Fortifying our frontline: improving care through a sustainable prostate cancer workforce in England

Policy report 2026

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PROSTATE CANCER UK

Contents

Thank You and Contributions

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The Royal College of Radiologists

The Royal College of Pathologists
Pathology: the science behind the cure

The British Association of Urological Surgeons

BAUN BRITISH ASSOCIATION of UROLOGICAL NURSES

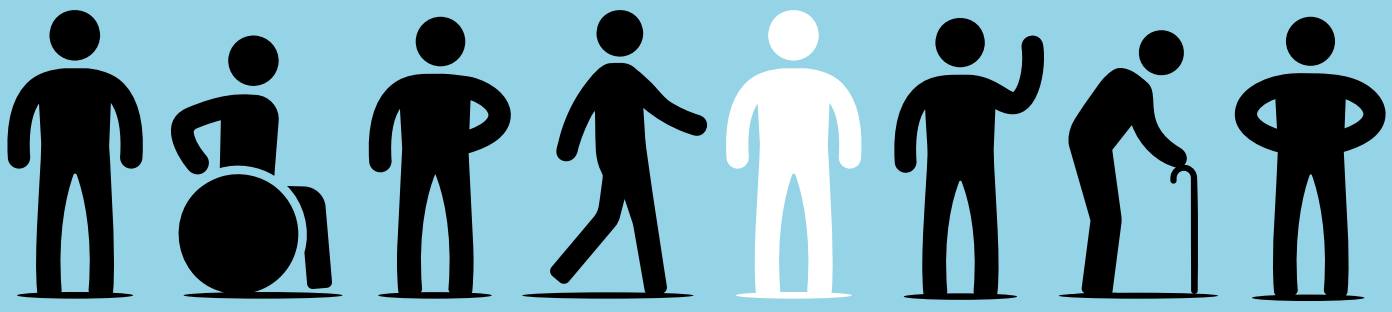
tackle prostate cancer

1. Who we are

We're Prostate Cancer UK. We're striving for a world where no man dies from prostate cancer.

1 in 8 men will get prostate cancer and we work to give every man the power to navigate it. Whether that's helping men understand their risk, make the right choice about treatment, or get the expertise they need to feel informed and in control.

We make every pound count. We've invested over £100 million into the best researchers in the world to unravel the complexity of prostate cancer, so we can give men precise and personalised care with the right treatments at the right time, for the best chance of living the full life they want.



2. Introduction

1 in 8 men will get prostate cancer in their lifetime in the UK. In England, 55,000 men were diagnosed in 2023 and currently, there are 600,000 men living with prostate cancer in the whole of the UK.[1]

While prostate cancer incidence rates are projected to rise by 15% in the UK between 2023-2025 and 2038-2040 there could be around 85,100 new cases of prostate cancer every year in the UK by 2038-2040.[2] It is vital that we address the issues surrounding the secondary care cancer workforce within our NHS. We hear an increasing number of patient stories about long waits for receiving a diagnosis or accessing treatments. Good patient care is predicated on a fully functioning, well-resourced team that can offer fast and accurate diagnosis and personalised treatment support throughout a patient's cancer journey. This is also integral for the best outcomes for patients.

To achieve this, the prostate cancer workforce needs to be future proofed. Strategic investment and targeted staff planning are essential in achieving this. The total NHS workforce increased by only 1.1% between October 2024 and October 2025, in comparison to a 3.3% rise in the previous year 2023-2024. Growth has also not been evenly spread across staff groups.[3]

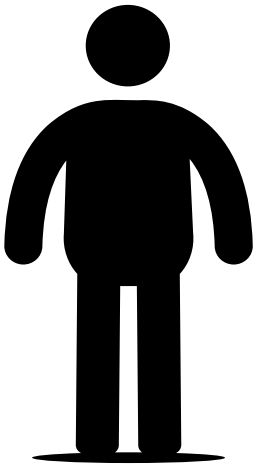
The pandemic is a key factor in why we now are seeing increased delays to services within secondary care. During that time many cancer testing services and routine procedures across the country were postponed, creating delays in diagnosis, service disruptions, and a backlog of patients needing treatments. These delays ultimately impacted overall cancer waiting times and in 2023, Prostate Cancer UK conducted a report looking into referrals and access to treatments during and after the pandemic.[4]

In this report it was found that 52,000 fewer people were referred for urological suspected cancer each month from April 2020 to March 2021, which translates to 14,000 fewer men starting treatment across the UK during that period. Post-pandemic (as of Feb 22), prostate cancer accounted for over a third of all cancer patients missing treatment and although there has been a gradual recovery, by September 2023, there remained a gap of 7,549 patients who had not yet initiated treatment. According to cancer waiting times data from January to August 2025, 38% of patients waited more than 62 days from referral for suspected cancer to starting prostate cancer treatment.

These backlogs, plus the ever-increasing number of diagnoses of prostate cancer placed additional pressures on already stretched services and staff. The BAUS workforce report for the year 2024 highlighted that although the urology waiting list has shrunk since the pandemic, it was only considered a modest reduction (~4.9% in the 12 months to March 2025).[5] Yet analysis of the official Cancer Waiting Times (CWT) statistics for urological cancers between November 22 and November 24 reveal that trusts were unable to the meet the 62-day referral to treatment standard. This standard ensures that patients are treated no more than 62 days following an urgent GP referral. While there may be other factors at play, workforce issues only contribute to bottlenecks and waiting times.

1 in 8

Men will get prostate cancer in their lifetime in the UK



55,000

Men were diagnosed in 2023

The UK government's Workforce and National Cancer Plans are opportunities to strengthen the cancer workforce. For prostate cancer, it's a chance to reimagine how information, support and care is delivered to men at risk of, and living with, prostate cancer in line with the Government's 3 shifts (sickness to prevention, analogue to digital, hospital to community).

