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Clinical Oncology
The Royal College of Radiologists

Clinical oncology job planning guidance for consultant and SAS doctors 2022

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1 Introduction

Workforce pressures in clinical oncology (CO) have continued to grow since the publication of the third edition of the guide to job planning in CO in 2015. More clinical oncologists are retiring early, more are 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 fourth edition is therefore a complete update to the previous guidance. It includes clear direction on how oncologists should aim to work in a supportive environment and at the top of their licence.

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 CO 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.

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 should 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 to the wider NHS and profession
- A description of external duties (eg trade union duties, work for a Royal College, etc).
- Any arrangements for additional programmed activities (APAs) or sessions, over and above the standard contract
- Any arrangements for education and training roles
- 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 or working from home.

Example SMART objectives

1. To treat our first patient with spine stereotactic ablative radiotherapy (SABR) by the end of the calendar year, ensuring that this service is then open to patients in our operational delivery network (ODN)/cancer alliance, as per our department strategy. This will require collaboration with physics and radiographer colleagues and will be enabled by 0.5 PA in my job plan for the next 12 months.
2. To move 25% of my thyroid cancer follow-up work to a CNS-led clinic by the end of the calendar year. This will ensure service sustainability and help patient-centred follow-up which is part of the hospital cancer strategy. This will require collaboration with my CNS colleague including regular timetabled meetings to mentor her included in my SPA time.

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) grade contract for England, Wales and Northern Ireland. A Scotland SAS contract is being negotiated. The NHS terms and conditions of service can be found here.

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 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 BMA (British Medical Association) 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 lasting four hours (3.75 in Wales) that takes place every week while they are not on leave, for example an out-patient clinic, 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 outpatient clinics, radiotherapy planning sessions, multidisciplinary team (MDT) meetings, clinical administration and so on.
- **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 (e.g. a medical school) and which are beyond the normal range of SPAs. They will include department leadership roles such as service director, audit lead, governance lead etc.
- **External duties** are work not done directly for the NHS employer and might include Royal College roles, 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 Royal College of Radiologists (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 10 PAs or sessions per week and is not obliged to agree to a contract containing a greater number of PAs or sessions.

An employer may offer 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 additional responsibilities.

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, 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 here. 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, 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 on top of their normal working week.

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 any potential conflicts of interest. Any secretarial or administrative work required to support a doctor's private practice should not be performed in NHS time. 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. 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 (e.g. Dr 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 high-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.[3]

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.

A job planning meeting 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, for example, if a weekly ward round requires one in four cross-cover due to leave, then this should be timetabled with 25% PA allocation. 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 oncology consultants work less than full time (LTFT), with the proportion of LTFT workers increasing in the last five years. The RCR strongly supports hospitals and departments in enabling LTFT working to provide a more supportive working environment (for example, for those with caring responsibilities) and to help minimise early retirement.

The principles and examples in this document apply equally to those on a less than full-time contract. Most elements of the job plan should be pro-rata in proportion to those on a full-time contract. This would include, for example, an option for reduced on-call frequency.

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 employing organisations.

3 The role of a clinical oncologist

3.1 Overview of the role

There are 60 cancer centres in the UK. They provide radiotherapy, systemic anticancer therapies (SACT) and supportive care to patients with cancer and, occasionally, benign diseases. Clinical oncologists are usually employed by a cancer centre to provide and lead these services. Successive workforce censuses show that there is a consultant workforce shortfall of about 17% which will take many years to close even with a large increase in training numbers.

