



Clinical radiology job planning guidance for consultant and SAS doctors 2022

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1 Introduction

Workforce pressures in clinical radiology (CR) have continued to grow, with more clinical radiologists retiring early or working less than full-time (LTFT), and the Covid-19 pandemic has changed the workplace forever. In this context, the job planning process is more important than ever to ensure hospitals support a workforce that is able to deliver the excellent clinical care to which we all aspire. This document aims to provide clear direction on how radiologists should aim to work in a supportive environment.

It is hoped that this document will provide clear advice for every consultant and specialty and associate specialist (SAS) doctor as they have their annual job plan meeting, for service leads leading the job planning process and for hospitals to ensure CR job plans are well supported and appropriately funded.

2 Background, definitions and current contracts

2.1 What is a job plan?

A job plan is an annual agreement between a doctor and their employer setting out the duties, responsibilities and objectives of the doctor for the coming year. The job planning process should be collaborative so that a job plan is negotiated and agreed, not imposed. This should be equally applicable to staff working in multiple organisations concurrently.

The job plan should summarise how a doctor can use their time and resources to deliver individual and service objectives with improving patient outcomes, safety and experience at its heart. Both the job plan and the job planning process should have a strong focus on ways to motivate, support, develop and retain staff.

A job plan is therefore much more than a timetable of agreed activities and could include:

- A list of personal SMART (specific, measurable, achievable, realistic, time-bound) objectives covering direct clinical care (DCC) and supporting professional activity (SPA) roles. These should link with the objectives agreed at the annual appraisal meeting and set out in the personal development plan (PDP).
- A list of supporting resources necessary to achieve those objectives.
- A timetable of activities including DCC and SPAs.
- On-call arrangements including rota frequency and availability supplement category.
- Details of travel time to other sites.
- A description of additional responsibilities (AR) to the wider NHS and profession.
- A description of external duties (for example, trade union duties, work for a Royal College).
- Any arrangements for additional programmed activities (APAs) or sessions over and above the standard contract.
- Any arrangements for education and training roles.
- Time for delivering training.
- Any details of regular private work.
- Any agreed arrangements for carrying out regular fee-paying services.
- Annual and study leave arrangements.
- Any special agreements or arrangements regarding the operation or interpretation of the job plan.
- Accountability arrangements.
- Any agreed flexible working arrangements, for example, job sharing, portfolio careers annualised job plans, working from home.

A job plan must align with the terms and conditions for contracts that have been agreed nationally. Currently these are the 2003 consultant contract and the 2021 specialty and associate specialist (SAS) contract for England, Wales and Northern Ireland. A Scotland SAS contract is being negotiated. The NHS terms and conditions of service can be found on the [NHS employers website](#).

Example SMART objectives

- To set up a nurse-led line insertion service: Comply with governance arrangements within the organisation. Set up protocols and training pathway and sign off. Train nurses/radiographers in procedures under ultrasound/fluoroscopic guidance. Audit and monitor outcomes. Require 0.5 PA for 12 months.
- To set up cardiac computed tomography (CT): Create business case. Train to level I and II. Set up radiographer training, protocols and pathway for cardiac CT. 0.5 PA for setting up service for three months and then 1 PA for supervision and reporting of cardiac CT list.

2.2 The consultant contract

The [2003 consultant contract](#) underpins the requirement for consultant job planning to ensure effective and efficient organisation of resources across the NHS to the benefit of patients, doctors and the organisation as a whole.

2.3 The SAS contract

A new [SAS grade contract](#) was introduced in England, Wales and Northern Ireland in April 2021. The main changes are the introduction of a new specialist grade along with improved pay progression. It will provide the opportunity for career progression and recognition of clinical expertise and seniority for doctors in these posts.

Transition to the new specialist grade will not be automatic and employers should have discussions with individuals about transitioning to the new contract. Applicants for the new specialist grade must have a minimum of 12 years since passing their primary medical qualification and at least six years in a specialty doctor or other SAS post. Specialists will be senior clinical decision-makers, able to practise autonomously. They must meet the required generic professional capabilities as well as having specialty-specific capabilities.

The autonomy of the SAS doctor should be assessed by the trust or health board on an individual basis as set out in the British Medical Association (BMA) [Guidance template for the development of autonomous practice for SAS doctors and dentists](#). Appointment to a specialist post will involve an advisory appointments committee (AAC) process, as for consultants. Scotland is awaiting a Scotland-specific contract, due in 2022.