With prostate cancer now the most common cancer in England, it must be a priority that we staff a sustainable NHS that can accommodate the rising number of men with the disease both now and in the future. The Government must act now to address shortfalls in the cancer workforce. These issues will only be worsened by inaction and may even undo many of the gains that were made in the post-COVID recovery. Underpinning all of this, and to ensure a sustainable workforce for the numbers of men that will be diagnosed and living with prostate cancer, the government must critically focus on the following areas:

1. **Retaining and upskilling our current cancer workforce**
2. **Increasing the cancer workforce**
3. **Transforming ways of working within the cancer workforce***

*i.e. utilising tech, more flexibility in jobs and adopting agile ways of working, where possible.

3. Radiology

From diagnosis via MRI scans to monitoring for recurrence via PSMA PET, the radiology workforce is crucial to the prostate cancer pathway and any delays can cause bottlenecks. The Radiological Society of North America has found that Europe has 13 radiologists per 100,000 population but there are worryingly only 8.5 per 100,000 in the U.K.[6] There has also been unequal growth of the radiology workforce among the four nations. In 2024 the Royal College of Radiologists (RCR) reported that growth in Wales increased by 1.1% and England's by 5.2%, Northern Ireland's grew by 4.1% and Scotland by 4.9%.[7]

The RCR also reported in 2025 a 32% shortfall of clinical radiology consultants (2,313 doctors) which without intervention is predicted to increase to 40% by 2030.[8] According to the RCR published workforce data (2025) on radiologists' specific areas of expertise, there were only 351 uro-radiology consultants in the UK (equating to 0.5 per 100,000 of the population).[9]

These understaffing issues coupled with high workloads can mean that in some areas, patients are waiting weeks for their scans to be read. Similarly, workforce shortfalls can lead to burnout and reduced morale amongst staff, impacting retention.

Delays in access to a radiologist and radiological services can also severely impact a man's diagnosis and subsequent treatment. Prostate cancer patients will be severely affected in every part of the pathway if this isn't fixed, as radiology is not only integral for diagnosis of prostate cancer but also for monitoring those living with the disease. Delays in these services, can ultimately lead to much poorer outcomes.

3.1 The use of AI within radiology

Artificial intelligence (AI) is being spoken about more routinely in healthcare, this section will explore what this could look like for radiology and what factors must be overcome to ensure they are effective for all men.

Novel ways of streamlining radiology departments have been looked at. For example, the National Institute for Health and Care Excellence (NIHR) Rapid Service Evaluation Team conducted a systematic scoping review of 140 studies in the international literature on AI in radiology diagnostics.[10] Within it they found promising evidence that AI, when used alongside a human reader, could improve diagnostic accuracy and workflow efficiency. There is substantial interest in how AI can be used to relieve the burden on the system by saving radiologists time, in addition to standardising image interpretation and increasing clinicians' diagnostic confidence. However, the evidence is still limited overall and mixed across studies for some outcomes. According to the RCR 2025 census, they found that while the majority of radiology departments were using AI tools (75%), the positive workload aspects were limited and uneven. Factors behind this include having more data points for a radiologist to review meaning the time it takes to report is longer, and post-deployment monitoring of AI tools can add to workload too.[8]

3.2 AI's potential to transform working within radiology

The NHS has recently proposed piloting an AI-powered 'one-day diagnostics' service for prostate cancer, which could revolutionize the diagnostic process and potentially reduce men's waiting time for a diagnosis by up to a month. While this initiative is promising, it's important to recognize the limitations of incorporating AI into the NHS, particularly the risk of bias towards certain populations who may not be represented fully in the data used within AI applications. This is particularly relevant with regards to Black men who are twice as likely to develop prostate cancer but are likely to be underrepresented. Thorough evaluation of AI systems is essential before their implementation. The STANDING Together (STANdards for data Diversity, INclusivity, and Generalisability) guidelines were created to address bias concerns, advocating for the use of representative datasets and bias testing during AI development.[11]

We believe that any data used to train AI should be inclusive and representative. If an AI tool is trained on non-representative data, it must be tested to ensure it performs reliably across all groups.

