cover
- One tumour site without cover
- Cover for all tumour sites



Working patterns

Less than full time (LTFT) working is increasingly common. It is open to all postgraduate doctors, either during or after specialty training. Many use the option to work LTFT to balance their professional responsibilities against family commitments, to preserve their wellbeing, or to pursue further education or research.

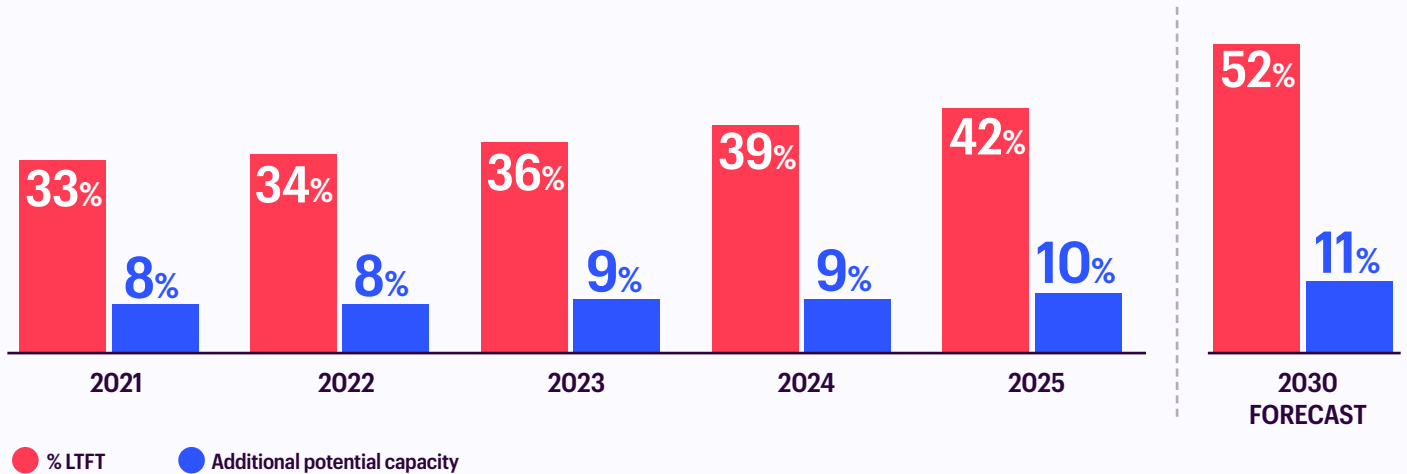
The proportion of CO consultants working LTFT rose to 42% in 2025.¹⁸ LTFT working is increasingly common across all age groups, though it is most common amongst consultants approaching retirement age. It is more common in large cancer centres, where 48% of consultants take this option, than in small centres, where 36% do so; this may be due to large centres' greater capacity to facilitate LTFT working requests. For the first time, the RCR can forecast that by 2030, over half (52%) of all CO consultants will be working LTFT.

'Additional potential capacity' is the amount of extra WTE the NHS would have if all CO consultants worked full time. This figure now stands at 9.6%. Workforce planning must account for the rise in LTFT working; workforce modelling should be based on WTE requirements to deliver the desired outcomes, rather than headcount.

It is important to note that most staff who work LTFT are working close to full time, with a median workload of approximately 8 PAs, as compared to 10 PAs for a full-time contract. This means that the amount of capacity 'lost' per consultant is low. Moreover, the RCR strongly supports the ability for staff to work LTFT, since it can significantly contribute to their wellbeing, morale and productivity at work, hence to staff retention.



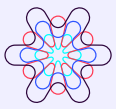
LTFT working, CO consultants





Resident doctors





Workforce statistics

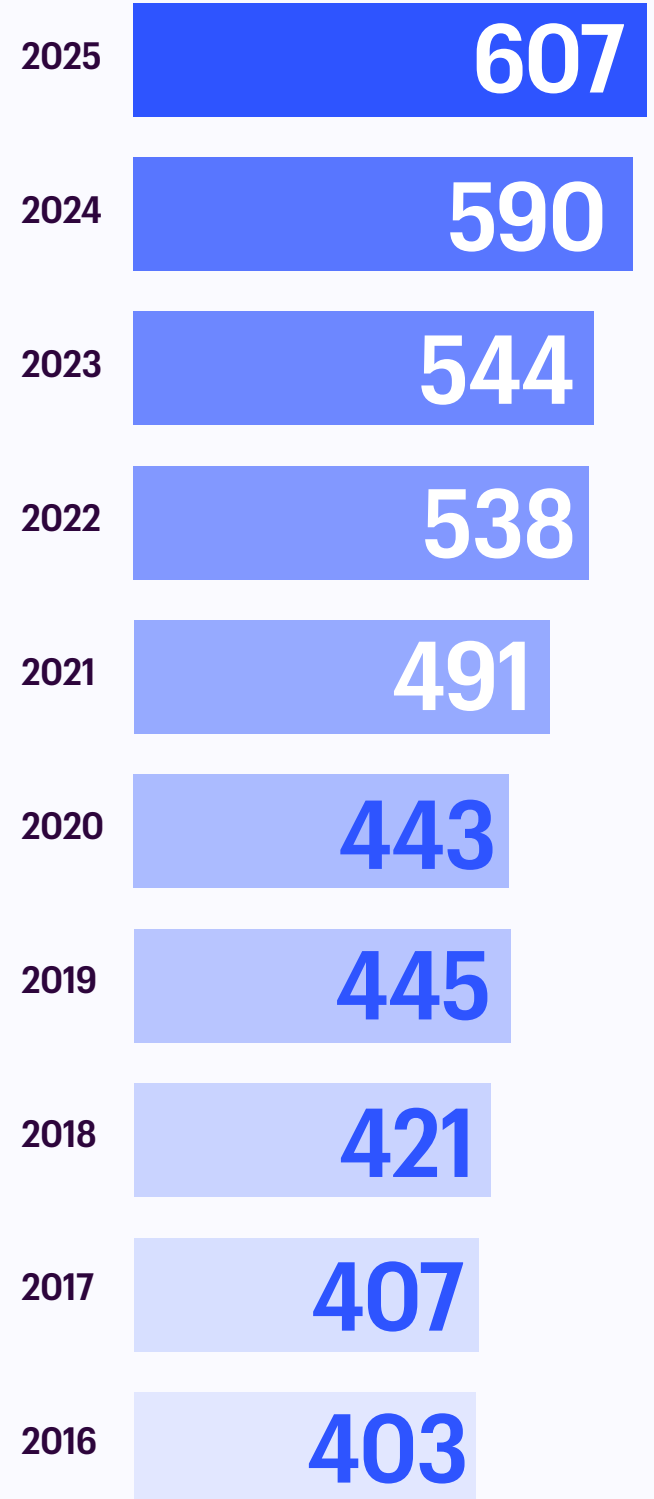
Resident doctors are an essential component of any oncology service. There are currently 607 resident doctors in CO specialty training (up from 590 in 2024); this is equivalent to 31% of the total CO workforce (consultant, SAS and resident, including locums). Over the past five years, the UK's CO resident workforce grew by an average of 6.5% per year.

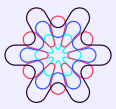
Regions like the East of England (12.9%) and the North East (14.9%) saw strong growth. But the resident workforce in Scotland declined by an average of 1.4% and in Northern Ireland it declined by an average of 2.8%. Wales saw 4.9% average growth. The average annual increase of CO residents in all of England's training regions was 7.7% over the past five years. This discrepancy between England and the other nations is highly concerning.¹⁹

Relative to other specialties, clinical oncology is more reliant on IMGs. The number of IMGs in CO specialty training has risen to 30% in 2025 from 17% in 2015. NHS England data reveals that, in 2024, of the 113 individuals who accepted a CO specialty training post, 53% were UK medical graduates and 47% were IMGs.²⁰ Careful impact assessments will be needed to analyse the effects of the Medical Training (Prioritisation) Bill on individual medical specialties, particularly those that are more reliant on IMGs, like CO.²¹



CO resident doctors (headcount), past decade





Resident doctor demographics

63% of current CO resident doctors are women. This proportion has varied from 61% to 66% over the past decade. The median age at which individuals started CO specialty training over the past five years was 31 years, the median age at which individuals completed training was 37 years, and the median age at which they gained their first NHS consultant post was 38 years. The gap between completion of training and commencement of consultant work includes time spent in the post-training grace period, which extends up to six months (see page 24); the proportion within the grace period may be increasing due to recruitment freezes (see page 25).

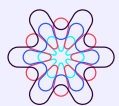
Length of training

The average length of CO specialty training has risen over time. In 2011-15, the average time to train was 6.7 years; by 2021-25 it had risen to 7 years. Drivers of this trend include a greater prevalence of LTFT working amongst residents (see below) and people taking 'out of programme activities' (OOPA), e.g. to conduct research or take up Fellowships.

LTFT working

34% of CO resident doctors work LTFT. As with consultants and SAS doctors, this choice is often made to meet other commitments, personal or professional, or for wellbeing reasons. Nonetheless, more residents working LTFT means that funding is absorbed that could otherwise go towards additional training posts. This is because funding for training is allocated on a headcount basis. If two residents each work 0.7 WTE (the average for this group), then there is an additional potential 0.6 WTE that could be allocated towards another resident doctor, were training posts and their funding instead allocated by WTE. (This is also known as 'slot sharing'.) Not only should LTFT working be factored into workforce planning, but also funding flows should be designed to maximise existing capacity in the system.