2.4 Programmed activities

Programmed activities (PAs) are blocks of time in which contractual duties are performed. The job plan will set out how many PAs a doctor has agreed to work.

One PA is four hours in England, Scotland and Northern Ireland in normal working hours (7am to 7pm, Monday to Friday in England and 8am to 8pm in Scotland) or three hours of activity at other times. In Wales, one PA is 3.75 hours in duration.

If a consultant undertakes a single activity of four hours' (3.75 in Wales) duration (for example an outpatient clinic) that takes place every week while they are not on leave then this would constitute one PA in their job plan.

There are four types of PA:

- **Direct clinical care** (DCC) is any work that directly relates to patient care, including reporting, multidisciplinary team (MDT) meetings and clinical administration (e.g. vetting and protocolling).
- **Supporting professional activities** (SPAs) underpin clinical care and contribute to ongoing professional development as a clinician. They include activities such as teaching and training, medical education, continuing professional development (CPD), clinical governance and preparation for appraisal and revalidation. Where consultants work at more than one hospital, each should contribute to funding the core SPA time within a job plan. For split academic/clinical roles the academic funder should contribute proportionally to SPA.
- **Additional responsibilities** (AR) are duties carried out on behalf of the employer or another relevant body (for example a medical school) and which are beyond the normal range of SPAs. They will include department leadership roles such as service director, audit lead or governance lead.
- **External duties** are work not done directly for the NHS employer and might include Royal College roles, regional imaging networks, work for the National Institute for Health and Care Excellence (NICE) etc. Time off for external roles should be agreed in the job plan and where possible accommodated using 'professional leave'. Professional leave is taken from the same allocation of leave days as study leave; in total, these would not normally amount to more than 30 days over a three-year rolling period. The RCR strongly encourages departments to support staff to take on external roles. Work for other NHS and healthcare bodies can help bring perspective and energy to a job as well as helping to produce national guidance and support for other doctors, services and patients.

2.5 Additional programmed activities (APAs)

A doctor working full-time will work ten PAs or sessions per week and is not obliged to agree to a contract containing a greater number of PAs or sessions unless undertaking private practice, when an additional PA should be offered to the organisation.^{1,2}

An employer may offer additional programmed activities (APAs) in addition to the contracted number of PAs or sessions. This is to reflect spare professional capacity, agreed regular additional duties or activities not contained within the standard contract. They can be used, for example, to recognise an unusually high routine workload or to recognise AR.

2.6 Travel arrangements

Travel time to and from a doctor's usual place of work should not be included. When a doctor works at more than one location, additional DCC time should be included in the job plan to reflect travel from the base hospital to another place of work.

2.7 Annual, study and professional leave

Annual leave arrangements are agreed nationally and are summarised [on the BMA website](#).

Professional or study leave is granted for consultants for postgraduate purposes approved by the employing authority. It covers study (usually but not exclusively or necessarily on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences. For all consultants there is a contractual entitlement of 30 days' study and professional leave with pay and expenses within each three-year period.

2.8 Private practice

Private practice, or any other form of remunerated non-NHS work, must be declared in the job plan. This must include the time commitment and location of private work so the organisation agrees and understands when a doctor will not be available. Doctors should offer an additional PA to the organisation if undertaking private practice.^{1,2} LTFT consultants who wish to use some of their non-NHS time to do private practice would be expected to offer up to one extra PA on top of their normal working week.³

Private practice should not be scheduled to coincide with any NHS activity, and must not limit the ability of the doctor, when on call, to return to the hospital immediately if required.

All private practice undertaken must adhere to the NHS code of practice. Particular attention should be paid to potential conflicts of interest. Any secretarial work required to support a doctor's private practice should be performed out of hours and the doctor must pay for this work to be undertaken.

2.9 The job planning meeting

Job plans should be reviewed at least annually, separately to the appraisal process. The job plan review meeting should be expected to take at least one hour and should include the doctor and their medical manager (clinical or service director), though a non-clinical manager may also be present. In circumstances where there is potential disagreement it may be appropriate to have an external party present. The meeting should include:

- A review of the past year, identifying what worked well and where there is opportunity for improvement across the directorate/team.
- Current workload and likely changes to the doctor's duties and responsibilities going forward.
- The priorities of the hospital, department and team.
- The most recent PDP agreed within appraisal.
- Agreement of SMART objectives – personal objectives should link to those of the hospital, department, and team.
- Resources and support required by the doctor to meet objectives and achieve PDP.
- Agreement of the timetable.