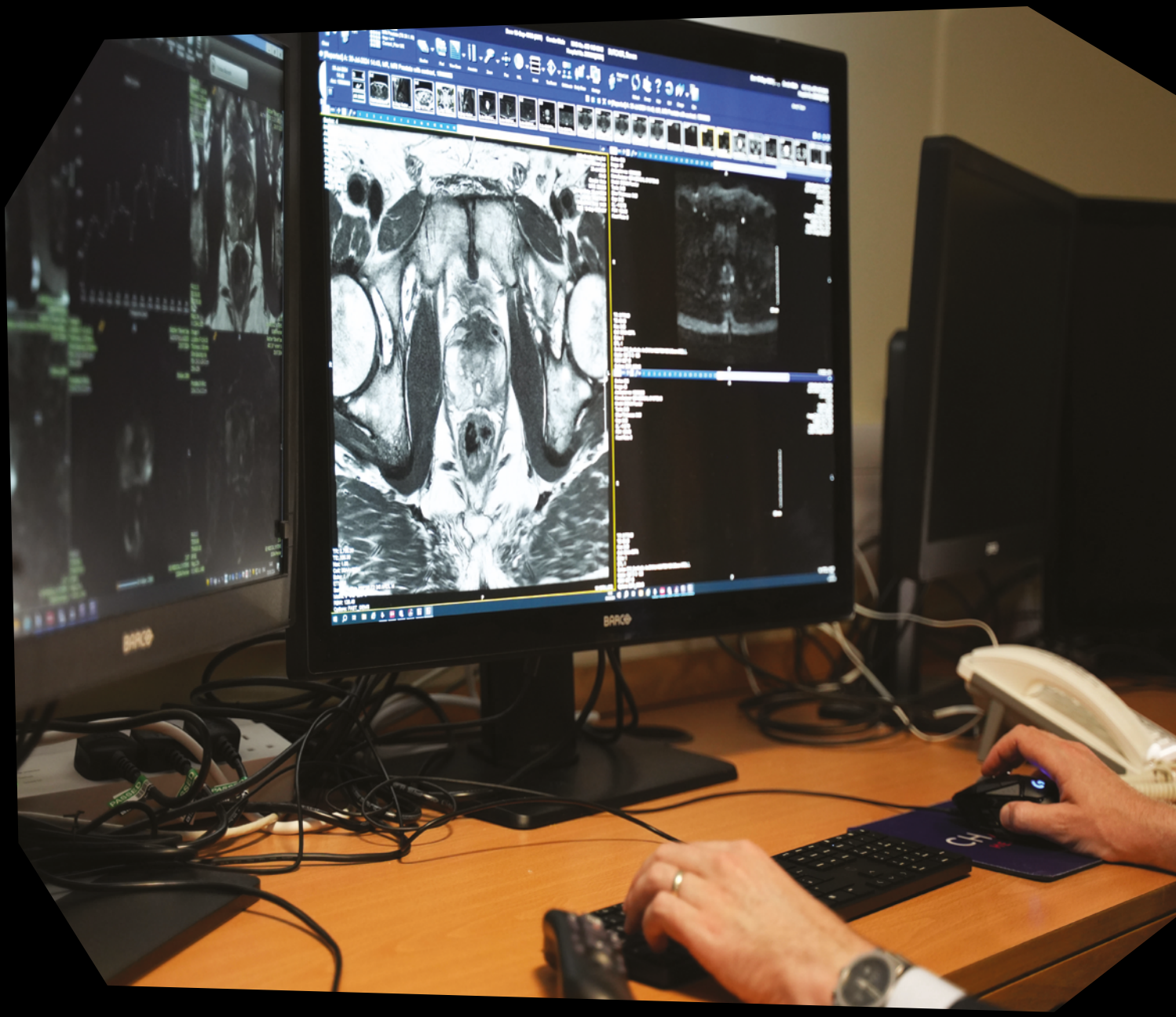
The PARADIGM trial is another example of the potential use of AI within radiology.[12] This trial, finishing in 2027, aims to assess whether AI is non-inferior to radiologists in diagnosing clinically significant prostate cancer. The primary outcome is the proportion of men with clinically significant cancer detected (Gleason grade group 2). The results will inform the best way for AI and radiologists to work together and will support its implementation into future clinical practice.

Research algorithms in AI are also coming through the pipeline and have the potential to transform prostate cancer detection once validated. The PI-CAI study investigated the performance of AI systems at detecting clinically significant prostate cancer on MRI in comparison with radiologists using the Prostate Imaging Reporting and Data System version 2.1 (PI-RADS 2.1) and the standard of care.[13] On average PI-CAI was found to be superior to radiologists using PI-RADS (2.1) at detecting clinically significant prostate cancer and comparable to the standard of care. Such a system, once validated, has the potential to serve as a supportive tool in a diagnostic setting within the NHS in the future.

It is also worth highlighting that the government, in its first-ever Men's Health Strategy, has committed to piloting "AI to assist radiologists using MRI to detect clinically significant prostate cancer", through the Cancer Programme Innovation Open Call. These technologies support the detection and grading of cancer and currently NICE are undertaking a health technology evaluation on them.[14] The results of this pilot could help us to further understand how AI can aid in prostate cancer diagnosis. Again, it will be vital that bias within the AI is addressed, which is crucial for prostate cancer patients given that Black men have double the risk of being diagnosed with the disease.

Case Study

An example of AI use within radiology can be seen in the Lucida MRI project at Leeds Hospital Trust. This project (across 15 hospitals) uses an AI tool to read prostate MRI scans. This project allowed radiologists to see highlighted areas of interest on scans and showed that AI effectively streamlined the triage process. It also calculated prostate volume amongst other aspects for the radiologist to use for diagnosis.



3.3 Utilisation of Community Diagnostic Centres

Community diagnostic centres (CDCs) may have the potential to alleviate some of the bottlenecks and pressures within MRI or interventional radiology.[15] We are not currently aware of any examples of prostate cancer being diagnosed or ruled out within CDCs. However, we know that there are initiatives and pilots underway to utilise MRI capacity within them. For example, NHS England's planning, design and implementation guidance for CDCs includes scope for local anaesthetic transperineal (LATP) prostate biopsy to be included within service provision.[16]

It is important that men have better access to faster and accurate diagnostics closer to home. Some of the tests included in the scope of a CDC currently are CT and MRI scans which could be opened to more men with an urgent suspected prostate cancer referral to support easier and faster diagnosis. Similarly, there are also optional tests that CDCs can offer, including simple biopsies (e.g. local anaesthetic trans perineal prostate biopsy (LATP)) and DEXA (bone) scans.

For this to work well, funding would be needed to ensure that CDCs are well-staffed, and have the equipment needed to carry out testing. There should also be more clinicians or allied health professionals trained to carry out LATP biopsy as part of CDC provision, working with the recently published British Association for Urology Nurses (BAUN) LATP competency framework.[17] This framework can help increase workforce capacity through the expanded scope of practice of Nurses and Allied Health Professionals (e.g. Diagnostic radiographers) trained to undertake LATP biopsy. As with any initiative like this, increased access to scans can be seen as a positive, however ultimately there will need to be more radiologists available to read and interpret those scans. Without more radiologists available, patients will face unacceptably long waits for a diagnosis.