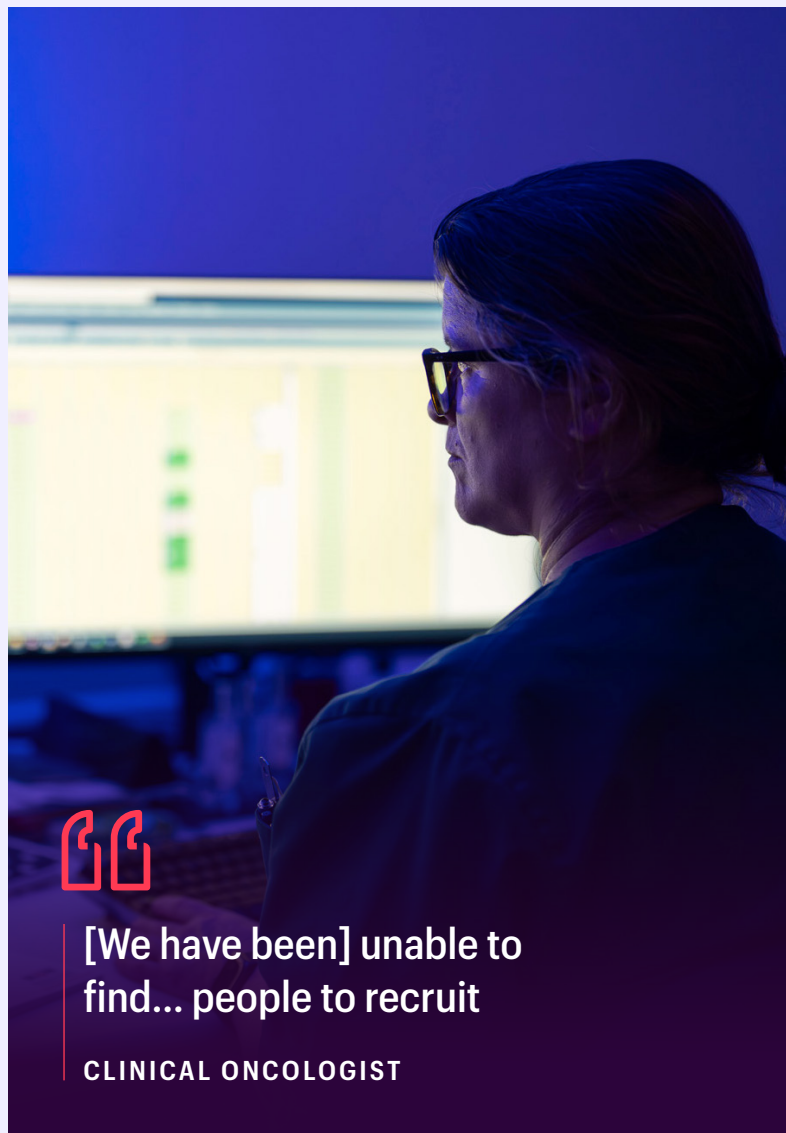


Clinical oncology fill rates

CO does not always fill its allocation of specialty training places. The fill rate for CO training posts in 2025 was 86%.²² Some regions, like the North West and North East, had 100% fill rates in 2025. However, Yorkshire and the Humber had a 70% fill rate, and Northern Ireland had a 67% fill rate.

Lower fill rates in CO are attributable to multiple factors, including a lack of exposure to clinical oncology in undergraduate, foundation and internal medicine training, the inclusion of medical physics in the curriculum, and misperceptions around cancer care being 'emotionally draining'.

The 2025 fill rate was a notable improvement on the years prior: 54% in 2023 and 71% in 2024. However, it should be noted that the same number of posts were filled in 2025 as in 2024, with the higher fill rate resulting from the fact that fewer posts in total were on offer. Nonetheless, higher fill rates were secured by several means, including a CO recruitment campaign led by the RCR and supported by NHS England, an increase in size of the internal medicine training (IMT) cohort, and the commitment of clinical oncologists across the country to promote their specialty. There are numerous things that cancer centres and the wider NHS can do to increase recruitment into clinical oncology, such as providing taster sessions or careers events, or providing oncology teaching and supervision for undergraduate projects. Implementing equitable rotation of residents through the regions that have historically struggled to attract residents could boost their ability to recruit and retain doctors.



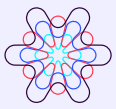
**[We have been] unable to
find... people to recruit**

CLINICAL ONCOLOGIST

Training attrition

Attrition during CO specialty training in recent years has returned to historical levels. In the period 2006-10, attrition ran at 11%; it then rose to 19% in 2011-15 and 16% in 2016-20. By 2021-25 it had fallen to 13%. Attrition is higher in England than the other nations, and is lowest in Wales (6%). Of those who leave, approximately 40% do so within the first two years of training. Regionally, attrition rates were concerningly high in areas like the West Midlands

(35%) and the North West (21%). This has contributed to the above average workforce shortfalls in these areas. These data exclude inter-deanery transfers. A significant proportion of CO residents who leave training do, however, remain in the NHS by transferring to a different training programme – above all, to medical oncology. 17% of those who left CO training between 2010 and 2020 have subsequently completed their MO specialty training.



Post-training movements

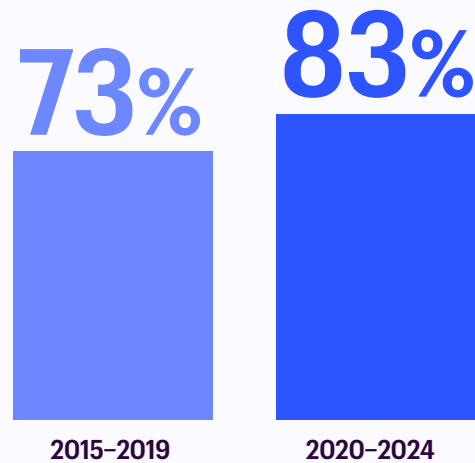
Of those who completed training in 2024, 91% were registered as occupying an NHS consultant post within one year. In recent years, more residents have taken up consultant posts within one year of completing training than in prior years; 83% of those in 2020-24 were consultants within a year, compared to 73% of those in 2015-19.

More recently, there has been an increase in the number of residents remaining in their grace period by the end of the year in which they completed training. 20% of those who completed training in 2024 were still in the grace period by the end of 2024, but 32% who completed training in 2025 remained in their grace period by the end of 2025. This can be explained by the significant rise in recruitment freezes over the past year, because these are limiting a timely transition into substantive consultant posts. Indeed, in England, where

recruitment freezes are most prevalent (see page 25), the share remaining in the grace period rose from 19% to 36%.

These two data points suggest that over a longer period, more people have wanted to become consultants more quickly. But in the past year, recruitment freezes frustrated that desire for some. Not only is this a problem for those who are struggling to find consultant posts. The longer one spends in the grace period, the longer their training post is not freed up for a new resident to enter.

Share of resident doctors who become consultants within one year of completing training, past decade



[There is] real panic from senior [residents] that there may not be a job for them at the end of training in centres which are struggling and desperately in need of more consultants.

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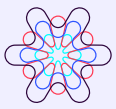
Post-training attrition

Of those who completed training in 2021-25, 96% remain registered with a licence to practise. 3% of those who completed training in 2021-25 are registered with the GMC without a licence, so are likely living and working overseas or are taking a career break. A further 1% are unregistered. Approximately 10% of residents do not take up a consultant post within 2-3 years of completing training. Some of this cohort will remain licensed and registered, but may be working in private practice.

There is a strong tendency for residents to remain in the region in which they trained after completion of training.²³ Across the past five years, on average 79% of those who

completed training took up an NHS post in their training region within three years. During training, many will have established local connections and made major life decisions, such as buying a house or starting a family.

Where residents do move to a new region upon becoming a consultant, there are clear patterns that emerge. London and the South East act as donors of new consultants to other regions; they acquired six new consultants from the 2020-22 cohort of new consultants, but lost 16 of their own residents upon their becoming consultants. By contrast, the South West saw a net gain of eight new consultants from other regions over that period.



Recruitment freezes

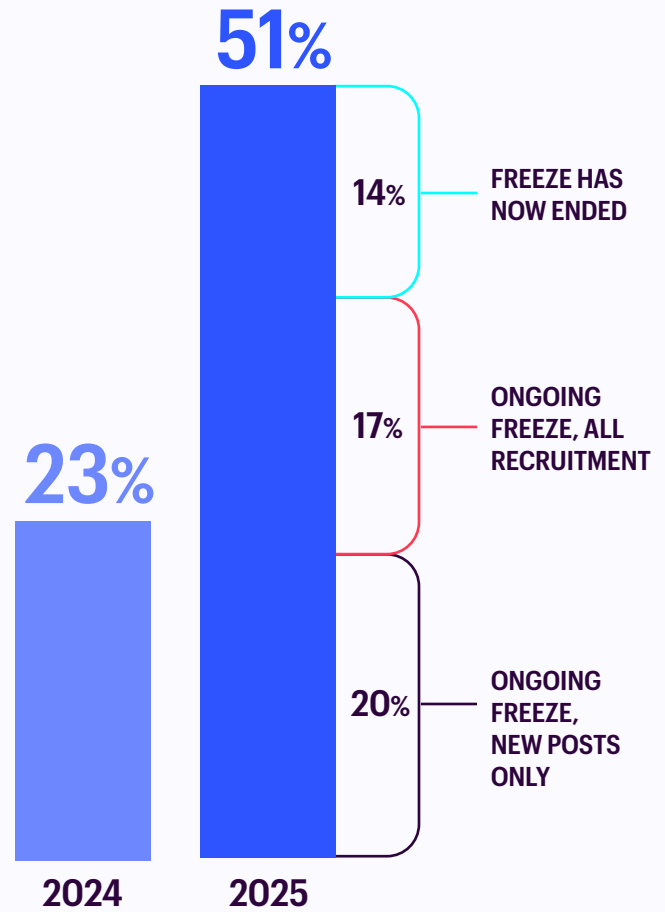
Since 2024, the number of recruitment freezes across the UK has more than doubled. Just over half of all cancer centres (51%) in 2025 reported experiencing a recruitment freeze. 37% reported that this freeze was ongoing at the time of data collection. 20% of centres reported a freeze affecting new posts only, and 17% reported a freeze on all recruitment, including to fill vacancies. In 2024, only 23% of cancer centres reported experiencing a freeze.