For established consultants, negotiation of job plans is best done on the basis of proven activity from a diary. New consultants will need to negotiate a preliminary estimated sessional work plan that is then reviewed annually.

Things to consider in preparation for the job plan review:

- Complete a work diary over one rota cycle. This can be particularly useful when changes to a job plan are likely.
- Ensure that all the work you have been doing is recognised with an appropriate allocation of PAs or sessions.
- Identify potential workload problems and workforce gaps.
- Consider whether resources to support the job are adequate.
- Identify changes in the job that may increase the ability to deliver a quality service to patients.

- Consider any requirements for personal career development as identified in the PDP at the last appraisal meeting
- Identify objectives for the coming year and resources needed to carry these out.
- The UK Working Time Regulations.⁴

If a consultant's job requires more SPAs, or includes additional NHS responsibilities or external duties, this must be reflected in the job plan by a reduction in DCC or the payment of APAs or both. Where consultants are constantly working in excess of their contracted PAs, as supported by a job planning diary, a workforce review may be necessary to identify whether a reduction in workload or an increase in PAs is needed. It is important to note that an ever-increasing number of PAs is unlikely to be sustainable and risks burnout, reduction in quality of care and poor staff retention.

Job planning may occur more frequently if there are particular issues or problems that need raising and addressing by either the clinician or clinical manager during the cycle.

More detailed guidance on how to prepare and negotiate for a job review can be found in the BMA guidance on [Reviewing your job plan](#).

2.10 Annualised job plans

Many employers and many employees are choosing to annualise job plans and calculate the annual number of each type of DCC session. A common estimate is for the working year to be considered as 42 weeks (allowing for study/professional leave and annual leave, and 'stat days'). E-job planning tools are usually set up to work on an annualised basis. Many doctors prefer this approach as it can allow more flexibility around working patterns, for example to allow a period of extended leave or to facilitate childcare. It should be combined with a team-based approach to service organisation.

2.11 Team or departmental job planning

Team job planning can encourage transparency and ensure there is parity within a team for the same or very similar activities. It can also help foster a team-based approach to clinical care so that services are not disrupted by the planned or unplanned absence of one clinician. Employing organisations should ensure that all team members have time for providing cross-cover within their job plans. A team job planning meeting is strongly encouraged and should precede any individual job planning meeting.

2.12 Less than full-time working

31% of clinical radiology consultants work less than full time (LTFT), with the proportion of LTFT workers increasing in the past five years. The RCR strongly supports hospitals and departments in enabling LTFT working to provide a more supportive working environment (e.g. for those with caring responsibilities) and to help minimise early retirement.

The principles and examples in this document apply equally to those on an LTFT contract. Most elements of the job plan should be pro rata in proportion to those on a full-time contract.

Core SPA time necessary for revalidation and appraisal should not be reduced in direct proportion. A part-time consultant, especially early in their career, should not be allocated less than 1.5 SPAs, to ensure that they have time to undertake internal CPD, a minimum level of quality improvement activity and personal appraisal and other activities. Similarly, study and professional leave should be 30 days in a three-year cycle for people working LTFT.

2.13 Parental leave

Parental leave should be encouraged if applicable. A team-based approach to service provision will help to ensure service continuity.

2.14 Career breaks

Career breaks such as a sabbatical need to be agreed separately as the process differs between trusts.

3 The role of a clinical radiologist

3.1 Overview of the role

Clinical radiologists work as part of teams of professionals and there are many variations in the job plan of a clinical radiologist depending on variables such as:

- Location.
- Specialty.
- Stage of career – one person's job plan is likely to change significantly over the course of a career.
- The number of reporting sessions designated within the job plan, and the number of clinical and radiological meetings the consultant is required to attend.
- Number of radiology trainees – training posts contribute to service delivery but also require time in the job plan for supervision and education.
- Allowance for clinical interruptions. This may take the form of a 'consultant of the day' role or 'hot-desking' within some departments but fulfils an important role in providing integrated clinical radiological services. The department should strive to protect the time of the consultants who are not in this role.
- If a radiologist has an interventional workload, time for assessing the imaging, planning the intervention and 'consenting' the patient is required. It will be necessary to factor in ward work as well as provide and support outpatient clinics.
- Supervision and training of allied health professionals (AHP) such as clinical nurse specialists, radiographers, including advanced clinical practitioners (ACP), and others who are part of the multiprofessional team and who usually contribute to the skill mix – the provision of care based on capability not job title.