Clinical oncologists work as part of large teams of people treating cancer patients. There are almost infinite variations in the job plan of a clinical oncologist depending on variables such as:

- Location – specialist cancer hospital, part of a large teaching hospital or a smaller department in a local hospital. Most clinical oncologists will be employed by a cancer centre, but some posts also provide outpatient, SACT, acute oncology service (AOS) or inpatient services for other nearby trusts. It should be unusual for a consultant to have duties at more than one unit or satellite facility other than the main cancer centre and certainly there should not be a commitment to more than two peripheral sites.
- Balance of SACT and radiotherapy – which may depend on service organisation, workforce and tumour sites.
- Tumour sites – providing highly specialist radiotherapy to a child with cancer, palliative chemotherapy and supportive care to someone with pancreatic cancer and adjuvant breast cancer radiotherapy are all very different but may all be provided by clinical oncologists.
- Medical oncologists – some cancer centres have large medical oncology departments who undertake much of the SACT workload. In others, clinical oncologists are a large part of the SACT workforce.
- Number of clinical oncologist trainees – training posts contribute to service delivery but also require time in the job plan for supervision and education.
- Allied health professionals (AHP) – clinical nurse specialists; radiographers, including advanced clinical practitioners (ACPs) such as consultant radiographers; pharmacists; physicists and others who are part of the multi-professional cancer team and who usually contribute to 'skill mix' – the provision of care based on expertise not job title. They contribute to service delivery but also require time in the job plan for supervision and competency-based training.
- Stage of career – one person's job plan is likely to change significantly over the course of a career.

3.2 Site-specific working

The treatment of cancer is increasingly complex. Modern radiotherapy requires detailed anatomical and clinico-pathological knowledge of how cancers spread. There are increasing numbers of SACT options including chemotherapy, immunotherapy and targeted agents. Advances in genomics help options to be tailored to tumour types, subgroups or even individual patients. Cancer services are organised into MDTs – groups of highly specialised doctors, nurses and AHPs who can together advise on optimal therapies – and who usually meet at least once a week to discuss patient care.

To keep up to date with treatment options and to be active MDT members, oncologists should provide treatment to one or two tumour sites. The RCR recognise that this may not be possible to achieve with current workforce challenges, especially in smaller centres, but would strongly recommend that this is the ideal to aspire to.

Within each cancer centre there should be time in at least two consultant job plans for RT and SACT for each tumour type. This will ensure appropriate cross-cover so that services have minimal disruption for planned or unplanned absence. Where this is not possible, cover from other centres in a network or alliance should be agreed and included in job plans. The NHS England service specification for radiotherapy explains how radiotherapy operational delivery networks (ODNs) in England can support such cross-centre working.

The employer and treating consultants should hold the relevant Administration of Radioactive Substances Advisory Committee (ARSAC) licence certificate for the administration of radioactive substances (i.e. brachytherapy and isotope therapy). Ideally two consultants (practitioners) should be licenced for each indication.

3.3 Working at the top of your licence

Many departments have provided a very consultant-delivered service for many years. Workforce shortages and an ever-increasing service demand necessitate a change in ethos towards working in multi-professional teams with other healthcare professionals (HCPs) providing care that was previously delivered by doctors. There are good examples of this in all UK cancer centres, but there are also areas that could be improved in almost every department. Examples of other HCPs providing traditional medical care include:

- New patient (NP) clinics – radiographer consultants seeing new cancer patients within a defined scope of practice
- Follow-up (FU) clinics – AHPs providing clinic appointments, patient directed follow-up programmes, personalised stratified follow-up pathways and late effects clinics
- Systemic anti-cancer therapy (SACT) – chemotherapy nurses, clinical nurse specialist (CNSs) or pharmacists providing reviews during treatment with doctors only involved at decision points, for example, to assess response or stop or change treatment
- Radiotherapy – radiographers, CNSs and radiotherapy nurses performing all on-treatment review visits for all tumour types. Contouring of organs at risk and tumour volumes by radiographers, physicists and dosimetrists
- Consent – it is envisaged that this will increasingly be delegated to suitably qualified AHPs working to protocol within a wider multi-professional team
- Outcome and toxicity data collection, which should ideally be automated
- Management roles – some tasks like drafting rotas can be completed by admin staff.