CDCs could also focus on using biparametric MRI (bpMRI) which uses short scans that negate the need for contrast dye to be injected into the patient, subsequently removing the need to have a consultant radiologist on hand. Recent research from the PRIME trial has shown that when performed at a high standard, bpMRI can be just as safe and effective as multi-parametric MRI (mpMRI) and reduces the scanning time by a third. However ultimately, we will need to wait for the results from the PACIFIC trial to assess whether this works in a UK setting.[18]

Policy recommendations

We are calling for:

1. The government to fund more radiology training posts to increase the number of radiologists and bring the UK in line with other European countries, closing the shortfall.
2. Developers of AI tools to ensure diverse representation within patient training data.
3. NICE to ensure that within their evaluations of AI tools, bias and performance are examined across different demographic groups. Evaluation of these factors should also be incorporated into routine local evaluations of tools by NHS trusts, following adoption. This will safeguard against unintentional exacerbation of health inequalities for men with prostate cancer. For this to work well, NHS Trusts must ensure accurate and consistent recording of ethnicity data.
4. Better utilisation of CDCs – specifically, their provision of LATP biopsy, and even potentially using faster and easier scans taking some of the diagnostic burden away and alleviating some of the delays occurring within the hospital setting. The CDC diagnostic workforce should be upskilled to support this ambition.

4. CNSs (Clinical nurse specialists)

With increasing prostate cancer incidence, it is important that the CNS workforce has the capacity needed to support men through their cancer journey. A CNS should be one of the first medical professionals a man encounters following a prostate cancer diagnosis. A study in 2021 found that being assigned a clinical nurse specialist (CNS) is associated with better experiences of cancer care. Patients who reported being given the name of a CNS mentioned better experiences with involvement in treatment decisions, care coordination, and overall care experience. Experience of being involved in treatment decisions was the aspect of care most strongly associated with being given a CNS name.[19]

We hear that patients often struggle to get hold of a CNS when they need them, or do not have one to contact at all. We also have been made aware that in some trusts, posts are not being filled when nurses are retiring or moving onto other roles. This has a substantial workload impact, resulting in CNSs taking on more clinics or having more patients to see during clinics, increasing their workload. For patients, it means disruption in their care with longer waits for an appointment with a nurse in clinic and potentially shorter appointment times overall. This often leaves patients feeling rushed and unable to express their concerns fully or they are left unable to ask questions as they would like to.

It has also been reported that as the treatments space grows with a more personalised approach to treating prostate cancer, so does the CNS workload with face-to-face patient appointments becoming limited and clinics taking much longer due to more complex cases. To allow nurses adequate time to spend with patients we need to free up aspects of their work, whether that's by funding additional roles such as care pathway navigators or Macmillan support workers. It will be important for trusts to consider other roles that can take on admin- based tasks, and free-up CNS capacity.

Case Study

In 2020 East Sussex Healthcare NHS Trust found that patients who needed a robotic-assisted radical prostatectomy (RARP) for prostate cancer were waiting an average of 60 days from referral to diagnosis and 80 days to commence treatment, which breached the timed pathway criteria. The trust established a uro-oncology cancer pathway navigator role which is used to initially make contact with patients for a telephone assessment and to book them for an MRI scan. The navigator is available to the patient via email, phone and text until they have a diagnosis.

As a result of this innovation, the average time that patients requiring RARP for prostate cancer wait for their diagnosis has almost halved from 60 days to 32. The time to treatment is now 60 days.

4.1 Upskilling the CNS workforce

The Prostate Cancer UK CNS framework supports existing and aspiring nurses in understanding what competencies are required to support men with prostate cancer.[20] The recently published Cancer Plan sets out ambitions that every patient will have access to a clinical nurse specialist or other named lead to support them through diagnosis and treatment so this framework will be pivotal in upskilling the current and future prostate cancer nursing workforce.

In addition, upskilling the current CNS workforce will aid retention as it leads to greater job satisfaction and allows for career progression. Upskilling will also help to alleviate pressure on other clinical areas where bottlenecks may occur, an example of this can be seen in biopsies. Initiatives have been set up to upskill nurses within Local Anaesthetic Trans perineal Prostate (LATP) biopsy, allowing for clinicians who historically would have taken these biopsies to undertake more complex areas of diagnosis and clinical work. In Cance Alliance planning packs for 2025/26 Cancer Alliances were instructed to "rollout training for non-medical LATP biopsy for suspected prostate cancer with a minimum of one trained non-medical staff for all providers by Q4 2025/26".[21] Guidelines by the British Association of Urological Nurses have been developed to help provide an overview and facilitate the minimum training requirements of competency for the trainee to deliver the biopsies safely and effectively.[22]

Similarly, nurse- led diagnostics upskill nurses whilst simultaneously helping to ease bottlenecks within diagnosis of prostate cancer.

Case study

A nurse-led diagnostics service for prostate cancer has been trialled in a new initiative in some North London hospitals with very successful results.[23] Through substantial training (taking over a year to complete) CNSs and Advanced Nurse Specialists (ANSs) within the team triage patients after their referral. They request imaging and investigations, interpret MRI scans for signs of cancer, and counsel patients about further investigations if necessary. ANSs are also trained to perform biopsies. Since the trial began, nearly 80% of patients have been diagnosed within 28 days of referral, in line with the NHS Faster Diagnostic Standard.

4.2 Nurse-led active surveillance (AS) clinics

Nurse-led active surveillance clinics support men whose prostate cancer can be safely monitored without radical treatment. It is estimated that up to 1 in 3 men are diagnosed with CPG1/2 prostate cancer and are potentially suitable for AS every year in England alone (approx. 20-25,000 men/year).[24] The STRATCANS (STRATified CANcer Surveillance) model demonstrates resource savings (fewer clinical appointments and MRI scans), freeing up capacity to manage men at higher risk.[25]

Nurse-led AS clinics have also been shown to be safe and effective, with high levels of patient satisfaction. Findings from the ProtecT trial further suggest that nurse-led AS is highly rated among clinicians, with continuity of care and resource savings identified as key attributes. Additionally, both patients and clinicians believe that nurse-led care has the potential to relieve pressure on urology clinics without compromising patient care.[26]