3.2 Productivity, case numbers

Job planning for doctors should look at procedural and reporting activity within the context of the whole team rather than individuals in isolation as outlined in the RCR reporting figures document.

See sample job plans (Appendix 1).

3.3 Unpredictable work and responsiveness

Some allowance should be made in an individual's job plan for unpredicted workload such as over-run interventional lists, postoperative checks, postoperative care or complications, phone calls to review external images and second opinion reviews etc. Adequate cross-cover provision for emergency work needs to be factored into the overall working of a department and may require a team approach to both daytime lists and on-call provision.

3.4 Team working and cover

The RCR strongly supports a team-based approach to service organisation and to providing patient care. As a minimum, services and job plans should be designed to ensure cover in the event of planned leave so that all clinical work is delivered in a timely way allowing for adequate staffing. Good consultant team working will support the wider imaging department team and encourage multiprofessional team working.

3.5 What a clinical radiologist should expect from their employer (IT, admin etc)

Administrative and IT systems are a frequent source of inefficient working and are an important cause of workforce stress. All clinical radiologists (consultants and SAS) should be provided with:

- A modern hospital PC or laptop with up-to-date software and access to all relevant IT systems in as easy a way as possible.
- Appropriate office space at each place of work with internet/intranet access (quiet area to report, see and discuss confidential cases with colleagues, to meet with patients when necessary etc).
- Appropriate admin support from each place of work.
- A formal induction programme when starting a new post. This can be modified to be used when someone is returning to work after a long absence such as parental leave.

3.6 Changing working patterns

The Covid-19 pandemic has shown the importance of a more flexible approach to working patterns. With appropriate IT provision, some DCC and many SPAs can be carried out at remote locations or from home. For some doctors, a more flexible approach may help them balance work with other roles. It can be more difficult to provide clinical leadership when not in the hospital, particularly for new consultants. Easy access to email and other systems can make it more difficult to take a proper break from clinical work.

Job plans should take into account the personal and home life of a doctor while ensuring that the clinical service is maintained to a high quality, wherever that work is carried out. In particular, there should be a minimum consultant presence to manage urgent clinical queries. Job plans should include adequate breaks from clinical work during the day. Departments should encourage all staff not to check emails when they are not working.

3.7 Support and wellbeing

Managing workload, working in effective clinical teams, good IT and admin support and supporting different working patterns are all important to reduce the risk of workplace stress and burnout. Departments and hospitals should encourage formal wellbeing programmes and offer mentorship for new consultants. The RCR published *Care is not just for the patient* in April 2021, which provides more detailed information for support and wellbeing of staff.

4 Job planning throughout a career

Consultant job plans are likely to change very significantly during the course of a consultant's career. Indeed, departments should find ways to encourage consultants to adapt their job plans to changing personal circumstances and new areas of interest. The RCR supports the development of portfolio careers, which are becoming increasingly common and are likely to result in a workforce that is more engaged and adaptable. See section 2.12 on LTFT working.

4.1 Initial job description

Job descriptions for new posts are quality assured by a team of RCR reviewers against approved criteria.

4.2 Moving between hospitals or taking on new specialties

A newly appointed consultant may not have previously worked in their new department. Some consultants may also change or take on new specialties during their career. This can be individually stimulating and can bring fresh perspectives to a team. Appropriate support from colleagues, not necessarily from the same hospital, is essential. CPD activities should be planned to support such a transition.

When a doctor reports for a new specialty, a formal competency assessment should be carried out. This should involve observation, discussion or peer review of a defined number of cases covering all common scenarios. An appropriate expert and the service director should sign the doctor off as competent to practice at consultant level within that team. Hospitals should keep a record of competencies for all medical staff.

4.3 External duties

Many doctors take on external duties such as work for the General Medical Council (GMC), Care Quality Commission (CQC), NICE, RCR or BMA during their career and find such roles very professionally rewarding. These roles are not always paid and can require additional periods of professional leave, for example to be an examiner. The time and support for these roles should be identified in a job plan before they begin.

The RCR strongly recommends employers consider the important role of consultants and SAS doctors in the wider NHS and provides support for consultants and SAS doctors to take up external roles. Doing so will help keep their workforce engaged and productive and will bring useful external perspectives to the department.

4.4 Retire and return

Consultants reaching their retirement age may wish to access their pension lump sum and monthly pension, but then return to their job. Hospitals who support this are able to benefit from very experienced consultants returning to the same or reduced roles. The current retire and return regulations have been explained by the [BMA](#).