Moving to these different models of working will require clinical oncologist leadership, both to mentor new colleagues and then to lead and support new clinical teams. This work must be included in a job plan. It must also be recognised that taking some of the more 'routine' work away from clinical oncologists will leave them with more complex consultations and decisions so that they may be able to see fewer patients when working in newer models of care, with an associated increase in emotional load. A clinic template may need to be changed to accommodate longer consultations as well as time to supervise and address queries from other HCPs (see section 3.9).

Examples of skill mix in current practice

Consultant radiographer in palliative radiotherapy (Clatterbridge)

The consultant radiographer role allows an appropriately trained radiographer to specialise within an area of practice, meeting four key domains within the post: being an expert practitioner within their field of specialty, providing leadership in this area, undertaking education and development work to support the training of others, as well as continuing to develop practice through research and evaluation.

The consultant radiographer in palliative radiotherapy fulfils these objectives, with a specific focus on the palliative radiotherapy pathway. This is an autonomous role that allows the post holder to undertake all aspects of this pathway, from consultation with patients, consenting for treatment, approval for imaging and prescription of both radiotherapy and required medications. This role helps ensure the timely management of this patient group, with the additional aim of reducing some of the pressure on clinical oncologists.

Chemo clinics (Norwich)

Chemotherapy nurses undertake standard review checks before each SACT cycle for all patients. They phone patients the day before treatment and use a checklist to record performance status, toxicity and blood results. If there are no concerns the patient comes for treatment the following day. If there are concerns then the patient can be booked on a list to be seen by a covering clinical fellow/specialty trainee when they arrive. If a dose reduction is required according to protocol, the prescriber is alerted by email. There is also a rota of prescribers who can make prescription changes at short notice if need be. SACT is prescribed by the doctor at least three days in advance of treatment. At the time of prescribing the doctor can check that appropriate imaging and follow-up appointments have been requested. This system allows more efficient use of day unit capacity, frees up medical time from routine appointments and means patients spend less time in the department.

3.4 Productivity and case numbers

Because of all the variables outlined above and the way in which different individuals and services work, it is impossible to specify an exact number of patients that each consultant should see. Section 5 below provides more detail about components of a job timetable. The RCR strongly advises that most consultant job plans should be designed so that the consultant is responsible for the care of 150–200 NPs annually or a similar pro-rata figure for LTFT employees, based on a consultant led service. This will usually equate to three or four outpatient clinics per week, including new and follow-up patients. The number may need to be fewer where treatment is very complex, for example, in paediatric radiotherapy.

The NHS England radiotherapy service specification suggests that each consultant clinical oncologist should be responsible for at least 25–50 cases of radical radiotherapy per year for each tumour site treated.

Service and job plans should be designed with the aim that all new patients are seen within one-two weeks and urgent follow-up appointments for patients known to the service are available within days.

See sample job plans for suggested case numbers by tumour site (Appendix 1).

3.5 Unpredictable work and responsiveness

A large amount of DCC work is provided without the patient present, so called patient or clinical administration. This can be divided into predictable admin and unpredictable admin.

Predictable admin is directly linked to outpatient or inpatient care, for example, requesting investigations, booking SACT/radiotherapy or validating letters.

Unpredictable admin includes responding to calls, emails and letters from patients, colleagues and other services, with appropriate documentation. The relatively urgent nature of decision-making in cancer care means that these usually need responses within hours-days. A 10 PA job plan will usually have approximately 0.5–1 PA of unpredictable patient related admin in addition to approximately 1–1.5 PA predictable admin (see section 5.1). The exact amount is best determined by a job diary exercise and will vary according to clinical workload, multi-professional working arrangements and how many geographical sites are covered by the doctor. It may be helpful to establish the time taken in a week for phone calls and emails directly to patients so that this can be calculated as formal clinic activity.

3.6 Team working and cover

Some clinical services are run entirely on a team-based model with shared clinic lists. This makes cover for leave of absence easier and fosters true team working. Good team working makes it easier to plan for and deliver a 52-week service and to achieve cancer waiting times targets. DCC time for regular team meetings or huddles to ensure good communication needs to be included in job plans. Many patients value having a named consultant and it should be clear which member of the team is taking that responsibility for each patient.