Freezes were most common in England (57% of cancer centres, versus 20% across the other nations). They were also more common in cancer centres in rural or deprived areas (60% reported a freeze) than in those centres in urban or more well-off areas (48% reported a freeze). Similarly, 53% of small cancer centres reported a recruitment freeze, compared to 40% of large centres. Centres that have experienced a recruitment freeze are also more likely to have higher workforce shortfalls.

The increasing commonality of recruitment freezes is deeply concerning. They undermine the NHS's efforts to tackle backlogs for diagnosis and treatment of cancer, and jeopardise initiatives to reduce cancer mortality and meet waiting times targets.²⁴

Moreover, they have detrimental effects for training – both by reducing a cancer centre's capacity to deliver training and supervision to residents, and by making it harder for residents who complete training to find a consultant post in their region. There is some evidence emerging that freezes are increasing the time it takes for a resident who completes training to find a consultant post (see page 24). In the long run, both effects could translate into poorer care for local patients, with impacts reverberating long after the recruitment freeze ends.

Proportion of cancer centres reporting a recruitment freeze, 2024–2025



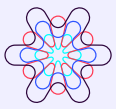
[A] recruitment freeze and [the] removal of 25% of radiography and physics posts has directly resulted in a 10-week waiting time for radiotherapy.

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[Recruitment freezes are] preventing timely recruitment... [which has] undermined productivity and compromised the ability to deliver timely, high-quality patient care.

CLINICAL ONCOLOGIST



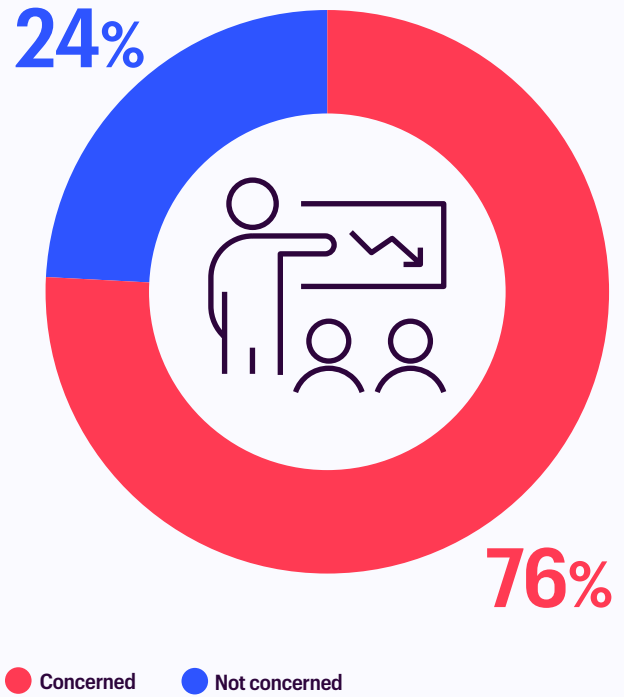
Barriers to CO specialty training

Heads of Service report a range of barriers to increasing or making best use of training places in their cancer centre. The most reported barrier was a lack of physical space, which would include clinic rooms, workstations, and staff break areas. 75% cited this as a concern.

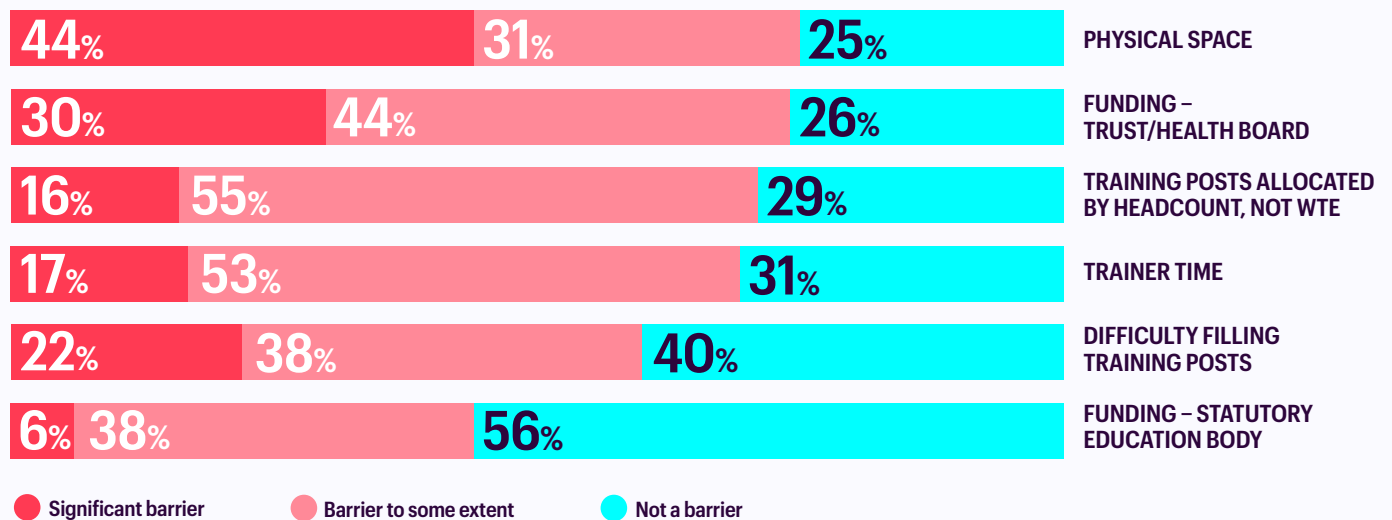
The finding that trainers in 69% of cancer centres do not have sufficient time to dedicate to delivering specialty training is concerning, and aligns closely with the UK's chronic CO consultant shortfall. Combined with rising demand, trainers have become ever more squeezed, struggling to care for their own patients whilst also educating the next generation of consultants.²⁵ This is having a detrimental effect on the quality of CO training, with 76% of cancer centres citing this as a concern (rising to 80% amongst small cancer centres).

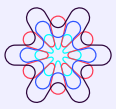
A lack of trust/health board funding is a barrier to training in 74% of cancer centres, but a lack of funding from statutory education bodies is a barrier in just 44% of centres. In Northern Ireland, Scotland and Wales, 100% of the costs of each specialty training place are funded by the central NHS, whereas in England, trusts are expected to meet 50% of the costs. Funding is less of a barrier overall in the devolved nations, with 44% of cancer centres reporting insufficient trust/health board funding and only 22% reporting insufficient funding from their relevant education body; these figures compare to 80% and 49% amongst English cancer centres, respectively. This suggests that the funding model in England is a genuine problem for cancer centres wishing to expand their workforce.

Heads of Service concerns for the effect of workforce shortages on CO training quality, 2025



Barriers to CO specialty training, UK, 2025





3

Resident doctors

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Large cancer centres are, across the board, less likely to face these challenges – though that does not imply that challenges do not exist for them. Just 60% of large centres are struggling for physical space, versus 73% of small centres. Small cancer centres find it more difficult to fill the training posts they have available; 93% of them report this as a barrier, compared to just 27% of large centres. This is due to the lower relative attractiveness to many applicants of working in a small centre – not simply because most small centres are in rural areas, but also because there may be a perception that large centres offer more educational and professional opportunities.

71% of Heads of Service report that training posts being allocated by headcount, rather than by WTE, is a barrier to training because it reduces their overall training capacity. This links to the prevalence of LTFT working amongst residents (see page 22). Because there is limited ability to reallocate funds from those residents working LTFT, cancer centres are training fewer individuals than, other things being equal, they would be able to.



[We have] registrars having to do appointments in cupboards because there aren't enough clinic rooms.

CLINICAL ONCOLOGIST



Valuable teaching opportunities are lost and the apprenticeship training model that I benefitted from is long gone.