People who retire and return will have to start their new job plan after at least a one-day break and only work 16 hours per week during the following month. There are factors to consider such as sick leave entitlement on starting the new job that managers can adjust to take into account previous work, but these are not automatic. It is not legal to limit the return to work for only one year as some hospitals have done in the past. Consultants in receipt of discretionary points and external merit awards should note that these cease on retirement, and new applications after return will only take into account work carried out since the return.

5 Direct clinical care (DCC) time

5.1 Reporting

Time for DCC reporting will vary hugely depending on the type of imaging, complexity, body parts etc.

5.2 Home reporting

Since the Covid-19 pandemic, home working has formed a much greater proportion of individual and departmental job plans. It is important to ensure that there is sufficient on-site staff to cover for the department, including ultrasound, procedural work and training. Senior colleagues should be available to discuss difficult imaging and interventional procedures. Many units have agreed two to three PAs of both reporting and SPA activity at home with an agreement to come in immediately if there is an urgent clinical need.

5.3 Interventional procedures

All procedures should have time allocated for discussing potential interventional procedures with both clinicians and the patient, either in an outpatient environment or on the wards. Time should be allocated for all elements in addition to the procedure time itself, including clinic time, pre-assessment, consent, WHO checklist, post-procedure review/discharge and follow-up of the patients. The time allocation will vary with the number and complexity of procedures undertaken.

5.4 REALM

Time should be made available for all members of the department to attend departmental discrepancy meetings. These should be regularly timetabled and attendance should be recorded. Further details can be found in the [Standards for radiology events and learning meetings](#).⁵

5.5 Multidisciplinary team meetings

Clinical radiologists are usually core members of more than one multidisciplinary team (MDT) and so often attend several MDT meetings during a week. Core members will usually attend the whole MDT meeting, which must be included in the job plan for both consultants and SAS doctors. This may mean more than one radiologist needing to be present at any given MDT meeting. Radiologists should attend two-thirds of the MDT meetings personally (without relying on cover arrangements).

Where large MDT meetings have rotational attendance, this should be reflected in a pro rata job plan time. A minimum of two radiologists should be allocated to each MDT meeting (one radiologist to attend the meeting, but two radiologists designated for each site-specific meeting). Time allocated should be consistent between clinicians attending the same MDT meeting.

There should be time allocated for prior review of all images by an individual with appropriate expertise and to provide an unhurried professional opinion for the MDT meeting and for follow-up actions. These times can amount to significantly longer periods than the meeting itself.

The RCR recommends that all MDTs should review their ways of working to ensure that MDT meeting discussions genuinely add value to patient care and that decisions can be written into protocol where possible. Appropriate IT systems should be available in the room and remote attendance should be facilitated where possible.

See the RCR guidance on *Cancer multidisciplinary team meetings – standards for clinical radiologists* for more detail.⁶

5.6 On-call work

The on-call component of the job plan needs to be assessed regularly. The on-call needs of most departments continue to increase in line with raised expectations for the availability of imaging on a 24/7 basis. These annual changes need to be reflected in robust and up-to-date job planning.

On-call rotas should be formalised, with no dependency on ad hoc rotas or informal rotas. If a department cannot provide a formal rota, the organisation has to clearly define the alternatives and support different ways of working via job planning. This may require developing an integrated approach with other neighbouring organisations. If a service is inadequate or cannot be provided, this should be added to the risk register.

Some departments perform routine imaging 'out of hours' and at weekends. Adequate cover to report this routine, often unsupervised, imaging needs to be built into the overall job planning of the department. If this is undertaken out of normal working hours, it should be at an agreed premium. Radiologists should not be required to undertake or report elective imaging or interventional radiology (IR) procedures during on-call hours.

5.7 On-call supplements

A consultant on an on-call rota is paid a supplement in addition to basic salary in respect of their availability to provide advice and support from home during on-call periods. The supplement is a percentage of the total salary depending on the rota frequency and the type of support required.

6 Supporting professional activity (SPA) time and additional responsibilities (AR)

The wording in the model contracts for England and Northern Ireland state that job plans 'will typically include an average of 7.5 PAs for DCC duties and 2.5 PAs for supporting professional activities'. The same split is set out in the Scottish consultant terms and conditions. In the Welsh model contract, three sessions of SPA time are recommended. All SAS doctors are contractually entitled to a minimum of one PA or session of SPA time, though some have negotiated the same SPA time as their consultant colleagues, and this will depend on experience and career level.