Case Study

Royal Cornwall NHS Trust – Implementation of STRATCANS - In early 2025, Claire Turner and her colleague Nic Munro (Consultant Urologist) implemented the STRATCANS approach to better manage their active surveillance cohort. Previously, all patients were treated the same despite differing disease profiles, leading to uncertainty among the CNS team regarding the frequency of MRI scans, especially when results were stable. The team also faced a high volume of unnecessary scans and re-biopsies at 12 months, causing some men to opt out due to the process. The strain on staff, clinic capacity and patients was tangible, highlighting the need for clearer pathways. On implementation of STRATCANS stakeholders saw benefits such as simpler processes, more consistent follow-up, fewer clinic visits, and improved patient safety. Claire and Nic consistently reinforced these advantages to maintain team motivation and drive the change.[27]

4.3 Other innovations

There are also new innovations being trialled in some hospitals which free up CNS clinical time. One such initiative is the self-removal of catheters (self-TWOC) post-prostatectomy which has been trialled at the Royal Surrey Hospital and also at University College London Hospital.[28] For some patients undergoing Robotic-Assisted Radical Prostatectomy (RARP), self-removal of their urinary catheter can be a safe and beneficial initiative which saves money on travel, and time for the patient. Not only this, but it can reduce clinic hours within their hospital, allowing nurses time to focus on other, more complex, aspects of patient care. More evidence is currently needed to confirm these findings, but initial results from these studies show promise in this area.

Policy recommendations:

We are calling for:

1. Funding to recruit more CNSs and advanced nurse practitioner roles. Alongside ringfencing time for upskilling the current oncology CNS community. This, coupled with reflective pay, will help ease the bottlenecks. An example of successful nurse-led diagnostics can be seen in the above case study.
2. Funding for supportive roles such as Macmillan health care support workers and care navigators. This increase in workforce would allow CNSs to take on more complex clinical based work. Patient navigators, for example, play a crucial role in ensuring that trusts achieve timely access to diagnosis and treatments.
3. Trusts to be given the funding needed to reorganise services and implement innovations like nurse- led active surveillance clinics. This would ensure more suitable men with low-risk prostate cancer (CPG1/2) can take up and be continually managed on active surveillance until radical treatment is required.
4. Trusts to consider the evidence for adopting innovative ways of working, such as self-TWOC, which can help free up CNS time enabling them to undertake more complex clinical work.

5. Pathology

Efficient pathology processes and reporting are fundamental both for a timely prostate cancer diagnosis and to ensure the swift commencement of treatment.

Developments and advancements in diagnostic practice are adding to increasing workloads. Examples of these advancements include increased numbers of biopsy samples per patient and the need to assess additional clinically significant features (e.g. cribriform architecture - a more aggressive growth pattern sometimes seen in prostate cancer). This, coupled with an aging workforce who are also nearing or hitting retirement, are currently putting pressure on the pathology workforce. In 2025, the Royal College of Pathologists Workforce census found that 47% of pathologists were aged 50 and over and that 78% of pathologists did not believe current staffing levels were adequate to ensure long-term stability of pathology services and to meet growing demand.[29]

Histopathology is central to the screening, diagnosis, grading, and treatment of prostate cancer. The rise in prostate biopsies, especially with the introduction and integration of emerging diagnostic tools such as pre-biopsy MRI, fusion targeted biopsies and molecular and genomic classification has increased the complexity and volume of cases that pathologists face. Implementing innovative diagnostic tools at scale also introduces workload and training demands on pathology departments.[30]

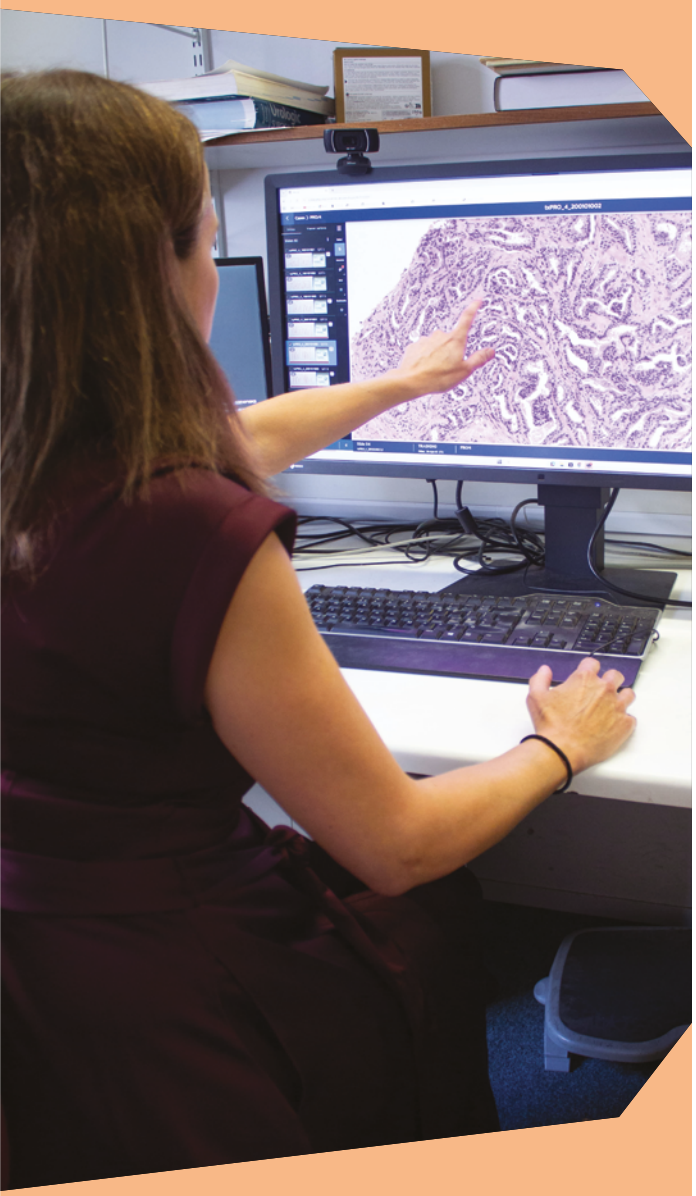
The government has now committed to screening men with a BRCA variation, as recommended by the UK National Screening Committee. In the near future, pathology departments could be impacted with much larger numbers of men receiving biopsies which will need to be tested via pathology labs. Digital pathology and AI solutions offer some promise, but according to the Royal College of Pathologists, adoption is slow, and regulatory frameworks and trust remain barriers. Novel predictive AI technologies that provide more detailed information about disease outcome, if adopted soon, may also have an impact on pathologists' workload. They would represent additional steps in the prostate biopsy process but bring potential to support more personalised clinical management decisions.