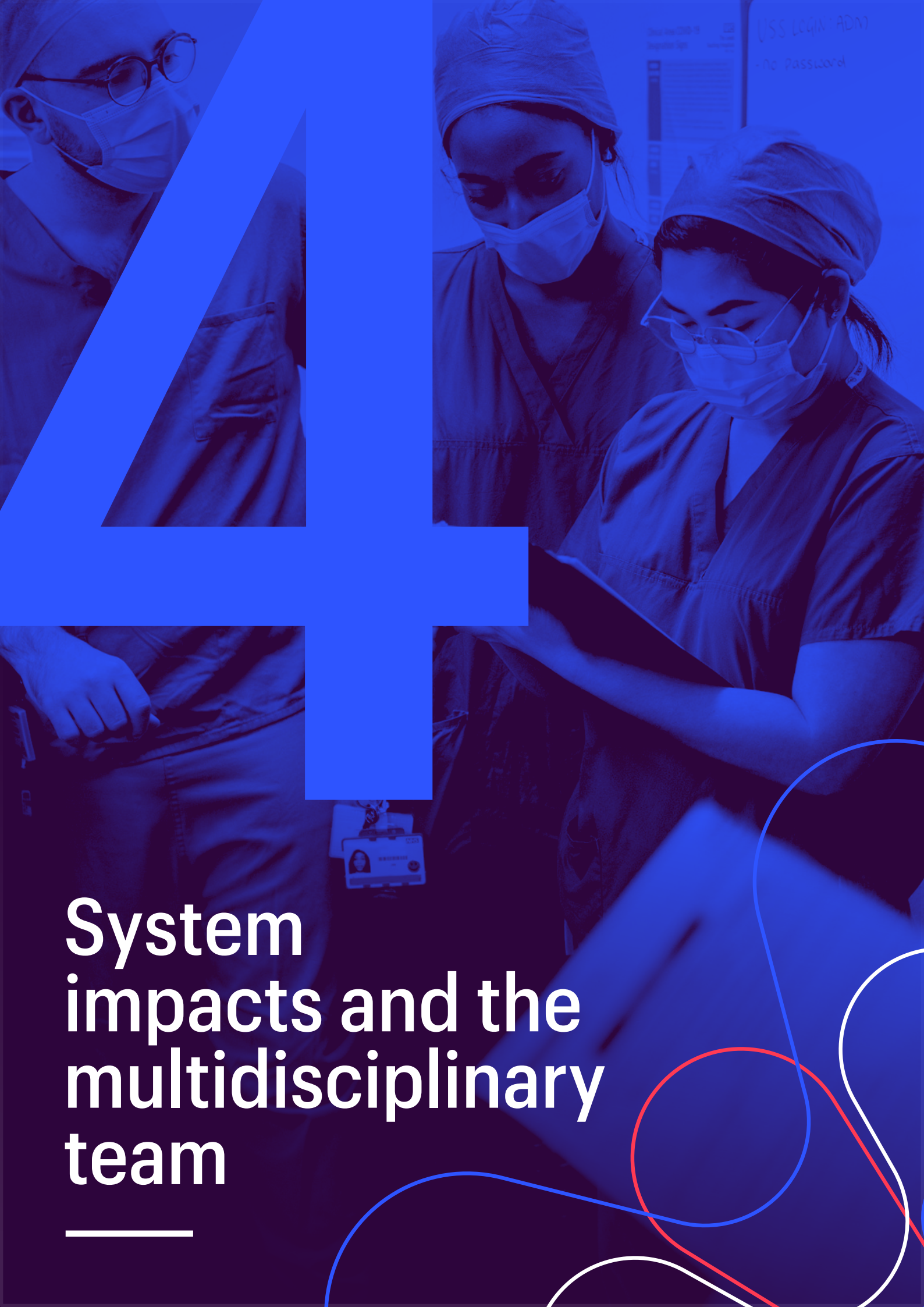
CLINICAL ONCOLOGIST



Residents are receiving much less hands-on experience and fewer opportunities to develop clinical judgment and procedural competence.

CLINICAL ONCOLOGIST



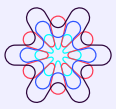


System impacts and the multidisciplinary team



The findings of the 2025 census have implications for the wider cancer workforce, within and beyond clinical oncology.

Staff shortages also have real effects for patients and for the healthcare system. These challenges are being met by clinical oncologists' drive to innovate and improve the quality of care they can provide.



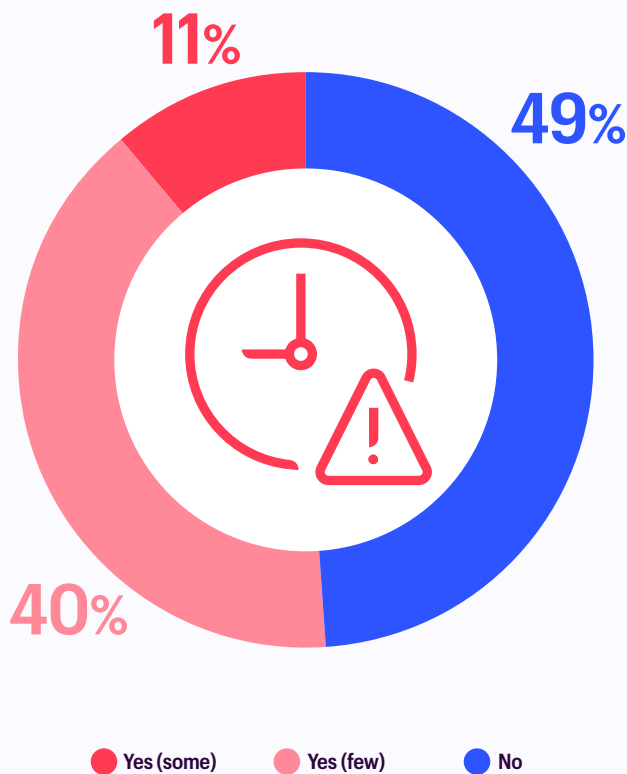
What are the effects of workforce shortfalls?

Workforce shortages result in patients' conditions worsening

Half of cancer centre Heads of Service report that they are aware of patients whose conditions have worsened because of delays caused by staff shortages. A cancer centre's size, rurality and the area's relative deprivation exacerbate this effect.

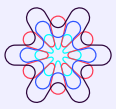
92% of Heads of Service are concerned that staff shortages are resulting in backlogs and delayed treatment for patients. This is consistent with Heads of Service once again reporting widespread and persistent delays to patient care.

Heads of Service aware of worsening patient conditions due to delays caused by oncology staff shortages



Unfortunately, we encounter patients whose radiotherapy strategy needs to be changed (or even abandoned completely) due to (disease) progression between referral and treatment.

CLINICAL ONCOLOGIST

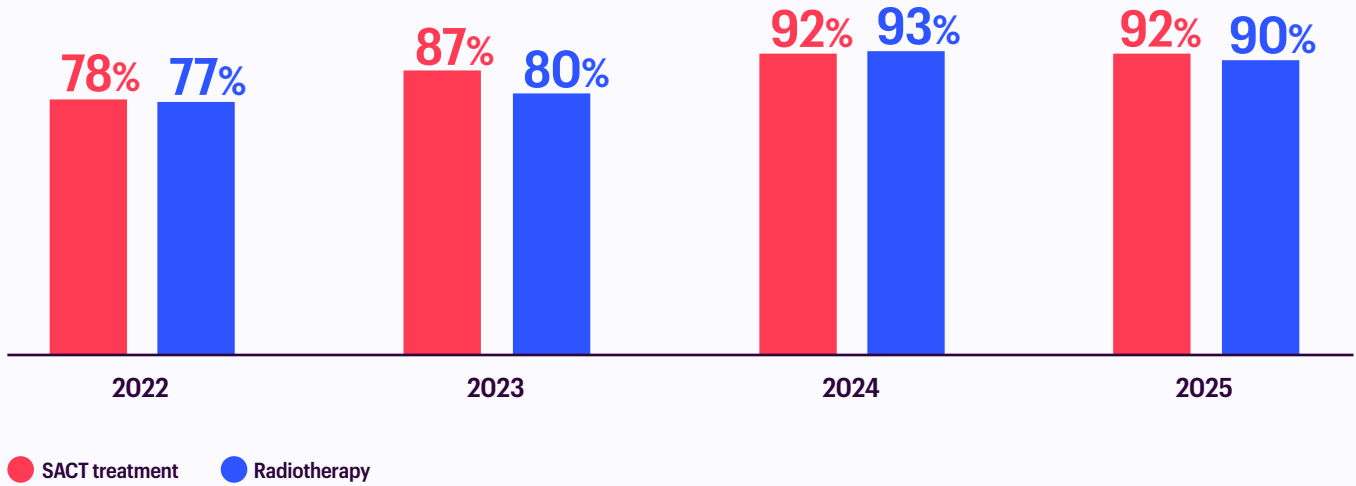


4

System impacts and the multidisciplinary team

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Percentage of Heads of Service reporting delays in starting patient treatment

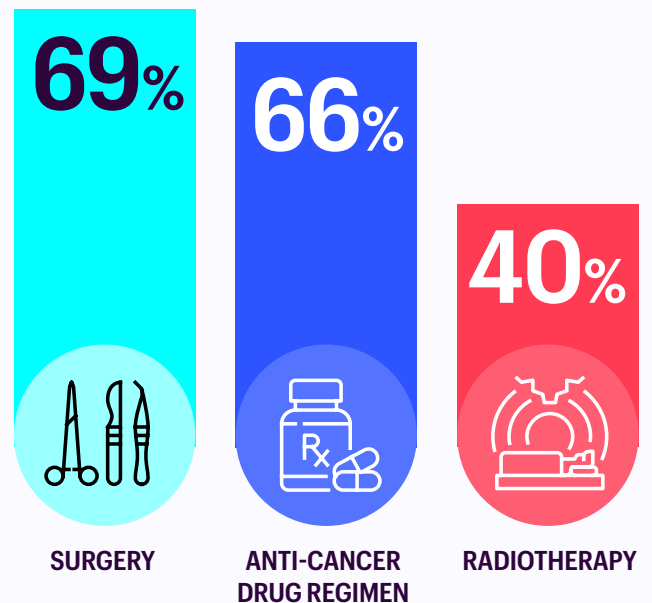


In 2025, staff shortages were linked to delays in patients starting SACT treatment in 92% of cancer centres and delays in patients starting radiotherapy in 90% of centres.

These findings are borne out by NHS England cancer waiting times data. Across 2025, just 69% of patients began their first cancer treatment within 62 days of their referral. Though annual performance has increased from 65% in 2023 and 68% in 2024, it is still far short of the constitutional target of 85%. Only half (50%) of providers treated 70% or more of their patients within 62 days. Worryingly, NHS performance against this target is significantly worse for radiotherapy than other treatments. Just 40% of those waiting for treatment with radiotherapy in 2025 began that treatment within 62 days. At the regional level, this radiotherapy-specific performance figure falls as low as 31%. Moreover, just 5% of all providers were able to treat 70% or more of their patients with radiotherapy within 62 days. This is clear evidence of the impact of CO workforce shortages on patients.

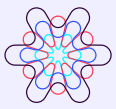
NHS England data does not adequately monitor the timeliness of subsequent treatment deliveries – of which radiotherapy is very common. This is a problem, because there is good evidence that delayed subsequent treatments also impact outcomes like recurrence and survival.