SPAs relate to professional, leadership, educational and academic responsibilities. They include activities that help maintain an individual's professional knowledge and skills, enabling them to build a portfolio of evidence for their annual appraisals to ensure they can be revalidated. Many hospitals separate this out as core or personal SPA time as every doctor requires this time within their job plan.

SPAs also include activities that are essential to develop, maintain and lead high-quality and safe clinical services and to educate and develop colleagues. These roles are usually accounted for outside core SPA time or coded separately as AR.

6.1 Standard personal 'core' SPA

Every doctor should have a minimum of 1.5 SPAs in their job plan for local CPD, mandatory training and appraisal, standard department meetings (for example, consultant meetings, governance meetings, morbidity and mortality (M&M) meetings etc). This should include time for some standard service improvement, quality improvement (QI)/audit, and teaching; for example, keeping protocols up to date, reviewing and updating processes and contributing to the regular teaching of doctors and other staff. It will usually include some time allocated to participating in national clinical trials; for example, as a local principal investigator. With agreement it may be beneficial for some SPA time to be worked flexibly off site.

As defined by the 2021 contract, SAS doctors should have a minimum of one SPA a week, irrespective of their whole-time equivalent percentage. This is to be used to meet the requirements of appraisal, revalidation and job planning.

6.2 QI/service improvement projects

Many consultants will have roles such as QI, audit or governance lead. This will usually be in addition to core SPA time and should be included in job plans and funded when the project is designed.

6.3 Additional responsibilities – management/leadership roles

All consultants are expected to provide some clinical leadership and management as part of their senior positions but formal roles should be appointed to and included in job plans. They should be time limited and reappraised at least every three years. The division of these roles and the time required will vary depending on the size of department. Clinical leadership of even a small department with approximately 100 employees is a considerable undertaking and is likely to need a minimum of two PAs if that lead role is to be effective. In larger departments there may be separate lead posts to cover part of a service; for example, IR service lead or section lead for paediatric radiology. The table at section 6.6 suggests time for and expectations of each role.

To support clinicians taking on leadership roles, there should be agreement with line managers about the support needed to perform that role effectively (for example, admin time, management support, corresponding support from nursing and other leads).

6.4 Additional responsibilities – training and education

The provision of training and education is a fundamental activity within the NHS, and the future of imaging services depends upon appropriately trained and validated practitioners. All doctors have a responsibility for teaching and training,⁷ however consultant input is essential to this function. There are a variety of formal roles in the training and education of UK specialty trainees that consultants may undertake, some of which may be funded by the relevant statutory education body. Time for training and for all of these formal roles should be recognised in job plans.

Training programme director (TPD): The GMC requires that training programmes are led by TPDs, in accordance with their Promoting Excellence standards. Further details on the role of the TPD can be found in the Gold Guide.⁸ The time required for this role will vary with the size of the training programme and the needs of individual trainees, but the demands of this role can be considerable, particularly for larger training programmes or those with trainees with higher needs. Changes to training due to the Covid-19 pandemic have also increased the demands of this role. For training programmes of up to 30 trainees a minimum of one SPA per week should be provided, while for training programmes of 30–50 trainees a minimum of two SPAs per week should be provided; this funding should be provided by the statutory education body.

Regional specialty adviser (RSA): RSAs are the regional representatives of the RCR with respect to education and training and work cooperatively with the RCR, their local training programme school of radiology and the GMC to support delivery and quality assurance of training and the annual review of competency progression (ARCP) process. RSAs may cover more than one training programme and have a role both within their own region and in other regions where they fulfil the requirements of the Gold Guide for an external specialty scrutiny at ARCP. A full description of the role can be found on the RCR's RSA webpages. As with the TPD, the demands of the role vary dependent on the number of trainees in the region and the needs of individual trainees; however, RSAs should be allocated a minimum of 0.5 SPAs per week per 25 trainees in the region/deanery. In addition to this, up to five days' leave per year is required to provide externality for ARCPs and attend meetings supporting this part of the role.

College tutor: College tutors are appointed to assist the RSA in supporting the delivery and quality assurance of training within their own department. Each training department will usually have one college tutor, although there may be more than one in larger departments. College tutors should be allocated 0.25 SPAs per week per five trainees.

Educational supervisor: All trainees following a UK specialty training programme must have a named educational supervisor who is responsible for the overall supervision and management of a specified trainee's educational progress. Further detail on the role of the educational supervisor can be found in the Gold Guide. Educational supervisors should be allocated a minimum of 0.25 SPAs per week per trainee.