5.1 Pathology Digitisation

Digital pathology has the potential to enhance workforce efficiency and support equitable access to diagnostics. Despite this, many pathology services still rely on outdated technology that limits efficiency and progress. Modernisation is urgently needed to support digitisation, interoperability and standardisation. Investment in digital pathology infrastructure – including scanners and image management systems – is essential in realising these benefits. Similarly, education and training to equip pathologists with the skills they need to use these tools effectively will be crucial.

Digitisation of slides could expand agile working within this area which may help with staffing issues, allowing for staff to work from home leading to a better work/life balance. To be able to work from home or in a more agile setting can have a huge impact on quality of life, allowing clinicians to have a more flexible approach to work and home life, which in turn can aid retention in posts or indeed increase the attractiveness of pathology as a profession. This flexibility could be especially impactful to those clinicians who might be pregnant, have families, or those who may have medical conditions which can impact their daily lives.

Case study
An example of this can be seen in work conducted by Professor Clare Verrill, Professor of Cellular Pathology and AI at the University of Oxford. Routine digitisation of the NHS laboratory of Oxford University Hospitals NHS Foundation Trust has been in place since 2020. Digitisation brings several advantages such as facilitating network working and creating permanent datasets for activities such as teaching. It also provides the infrastructure for AI and AI brings potential additional benefits in standardisation and workflows. AI is in routine use in Oxford for assistance in diagnostic prostate biopsy reporting. Paige Prostate AI was evaluated in the Articulate Pro study.



5.2 AI use within Pathology

To enhance the quality of services, some trusts are now using AI within their departments and labs however, there are still some issues. Firstly, digitising slides can add extra time before slide release and assessment, and secondly, AI thresholds within pathology are often set low which can increase the time spent on evaluation. We also know that some trusts are not yet utilising digital or AI pathology within their departments at all. Crucially, it should be noted that AI is not used as a replacement for the expertise of pathologists rather it is used to enhance the quality of services. Consultant pathologists continue to be entirely responsible for their outputs and AI remains a tool for them to use. However, with correct training and governance, digital pathology technology and AI could have the potential to allow for greater precision in biopsy assessment ultimately increasing the quality of these services within the NHS. Ongoing research aims to quantify the potential workflow benefits that could also help departments with efficiency. Governance on use of AI, as mentioned above in previous sections, will also be integral if the NHS were to roll it out further, with bias being a particular issue that needs addressing.

AI's potential within pathology is positive. The Royal College of Pathologists issued a position statement on AI in 2022 where it said that "AI could introduce efficiencies into pathology services by freeing highly trained pathologists from more routine and repetitive work – for example by searching lymph nodes for cancer (a task which takes human pathologists a lot of time and effort), performing simple quantitative tasks, or by automatically ordering additional tests on patient samples prior to review by a pathologist, saving time." At the time of writing, NICE is currently undertaking an appraisal looking at the use of AI within histopathology to assist in prostate cancer diagnosis.[31]

Policy recommendations:

We are calling for:

1. The government to increase funding to support recruitment and retention of the pathology workforce. This includes expanding the number of pathology training posts. Crucially, it can take up to 15 years to train a pathologist. It is imperative that funding is increased to mitigate the effects of a retiring workforce.
2. The government to prioritise investment in digital pathology and the development, regulation and adoption of AI (where evidence exists) to support and strengthen the pathology workforce, ensuring appropriate governance and patient safeguards are in place. Investment is also needed to build on NHS-funded centres of excellence, which can support wider rollout by sharing standards and expertise.
3. Trusts to support innovative ways of working for the pathology workforce to aid retention and increase job satisfaction. Digitisation of slides could lead to more flexibility, for example by being able to read the slides from a centralised database, enabling working from home.

Case Study

The VANGUARD PATH study, also conducted by Professor Clare Verrill at the University of Oxford, is a Prostate Cancer UK Transformational Impact Award funded study evaluating an AI called Artera MMAI (Artera AI Prostate Biopsy Assay). This study is exploring how Artera MMAI can provide additional predictive and prognostic information on prostate cancer outcomes. The study aims to give patients and doctors clearer, more personalised information to guide treatment choices, potentially avoiding unnecessary side effects or under-treatment. The impact of this kind of AI on pathologist's workload remains to be established but it would represent an additional step in the pathway that is not currently undertaken, if it were to become routine practice.

Case study

Another example of AI being utilised in the Pathology setting can be seen in the Betsi Cadwaladr University Health board, led by Dr Muhammad Aslam, using the Ibex AI system.[32 33 34]

The technology is being used to tackle projected increases in the number of suspected prostate cancer cases in Wales and has already successfully and accurately read over 12000 patients samples so far. Ibex AI reports suggest that a Pathologist manually checking samples can take between 50-60 minutes, but using their AI solution can reduce this to just a few minutes. For prostate cancer patients this could mean faster, accurate and reliable access to their biopsy results and subsequent treatments, potentially reducing the stress and anxiety that comes with waiting for results.