Percentage of patients beginning treatment within 62 days of referral, England, 2025



[The] biggest impact... is on patients, who see endless new doctors.

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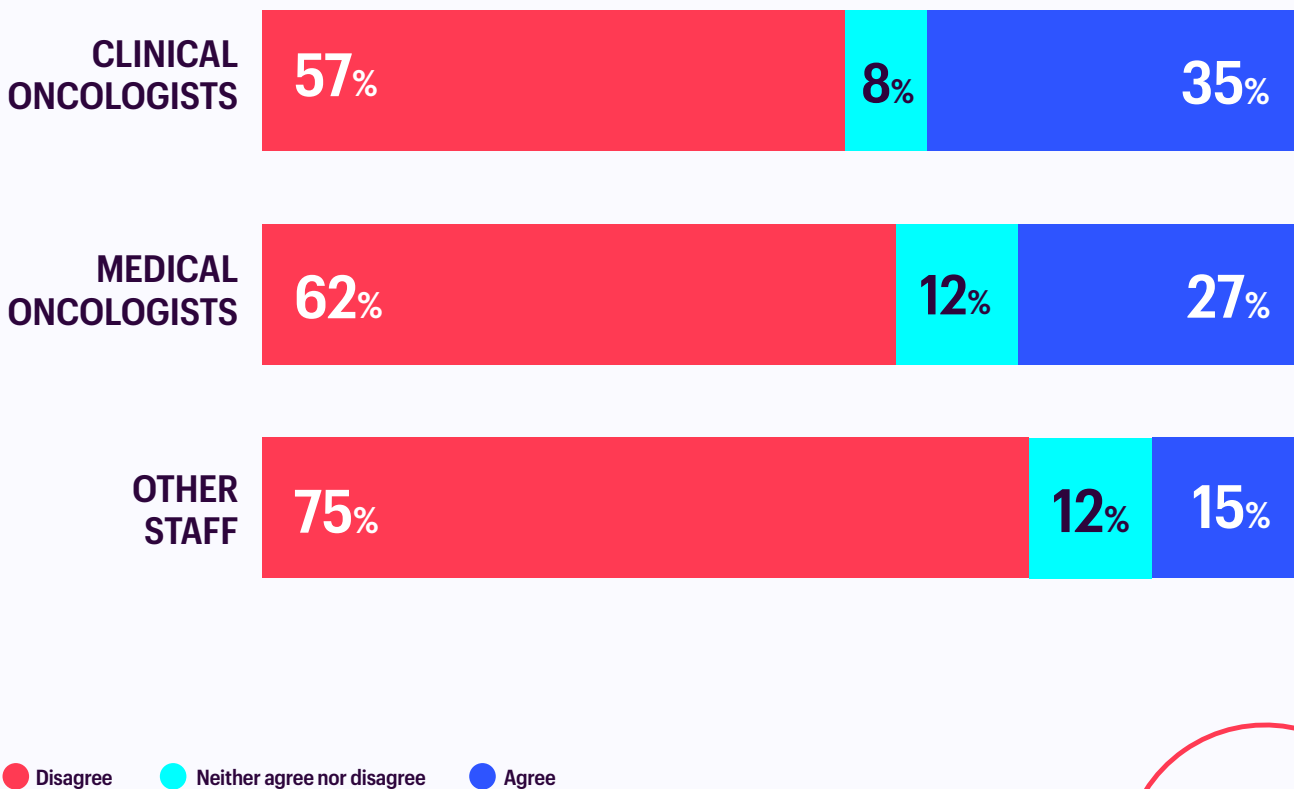
Heads of Service concerns

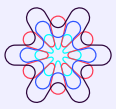
73% of Heads of Service are concerned about workforce shortfalls impacting patient safety. Only 35% of Heads of Service say they have sufficient COs, only 27% say they have sufficient MOs, and only 15% say they have sufficient other staff across the cancer team (such as nurses, radiographers, and medical physicists). This level of concern is at least as high as in 2024, when 60% said that a lack of cancer centre staff was jeopardising safe and effective patient care.²⁶

Only 13% of Heads of Service in rural or more deprived areas feel there are sufficient COs to deliver safe and effective patient care, versus 43% of those in urban or less deprived areas.



Proportion of Heads of Service reporting sufficient staff to deliver safe and effective care, 2025





Wider effects of workforce shortfalls

Every single Head of Service reports concern for the wellbeing and morale of their staff. Other sources suggest that low morale and high levels of stress and burnout are resulting in staff sickness and absences.²⁷

Heads of Service are also concerned about the wider implications of staff shortages. 98% report that shortages are resulting in insufficient time to make service improvements, 98% that they have insufficient time for clinical leadership, and 95% that they have insufficient time for clinical trial recruitment.²⁸ As with most census metrics, these problems are heightened in the responses of Heads of Service of small cancer centres, or of cancer centres in rural or more deprived areas.

Over time, doctors have seen their administrative burden rise in line with rising demand, but also as tangible administrative support for doctors has declined. This administrative burden is excessive and negatively impacting doctors' wellbeing and service quality.^{29,30}



[We have] long term sickness with some staff... [and] reduced capacity to take on leadership roles, which in turn impacts services such as acute oncology.

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[We have a] feeling that we have let patients down.

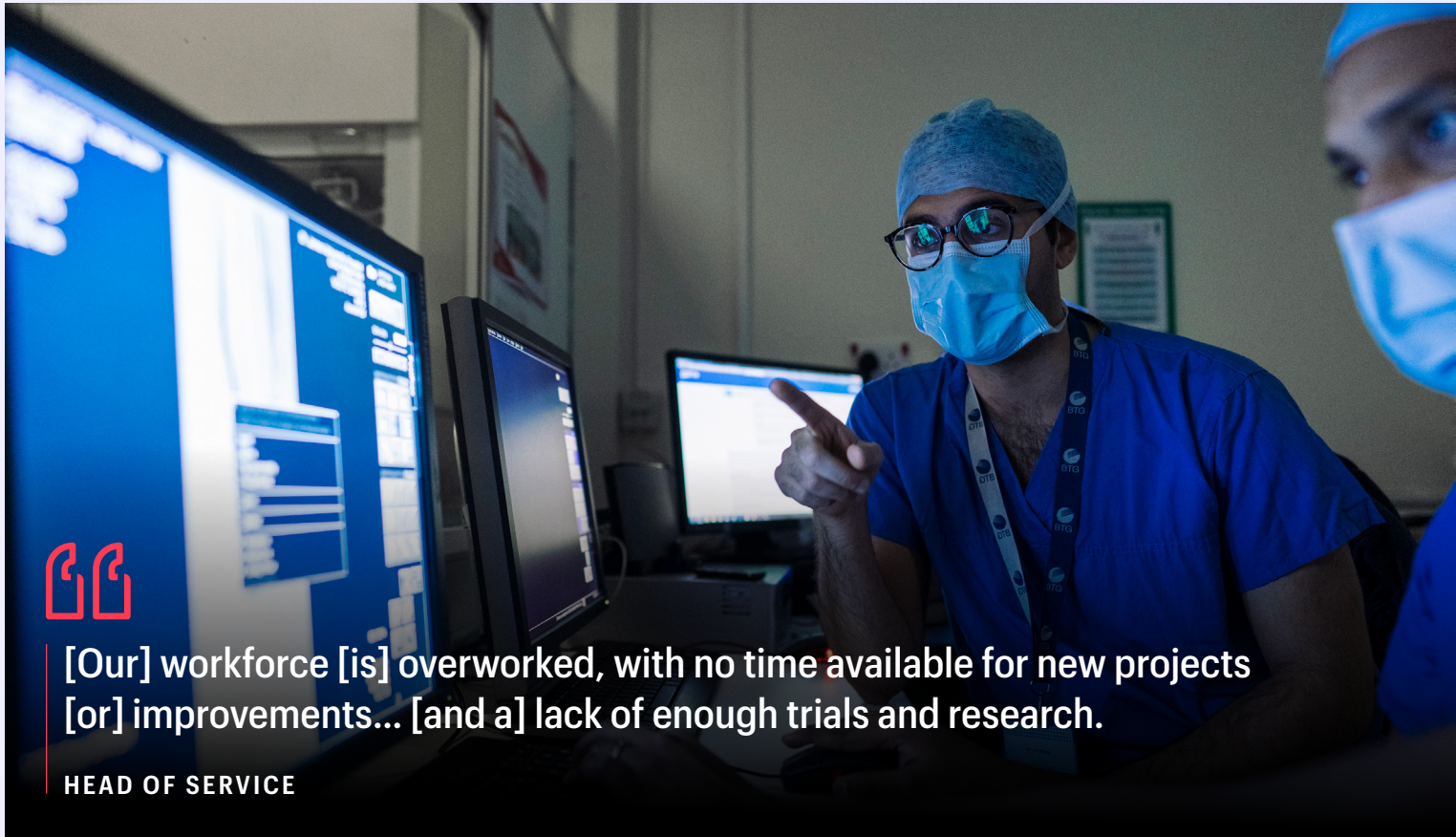
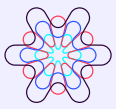
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All staff [are] working at the top of their competencies and most [are] working overtime in an unsustainable fashion.

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[Our] workforce [is] overworked, with no time available for new projects [or] improvements... [and a] lack of enough trials and research.

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Workforce pressures and consultants' time

Over many years, clinical oncologists' time has become increasingly pressurised, with activities other than direct clinical care being deprioritised to meet rising patient need. This, though, has negative consequences into the longer term for training, innovation, and care quality.