Clinical supervisor: All trainees following a UK specialty training programme must have a named clinical supervisor for each placement to ensure that educational governance requirements are met. This arrangement is distinct from the requirement for supervisory arrangements to meet local clinical governance requirements. A named clinical supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement. Further detail on the role of the clinical supervisor can be found in the Gold Guide.⁸ Clinical supervisors should be allocated a minimum of 0.25 SPAs per week per trainee.

CESR: Those evaluating and reviewing certificate of eligibility for specialist registration (CESR) applications should be allocated time to do so.

6.5 Research

Duties of a clinical academic should be set out in a single integrated job plan that covers the whole of their professional duties for both the hospital and the university. A nominated representative of the hospital and the university should be present with the clinical academic at their job planning meeting. The job plan must be jointly agreed by all parties and must include the clinical academic's management and accountability arrangements for both employers.

SPAs for research jobs that have a defined academic component are usually clear cut.

Where SPAs are expected to contain a contribution to research that is specified, it is reasonable that the following commitment is required, depending on the size of research study:

- Acting as principal investigator: 0.1–0.5 SPAs.
- Acting as chief investigator: 0.1–1 SPAs.
- Research and good clinical practice (GCP) training: 0.125 SPAs.

Some centres have central research funding to support clinicians with particularly high research commitments, or to support clinical research leadership.

6.6 Summary of suggested times for SPA/AR

Standard personal or core SPA	1.5 PA – minimal recommended for revalidation includes: <ul style="list-style-type: none"> ▪ standard department meetings (consultant meetings, governance meetings, M&M meetings etc) ▪ local CPD including clinical supervision ▪ mandatory training ▪ standard service improvement, QI and audit ▪ teaching ▪ research within national clinical trials.
Essential department SPA roles	PA allocation depends on department size, available support and potentially overlapping roles
Clinical director or service director	Leadership and management of all medical staff in the department. Overall operational leadership of the service with other senior managers (nursing lead, etc). 2–4 PA depending on department size and devolved roles.

Head of service/lead	Clinical leadership roles. May be included in the clinical director role in smaller departments. If separate, 0.5–1 PA. This is a delegated role within the employers' procedures and IR(ME)R regulations.
Governance lead	0.25–1 PA
Audit and QI lead	0.25–0.5 PA
REALM or morbidity and mortality lead	Ensuring systems and processes are in place to review mortality data and learn from it: 0.25–0.5 PA.
Other SPA roles	These roles may also be held by doctors from other departments so will usually be paid according to local hospital PA allocation
MDT lead	Leadership of a cancer team including preparation for and chairing of an MDT meeting: 0.5–1 PA.
Appraiser	Usually pro rata depending on the number of appraisals.
ODN roles	Depends on the role.
Educational roles⁹	
Clinical supervisor	0.25 SPAs per week per trainee.
Educational supervisor	0.25 SPAs per week per trainee to a maximum of 3–4 trainees. Similar time should be included for supervision of non-medical roles e.g. ACPs, consultant radiographers, non-medical prescribers.
College tutor	0.25 SPAs per week per 5 trainees for which the tutor has responsibility.
Juniors educational lead	0.5 SPA for IMT/Foundation-level doctors or undergraduate teaching.

Regional specialty adviser	0.5 SPAs per week per 25 trainees in the region/ deanery (this may cover more than one training programme or location). Up to 5 days' leave per year is required to provide externality for ARCP and attend meetings supporting this part of the role.
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Training programme director	1 SPA per week for training programmes up to 30 trainees; 2 SPAs per week for training programmes with 30–50 trainees.
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Other roles

Some large departments have other formal leadership roles to help support the clinical director. These might include:

- Guideline lead
- IT lead
- Infection prevention and control lead
- Inpatient lead
- Outpatient lead
- Lead for undergraduate education
- Research lead
- QSI lead.

7 Role of the service director/department in job planning

7.1 Data required for job planning from the organisation

The annual job plan meeting with the service director (SD) is likely to be most productive if there is accurate activity data to support the discussions. Service managers should ensure that there are processes available to provide the SD and the consultant with accurate data for the preceding years. Information on the staffing levels in each MDT will also be valuable. Consultants should sense-check this data and may wish to bring their own data to the meeting, as coding of activity is sometimes flawed and may be inaccurate.

When a service is truly provided by a team, it can be difficult to apportion workload to individuals. Such data should be reviewed by the whole team so that an equitable division can be agreed.