6. Urology

Urologists are an integral part of the prostate cancer pathway and provide guidance on the best candidates for surgery or combined treatments. Men who then decide to have radiotherapy or systemic treatments go on to see an oncologist. Not only this, but urologists can also co-lead care in the more advanced stages of a man's prostate cancer for example managing complications such as urinary obstructions and providing palliative procedures. Shortages in urologists cause bottlenecks in wating for surgery, often leaving men and their families stressed and anxious about what that means for their prostate cancer.

Demands for urology have increased.[35] Currently the UK urology workforce is severely under pressure due, in part, to the rising number of vacancies within the specialty. The BAUS workforce report for 2024 stated that at the time nearly 12% of urology consultant posts were staffed by a locum workforce.[6]

Pressure also comes from the aging surgical workforce where many consultants are nearing retirement age in the next ten years with over 16% of the current consultant workforce being over 60 years of age.[36] We also know that there are currently low numbers of training posts available resulting in training bottlenecks – in 2024 there were 299 applications for only 70 posts creating a competition ratio of 4.27.[37] We hear directly from patients on how this demand has had an impact, with reports of delays and long waits for surgery and the stress and worry that comes with it.

Complimentary services, such as access to health information or nurse led services, offered by charities can also help ease the pressures felt by surgical teams by offering an alternative way to support patients. The next section examines how direct referrals can support busy cancer teams by helping patients access general and specialist support.

6.1 Direct referrals to charity support

Direct referrals have been found to reduce the number of clinical appointments and administration that's normally associated with them.

It's crucial that men receive quality, post-treatment support for living with prostate cancer, ensuring a good quality of life. The recent CLASP (2025) study found that cancer survivors' quality of life improved with detailed generic online support.[38] Charities are well-placed to offer support for people living with cancer. They can inform patients of how to manage their condition and mitigate side effects of treatment. Initiatives like Diagnosis Connect can support this, whereby patients with long-term conditions will be referred directly to charities and organisations which provide support and personalised advice to help patients manage their condition and feel more in control of their health.[39]

For men with prostate cancer, it would mean that patients would be able to routinely access Prostate Cancer UK's health information, nursing service, peer-to-peer support service, risk information service, and sexual support service. Alongside clinical care, peer support in particular, has an important role to play across the prostate cancer pathway, helping people living with and affected by prostate cancer feel informed, less isolated and better supported to navigate treatment decisions and life beyond diagnosis.

The Healthcare Collective represents Blood Cancer UK, Breast Cancer Now, Prostate Cancer UK and Pancreatic Cancer UK, and alongside Cancer52 and Macmillan called for Diagnosis Connect to be piloted in secondary care in the Cancer Plan, by ensuring that cancer patients are triaged to charities offering either generic or highly specialised support. The government has since stated within the Cancer Plan, that it sees Diagnosis Connect working well, particularly for people living with cancer and at least one other medical condition. We await with interest to see how this could work for men with prostate cancer.

The Collective, also conducted research examining the roll-out of direct NHS referrals and found that if carried out by the Collective, the estimated savings are between £424 million and £574 million over the next 5 years. Initiatives like this that formalise and streamline referrals to support will improve people's experiences of cancer. By complimenting clinical care with wider, wrap-around support, direct referrals have the potential to reduce the administrative workloads and reduce the number of appointments or clinic time.

6.2 The role of active surveillance

For men considered low risk - defined as Cambridge Prognostic Group (CPG) 1 and 2, active surveillance is an approach that allows for the close monitoring of prostate cancer rather than starting treatment right away.

The STRATCANS programme, along with efforts to promote active surveillance for CPG1/2 (GIRFT), has shown that a less intensive follow-up plan is safe and acceptable for these groups of men. It also leads to fewer MRI scans and clinic visits compared to current NICE recommended active surveillance follow-up protocols.[40] This approach ensures that surgery is offered only to patients who will benefit, while also reducing the use of resources and the number of secondary care appointments, freeing up a urologists' time to focus on other areas of work. However, it should be noted that it may increase the need for more staff in roles like clinical nurse specialists and primary care.

Prostate Cancer UK's Active Surveillance toolkit highlights recent evidence and data-driven practices that NHS trusts, health boards, and Cancer Alliances can use to improve their active surveillance protocols.[41] The toolkit was recently referenced in the Scottish Cancer Clinical Management Pathway for Prostate Cancer.[42] We are now encouraging NICE to update their guidelines so the NHS in England can adopt a similar approach.

Policy recommendations

We're calling for:

1. The government to commit to increasing the number of training posts within urology. This will, over time, reduce bottlenecks and maintain the current workforce despite rising vacancies due to retirement.
2. NICE to include our Active Surveillance toolkit in updates to prostate cancer guidelines to increase awareness of active surveillance among patients and healthcare professionals. This will ensure that within the NHS men with lower risk prostate cancer are not undergoing unnecessary surgical intervention.
3. The government to continue to recognise the benefits of direct referrals for people living with cancer. Working with charities such as Prostate Cancer UK and VCSE groups can ensure that people living with cancer can be triaged to charities offering either generic or highly specialised support, depending on need.

7. Oncology

Currently, there is a shortfall of clinical oncologists (17%) across the UK. By 2030 the RCR predict that the UK-wide shortfall will have increased to 26%, which is 234 clinicians short of the workforce required to provide safe and effective levels of care for all patients.[43] There has been a similar picture unfolding within the medical oncology community across the devolved nations. As of 2023, Scotland and Northern Ireland saw a collective net loss of 7 medical oncologists (MO). However, Wales did see an increase in 8 and England 40 MOs. According to the RCR published workforce data (2025) on oncologists' specific areas of expertise there were 330 full time equivalent genito-urinary CO consultants in the UK (equating to 1.2 per 100,000 of the population).[9]

There are also disparities in the number of clinical and medical oncologists in certain geographic regions. For example, per 100,000 of the population, who are aged 50+, London has 12.3, but in comparison Yorkshire and the Humber has just 5.2 oncology consultants.