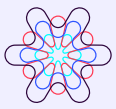
Supporting Professional Activities (SPAs) are non-clinical activities formally worked into consultants' job plans, and include teaching, medical education, CPD, leadership, research, service improvement and preparation for appraisal or revalidation. They underpin clinical care and contribute to the quality of the individual clinician and the service. In the past decade, CO consultants have experienced a 25% decrease in the median number of SPAs in their job plans.

In 2015, the average consultant had 1.9 SPAs (approx. 8 hours) in their job plan, compared to 1.6 (approx. 6 hours) in 2025. This erosion is partly explained by newer cohorts of consultants having slightly fewer SPAs in their job plans than older cohorts; the average consultant who joined the

workforce in the past five years has 20 minutes fewer than the average for all consultants. The risks to patient care, staff wellbeing and service innovation are therefore backloaded, with significant potential challenges still to emerge. It also has important implications for staff retention (see page 16).

One-fifth (22%) of CO consultants currently have fewer than 1.5 SPAs in their job plan, in contravention of RCR guidance.³¹ Whilst this is an improvement on recent years, it remains higher than the 15% recorded in 2015.

Simply because they are not written into consultants' job plans does not mean that professional commitments outside of direct patient care do not exist. Increased administrative burdens and rising demand for patient care bleeds into allocated SPA time. This means that many consultants spend a significant portion of their non-working hours meeting their SPA commitments and additional responsibilities, which contributes to elevated levels of stress and burnout.³²



4

System impacts and the multidisciplinary team

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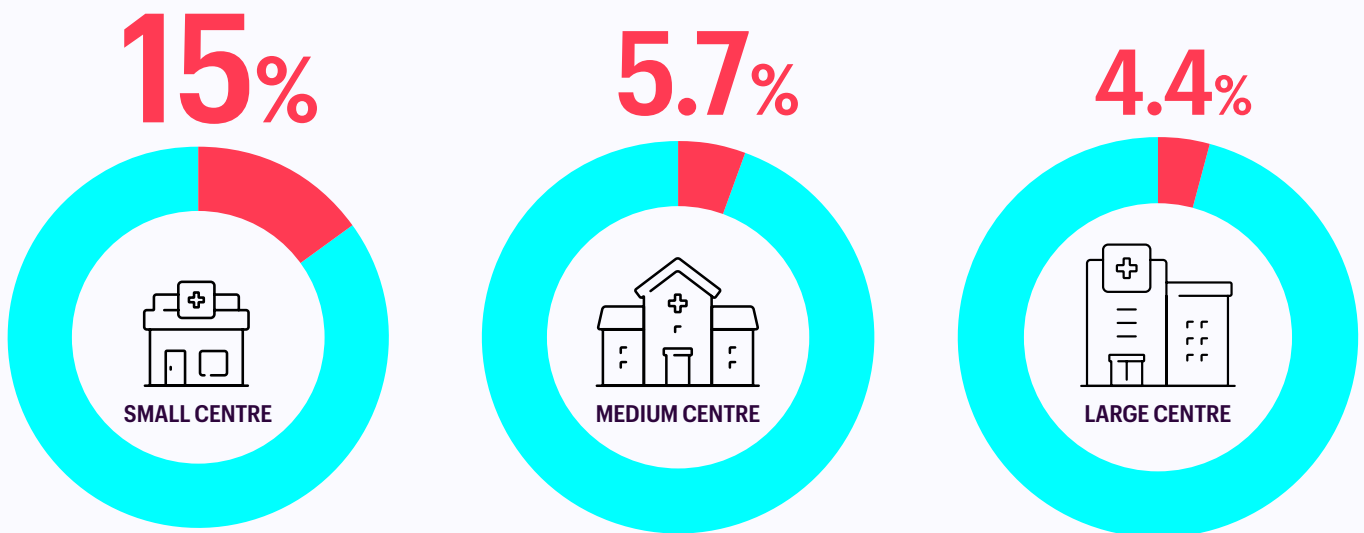
Cancer centre attrition

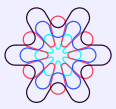
Though reported by all Heads of Service, concerns about staff morale are more pronounced in small centres, where 87% are highly concerned, than in large centres (60% highly concerned). One possible effect of higher levels of stress, or lower levels of morale, is to drive staff to either leave the NHS or to move to work in another cancer centre. (Other effects include higher levels of absenteeism and presenteeism, increased rates of error, and reduced productivity.)³³

Combined average cancer centre attrition across the past five years, covering both workforce leavers and inter-cancer centre movers, was 6%. However, this varies hugely by individual cancer centre, from as high as 30% to as low as 2%. Attrition amongst small cancer centres averaged at 15% over the past five years, versus just 4% in large centres. At the national level, average attrition was highest in Wales (8%) and lowest in Scotland (5%). Cancer centres with persistently high attrition risk losing specialist expertise that is difficult to replace, leaving patients potentially short of expert care.



Average attrition by cancer centre size, past five years





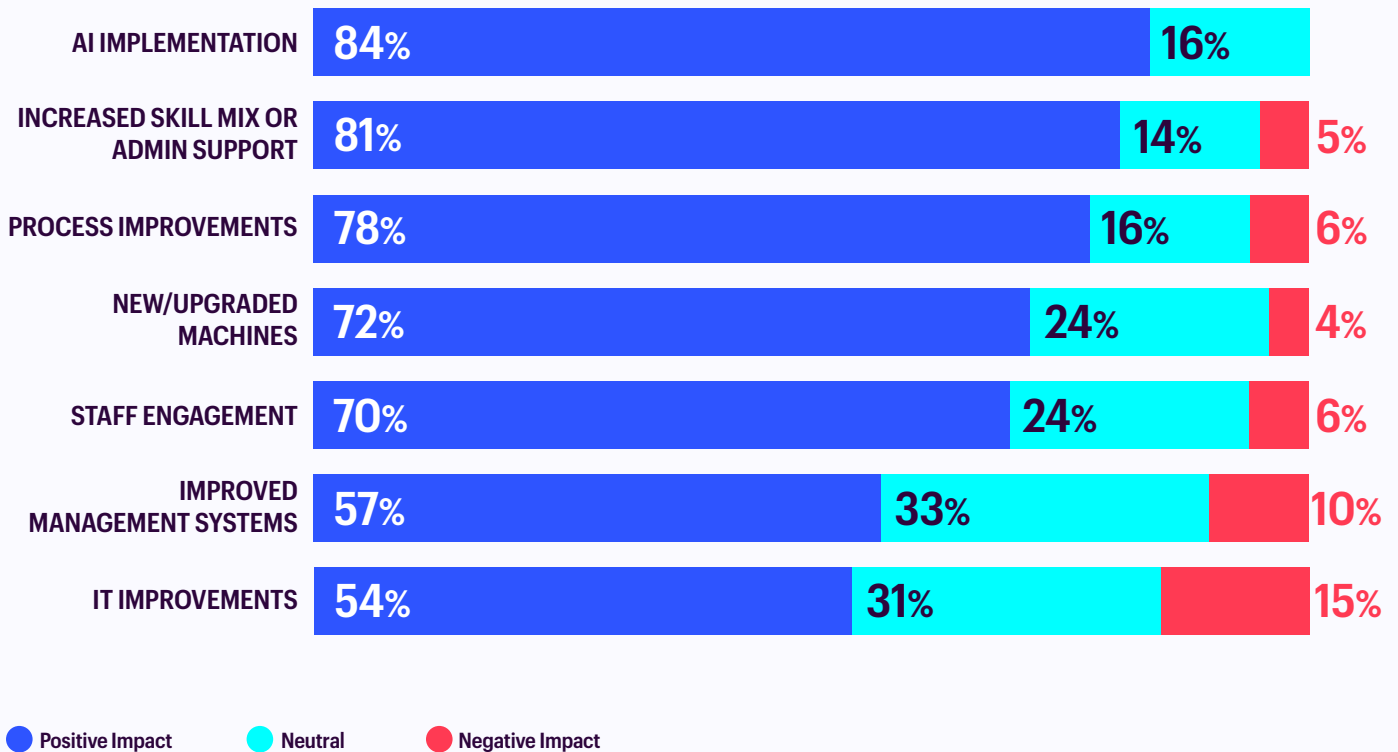
How are clinical oncologists responding to these challenges?

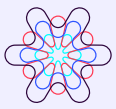
Improvement initiatives

Encouragingly, every single UK cancer centre implemented at least one improvement initiative in 2025. Indeed, the average cancer centre implemented four different initiatives. The most common of these were process improvements (76% implementing) and IT system improvements (76% implementing). 67% implemented skill mix and/or additional administrative support, 66% implemented some form of artificial intelligence (AI) (see below), and 64% introduced improvements to management systems (e.g. data dashboards, reporting). The least common initiative, perhaps due to the

higher costs involved, was new and upgraded machines, with only 54% reporting this. By excluding those who did not implement each type of initiative, it is possible to evaluate how successful cancer centres have found these various options. 84% of Heads of Service reported a positive impact to AI implementation in 2025, and 81% were positive about skill mix and admin support. Comparatively few were positive about IT improvements and management systems – and a portion (15% and 10%, respectively) reported negative impacts. Initiatives that concerned the human aspects of work were particularly popular.

Head of Service perceptions of the success of improvement initiatives, 2025





The use and impact of artificial intelligence

As of 2025, approximately four-fifths (81%) of cancer centres are using AI tools for at least one purpose. This varies from 100% in Wales and 83% in England to 60% in Scotland and 50% in Northern Ireland. Some of these trusts/health boards will have introduced these tools for the first time in 2025, but others would have been implemented earlier and are still in use.

This statistic masks the fact that AI usage in CO remains relatively narrow. 81% of cancer centres are using AI tools in primary tumour contouring and/or organ at risk (OAR) delineation during treatment planning. But the next most common use case, AI tools for quality assurance and checking treatment plans, is only used in 35% of centres.