For departments where the clinical director (CD) or clinical lead is not a clinical radiologist, the radiology lead should also be involved in job plan reviews for clinical radiologists to ensure that the requirements of the imaging service are adequately recognised in the job plan.

7.2 Distributing lead/SPA/AR roles

Departments should encourage all consultants to undertake leadership roles. These roles should be appointed to for a fixed term of perhaps three years with the option for a second term. Some departments will have capacity to create deputy roles for key posts so that there is succession planning and cross-cover for leave built into the service.

All consultants should have training to be educational supervisors and should expect to take on this role at some point in their career for doctors and other AHPs who are at all points in training, including ward-based and specialty trainees.

Departments are encouraged to set aside one day a year for a meeting of the consultant body and other senior staff to discuss and agree service objectives. Lead roles and their succession planning can usefully be discussed at such a meeting.

7.3 Ensuring equity/fairness

The CD should ensure that DCC time is consistent between consultants undertaking the same MDT meeting, clinic or ward round, as well as for on-call and travel times. Timings can be agreed and disseminated at the start of a department's job planning cycle.

7.4 Resolving disputes

Consultants may use this RCR, BMA¹⁰ or NHS job planning guidance to discuss any issues with their CD. A diary exercise may help to demonstrate activity levels. Consultants should consider taking a trusted colleague into job plan dispute meetings. Mediation can also be considered, as well as escalation to divisional or medical directors. BMA officers can also provide support and legal advice if appropriate. In any event, no consultant should work more than 48 hours for their trust, which is the limit under the [European Working Time Directive](#), also known as 'Working Time Regulations' in the UK, unless they have decided to sign an opt out.

7.5 Job plan documentation

Hospitals should have a formal job planning policy document explaining how consultant and SAS job planning is organised locally. A new job plan should be signed annually and implemented within 90 days unless otherwise agreed.

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Appendix 1

Sample job plans

These timetables are designed to represent the appropriate proportion of time in a 10 PA job that should be allocated to the diverse clinical tasks needed to support the patient pathway in clinical radiology.

They represent an 'idealised' job plan in that only one activity is occurring at any one time. It is recognised that this is not the normal experience of a clinical radiologist in day-to-day practice. The job plans cover the variation in current consultant practice among those who are working predominantly in diagnostic imaging as well as those working predominantly in interventional radiology (IR).

A number of assumptions have been made in the development of these plans, in addition to those outlined in this guidance. A minimum of 1.5 SPAs is required for revalidation and additional roles should be remunerated as extra to this.

1. All consultants require a minimum of 1.5 SPAs to support their personal revalidation. Other roles, for example, educational supervision or audit lead will attract extra SPA time and recognition in addition to the 1.5 identified above.
 2. The example 10 PA model job plans will vary for different trust and departmental needs, particularly in relation to IR and imaging mix and individual preferences, and many individuals may be on 11–12 PA contracts, which may vary over time.
 3. As highlighted in previous sections, teaching and training should be a key part of all consultant job plans to train the future generation and ensure sufficient numbers of high-quality clinical radiologists for our increasing needs.
 4. Although 2.5 SPAs should be the standard, it is appreciated that many units may use different amounts depending on local policy and needs.
 5. Significant academic roles and research commitments should be reflected in job plans as additional SPA.
 6. The amount of time for on-call work should be diarised, but it is assumed for the model job plans to be 0.5 PA for cross-sectional and 1 PA for IRs.
 7. The amount of home reporting will also vary with local needs for on-site cover and should be equitable and be available to all colleagues doing predominantly imaging or IR job plans.
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Example 1: 10 PA predominantly imaging with on call 0.5 PA


	Mon	Tues	Wed	Thurs	Fri
AM	Elective cross-sectional CT/MR/US To include elective biopsies	Hot CT or US to include acute drainages	MDT Planning / meeting time / post-MDT wash-up	Administration to include vetting / protocolling / letters SPA	SPA teaching / research
PM	Plain film reporting	SPA	Elective cross-sectional imaging reporting off site	Cross-sectional imaging reporting Off site	Plain films reporting

Example 2: 10 PA predominantly intervention with on call 1 PA

	Mon	Tues	Wed	Thurs	Fri
AM	SPA	IR procedures	MDT Planning / meeting time / post-MDT wash-up	IR procedures	SPA Procedure planning and ward work
PM	New patient clinic and follow-up to include telephone consultations	IR procedures	Cross-sectional imaging hot CT or US to include biopsies and drainages		SPA teaching / research



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