This, alongside demand for systemic anti-cancer therapy increasing by 6-8%, compared to the increase of only 3.5% in the consultant workforce, creates a huge inequality.[44] If left without intervention, this shortfall in consultants could well lead to further delays in treatment access for men with prostate cancer. Not only this but high workloads can lead to burnout of the current workforce leading to consultants potentially leaving the profession earlier.

This disparity is likely to have a significant impact on patients, many of whom are currently left waiting longer than necessary for radiotherapy or systemic treatment. Delays such as these can cause huge amounts of distress and anxiety. This can have a huge impact on quality of life for patients; some of whom may be unable to work or resume normal daily activities due to the stress or indeed the knock-on effects of the cancer itself.

The use of AI in oncology

AI has the potential to transform oncology. One example of AI within oncology is auto-contouring, in which tumours and other anatomical structures are outlined on MRI or CT scans to enable treatment planning and guide targeted procedures. This would normally be carried out manually by oncologists. The amount of reported time saved varies hugely across clinical studies, but clinical experts estimate 10-30 minutes per patient depending on the amount of editing needed.[45]

Auto-contouring has been evaluated by NICE, and although deemed to have similar results to those performed manually, they also stated that more evidence is needed on the clinical acceptability of contours, the specific time savings it would provide and identification of any errors and adverse events.[46] It should be noted that in summer 2024 NHS England undertook a baseline assessment of AI auto-contouring systems which indicated that, at that time, 39 trusts had some AI arrangements in place. This is in line with the RCR clinical oncology census report which found 38 cancer centres with AI tools in deployment.[43]

We have been made aware that at of the time of writing, many more centres have followed suit and have made use of the conditional approval by NICE, generating the further evidence required.

The RCR have produced guidance on use of auto-contouring technologies, and highlight the need for post-implementation assessments at least annually, to ensure that any drift in performance over time is picked up (as changes in settings, hardware, or memory can drastically affect performance), and to identify if there is automation bias taking place.[45]

It should be noted that many studies evaluating AI train and validate their algorithms on the same patient population, leading to a risk that the algorithms perform well on that data, but show worse performance when applied to other patients. This leads to the concern that technologies such as this could not only maintain health inequalities but exacerbate them.

Policy Recommendations

We are calling for:

1. The government to increase the number of oncologists in the NHS. Specifically, more training posts should be made available for oncology, especially in those areas of the UK which are shown to have less oncologists per 100,000 of the population.
2. NHS trusts to transform ways of working within oncology departments so that retention is bolstered. Less rigid working patterns and utilisation of other roles within the department to take on more administrative or surveillance-based roles could be one way to ease workloads.
3. Testing of AI within trusts currently not using it (AI is already being used in oncology 81% of trusts) can be another way to examine how services could be streamlined and treatments enhanced. Assessment is still ongoing, so further funding should be prioritised into research to determine how it could benefit the specialty further.

8. Conclusion

The rising number of prostate cancer diagnoses has made prostate cancer the most common cancer in England and because of this there is an urgent need to future-proof its NHS workforce.

Despite the NHS increasing staff numbers in the last few years there remains critical gaps across oncology, radiology, urology, pathology, and prostate cancer specialist nursing. These gaps risk increasing delays to diagnosis and treatment. The long-lasting impact of the COVID-19 pandemic, coupled with the growing number of cancer diagnoses in general, highlights the importance of strategic investment in workforce retention, training, and innovative ways of working—such as utilising and leveraging technology, innovations and flexible staffing models.

We know that there are three main areas which, if not addressed, can cause barriers to driving change:

1. Upskilling and retaining our current cancer workforce

This increases job satisfaction, provides career progression and shows an investment in an employee's future. We anecdotally hear about challenges around career progression, and it is often cited as a reason for high attrition rates within the prostate cancer workforce, especially in respect to nursing.

2. Increasing the cancer workforce

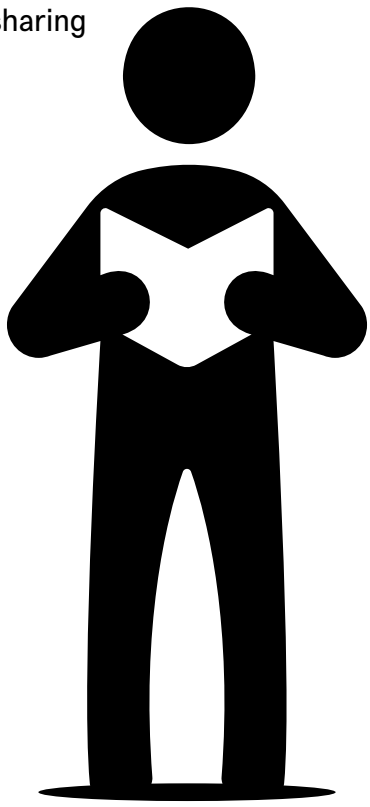
Funding and recruitment are imperative when addressing barriers within the NHS workforce. It will ensure that in years to come we are able to replace the retiring workforce.

3. Transforming ways of working within the cancer workforce i.e. utilising technology and adopting agile ways of working

Improved AI and technology use within prostate cancer has the potential to transform the pathway for men and the examples shown above highlight huge promise within this area. However, it should be noted that AI adoption is still in its infancy. It is hindered by the training it requires, outdated IT that operates only within the NHS, and the confidence and training of clinical staff. There are also considerations to be made regarding its governance and potential for bias.

Agile working is another area in which technology is enabling some in the NHS to work more freely away from more rigid and traditional work constraints and providing a more attractive option to those considering a career in the NHS.

Addressing all three of these areas through targeted policy actions and the sharing of best practice. will ensure timely, equitable, and personalised care for men with prostate cancer, leading to improved outcomes and quality of life.



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