By excluding those who do not use each type of AI tool, we can evaluate to what extent they are having a positive impact. Here, tumour contouring/OAR delineation again emerges top, with 76% of those using it saying it reduced their workload. In all other use cases, most Heads of Service report that AI has no effect on workloads. Notably, 11% report an increased workload caused by AI tools for staff rotas, and 14% report an increased workload caused by AI tools for managing patient appointments.

These findings can be explained by the fact that auto-contouring of primary tumours with AI is widely used

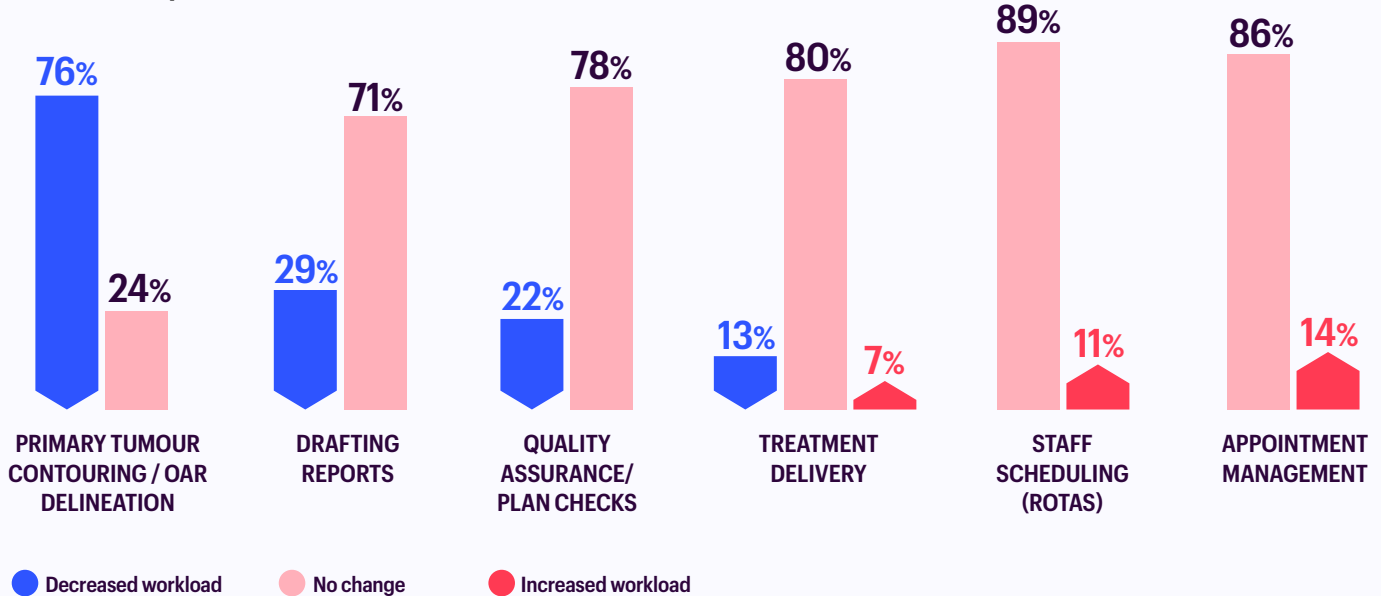
by clinicians and its strengths and limitations are well understood.³⁴ The contours must still be checked by an oncologist, but the software nonetheless saves time. On the other hand, other AI tools are yet to reach a similar level of quality, trust and coverage. Both the maturity of the technology and the level of staff familiarity with it are crucial for successful implementation. Where Heads of Service report no positive effects to workloads, or even negative effects, this may be the result of cheaper, less effective tools being procured, or the relatively recent introduction of a tool into service. Benefits of large projects can often take time to accrue, given timelines for implementation, the need to monitor and adjust the new tool, and the need to train staff in the new tool and way of working.

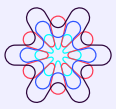


A critical eye is essential, with active questioning of whether the AI has got it wrong rather than assuming it is correct.

CLINICAL ONCOLOGIST

Workload impacts of various AI tools, 2025

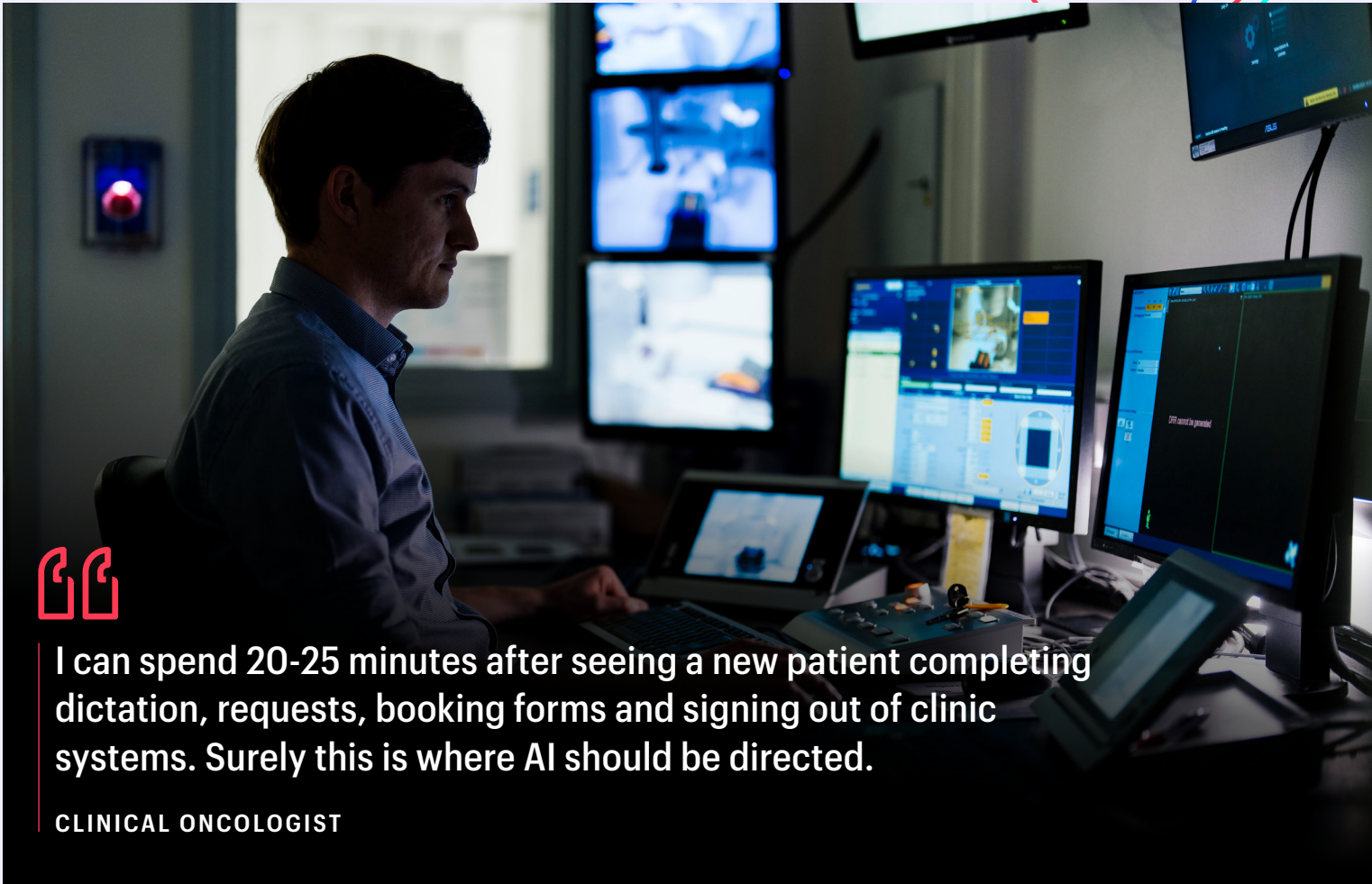




4

System impacts and the multidisciplinary team

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I can spend 20-25 minutes after seeing a new patient completing dictation, requests, booking forms and signing out of clinic systems. Surely this is where AI should be directed.

CLINICAL ONCOLOGIST

AI in contouring and OAR delineation should be seen as a positive story and as an indication of where other AI tools could get to, provided they are implemented safely and effectively, with sufficient clinical oversight. The NHS should work to ensure that every single cancer centre across the country has access to auto-contouring, given the benefits it appears to be bringing.

Attention should afterwards turn towards implementing effective AI tools for administrative tasks. These data show that it is these applications that have significant unexploited potential to reduce clinicians' workloads and enable them to spend more of their time more productively, either directly caring for patients or implementing service improvements.



[Our] admin burden is high, with [a] significant backlog.

HEAD OF SERVICE



AI auto-contours are very useful, and [have] saved a lot of time.

CLINICAL ONCOLOGIST



The national picture

Cancer care in England,
Northern Ireland,
Scotland and Wales



National and regional shortfalls

Scotland 18%

North of Scotland 21%

South West Scotland 19%

South East Scotland 13%

England 17%

East Midlands 27%

Yorkshire & Humber 22%

South West 22%

West Midlands 20%

North West 18%

East of England 17%

South East 17%

North East 14%

London 5%

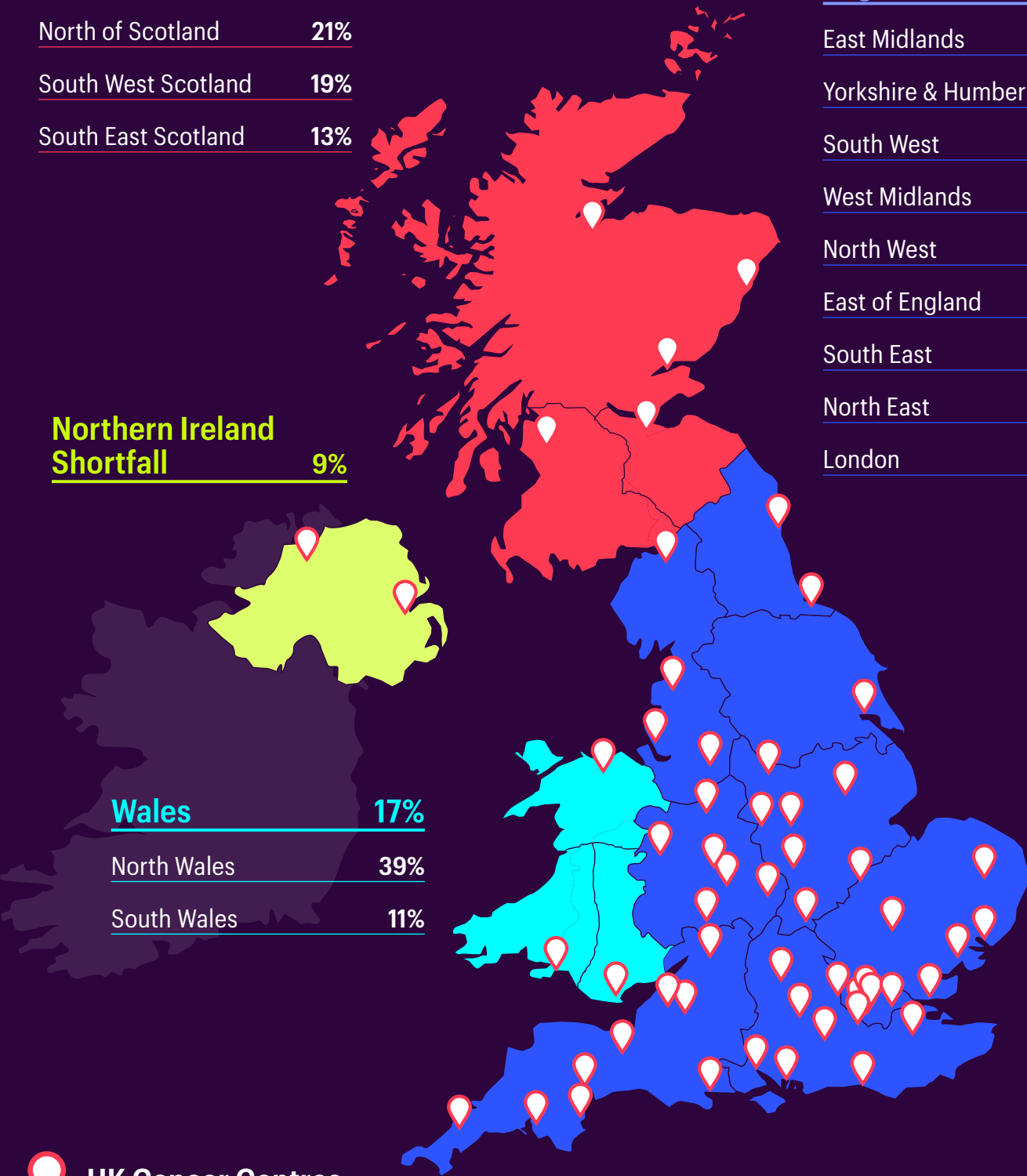
Northern Ireland Shortfall 9%

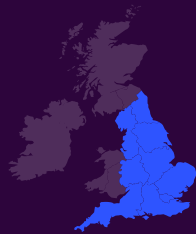
Wales 17%

North Wales 39%

South Wales 11%

 UK Cancer Centres





England

Submissions from England comprise over 80% of the data in the census. Its results therefore trend very closely to those of the whole UK. Amongst others, England is an outlier in the following data:

- + England has the fewest consultant oncologists per 100,000 older population of any UK nation, at 6.8
- + Recruitment freezes are most common in England, and are present in 57% of its trusts
- + Average annual growth in the resident doctor workforce was by far strongest in England in 2021-25, at 7.7%
- + This also means that England has the lowest consultant:resident ratio of any UK nation, so consultants in England have the highest 'training demand'.



Scotland

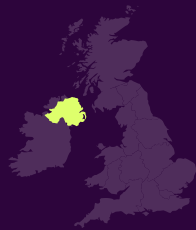
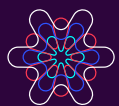
Scotland has the highest CO consultant workforce shortfall of any UK nation, at 18%. This masks a systematic issue with oncology in Scotland, namely, the divide between the South East (13% shortfall) on the one hand and the South West (19% shortfall) and North (21% shortfall) on the other hand.

Scotland is forecast to have a 38% CO consultant shortfall by 2030, the highest of any UK nation (versus 26% across the UK). The workforce is expected to grow by just 1.2% annually each year to 2030, an effect driven by the number of new consultants approximately equalling the number of WTEs lost by retirement and the LTFT effect. However, the workforce in the North of Scotland is forecast to shrink during this period, from 28 to 22 WTE by 2030.

Indeed, Scotland now has fewer CO residents than it did in 2021: 42 versus 45. This is due to a decline in the North of Scotland (with the number of residents in the other two regions unchanged over this period). Heads of Service indicate that attracting residents to the specialty and/or region, sufficient trainer time and the allocation of training places by headcount are their main challenges; attracting residents is a particular problem for the North of Scotland.

Scotland is least reliant of any nation on locums (4% of the consultant workforce, versus 8% across the UK) and employs the fewest SAS doctors (4% of the CO workforce, versus 7.6% across the UK). However, this means that Scotland's CO consultants are working extremely hard: 37% have 12 or more PAs in their job plan (versus 22% across the UK).

There are delays to patients commencing SACT in every Scottish cancer centre and frequent delays to patients commencing radiotherapy in four of the five cancer centres. The latest Scottish government data shows that just 71% of patients began treatment within 62 days, against an aim of 95%, with no Health Board meeting this target.³⁵



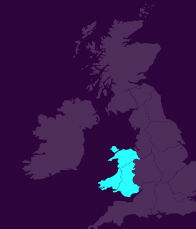
Northern Ireland

Northern Ireland (NI) has the lowest consultant workforce shortfall of any UK nation, at 9%. In part, this is due to its smaller population. However, the shortfall is set to soar to 35% by 2030. This forecast is driven by retirements amongst CO consultants in NI exceeding the number of new consultants from specialty training and global recruitment. A rise in LTFT prevalence from 29% (the lowest in the UK) to 42% will also contribute; by 2030, potential additional capacity in NI were all consultants to work full-time would be 17%, above the UK average.

Indeed, there are fewer residents currently in NI than there were in 2021. Heads of Service in Northern Ireland suggest that the main challenges in training are attracting resident doctors and providing sufficient physical space for them. The fact NI has a 67% fill rate for CO specialty training supports this conclusion. NI has the highest consultant:resident ratio of any UK nation, indicating that the issue is not a lack of trainer time (at least compared to the other nations).

NI is also highly reliant on locums, which comprise 12% of its consultant CO workforce (versus 8% across the UK). It also employs the most MOs of any UK nation, with MOs comprising 42% of the oncology workforce (versus 38% across the UK).

Heads of Service report delays to patients receiving radiotherapy and SACT, which is borne out by data released by the NI Department of Health: according to the latest data, only 88% of patients began cancer treatment within 31 days of a decision to treat, and just 30% began treatment within 62 days, against targets of 98% and 95%.³⁶



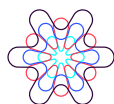
Wales

Wales' 17% CO consultant workforce shortfall matches that of the UK. However, it obscures a stark regional divide: 39% in North Wales, versus 11% in South Wales. The country's forecast workforce shortfall is 29%, above that of the UK (26%) but lower than that of NI or Scotland. This rise is due to trends in North Wales, which will be short of 13 WTE consultants (62%) by 2030. Across Wales, over the next five years the consultant workforce is expected to increase by 4.5% per year, with recruitment (from training and global joiners) exceeding retirements and attrition. However, in North Wales the workforce is expected to decrease from 10 to 8 WTE.

There are currently more residents in Wales than there were in 2021 (28 versus 23). Most of these are training in the South of the country, which explains the divergent forecasts for the North and the South. The North of the country faces challenges in attracting residents.

Wales is most reliant on locums of any UK nation; they comprise 17% of its CO workforce, against 8% across the UK. Half of North Wales' CO consultants are currently locums. Wales is also most heavily reliant on global recruitment; 37% of its consultant COs gained their PMQ overseas, versus 32% across the UK.

Heads of Service in Wales are concerned about having insufficient time for service improvement and clinical leadership. They also express concerns for patient delays and having insufficient staff for safe and effective patient care. Just 61% of Welsh patients began cancer treatment within 62 days of a decision to treat, against a target of 75%.³⁷



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2. Within staff contracted hours and adjusted to ensure there are sufficient clinical oncologists per 100,000 older population. For methodology, please consult this year's data worksheets.
3. This data results from applying the current workforce shortfall methodology backwards to previous years for which staff data are available. 2021 saw a spike, likely associated with the Covid-19 pandemic.
4. A 'small' cancer centre for the purposes of the census is defined as any one of the 25% of centres with the fewest CO consultants in post in 2025. 'Medium' comprise the middle 50% by no. consultants employed, whereas 'large' refers to the 25% centres with the most consultants.
5. Cancer centres in England have been flagged as 'more deprived' if they are located within the 25% most deprived Integrated Care Board areas, as per the UK government's index of multiple deprivation. Cancer centres in the devolved nations have been flagged as 'rural' if they are located outside of major conurbations. Measures of higher deprivation often coincide with rural and coastal regions.
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