Other services have evolved with individual consultant workloads and timetables. This may make lines of accountability clearer but can foster a culture of very autonomous decision-making which can leave individual doctors vulnerable. It also makes cover for leave more difficult.

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. Good consultant team working will support the wider cancer team and encourage multi-professional team working.

Team working examples

Norwich head and neck (H&N) team

The three consultants in the H&N team in Norwich have aligned job plans so that they have contouring and peer review time on the same day. All volumes are booked for the team rather than individuals and divided between team members on the day. Every volume has prospective peer review which fosters collaboration and consistency. When plans are ready to be reviewed, all three of them are emailed so that whoever has time can review and sign off the plan – not necessarily the one who did the contouring. In clinic, patients are booked to the oncology lists rather than to named consultants. This makes clinic planning easier to manage and ensures patients benefit from differing expertise and approaches, though some patients request to see a particular consultant which is accommodated where possible. Ad hoc queries from other team members are emailed to a joint account which the consultants take turns to cover, reducing wasted time seeking advice. The team meet regularly throughout the week to share ideas and discuss decisions. This system relies on mutual respect and trust, including accepting decisions that may be slightly different, but enables a much smoother service for patients and the MDT with seamless cover for absence.

Wirral lung cancer team

The Wirral lung cancer team initially ran as a single clinical oncology consultant practice but as complexity and numbers increased, it became increasingly unmanageable. Taking the opportunity to embrace team working it was reworked to include a clinical and medical oncologist working in tandem. With further expansion, the medical team now consists of two medical oncologists and two clinical oncologists. Each patient is assigned a responsible consultant, though any consultant can see any patient attending clinic. This model has proved very successful and resulted in the clinic having one of the highest levels of research recruitment in the Clatterbridge Cancer Centre and nationally for lung cancer.

The positives for team working outweigh the negatives. We do have complex patients who are sensibly seen by one of us most of the time. However, in the event of leave or other commitments, we will cross-cover for them if needs be. We have a brief (15 minute) meeting at the start of clinic to divide the new patients sensibly and pick out any specific issues best dealt with by one of us for the follow-up patients. Otherwise, we work through with any of us dealing with the patients as they come. The clinic is split administratively so the numbers can be cut down as needed.

We plan our leave to ensure that we're not all off at the same time and thus provide cross-cover by default for both clinics and MDTs.

Concentrating the consultants together has improved allocation of resources for research and both ANP/CNS input. It is also a popular pick for the trainees, and we provide a reliable education opportunity for medical students.

The vast majority of patients provide positive feedback and one of the benefits is an inbuilt opportunity for second opinions or a bit of team advice and reassurance on the difficult cases.

There are challenges: the clinic is now very large and so relies on the secretarial and support team having a good grasp on things, along with chasing the right doctor. However, overall it feels like an efficient way to work and takes away the isolation that can make solo practice such a challenge.

3.7 What a clinical oncologist 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 oncologists (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 a way which is as easy as possible (ideally single smart card login)
- Appropriate office space at each place of work
- Appropriate admin support from each place of work (personal assistant or secretary)
- Appropriate private physical space for face to face, video and telephone clinics with support from clinic healthcare assistants (HCAs) or nursing staff as needed for chaperoning, patient support and so on. It is not appropriate to conduct telephone or video clinics from a shared office space
- A formal induction programme when starting a new post. An example is shown in Appendix 2. This can be modified to be used when someone is returning to work after a long absence such as parental leave.

3.8 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.

3.9 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. All oncology departments should offer multidisciplinary Schwartz Rounds (or equivalent forum to facilitate staff reflection) to enhance staff wellbeing and optimise compassionate and humane patient care.

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 treating new tumour sites

A newly appointed consultant may not have previously worked in their new department. Some consultants will also change tumour sites 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 begins to treat a new tumour site or to work in a new location, 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 radiotherapy and SACT for all medical staff. See Appendix 3 for an example competency assessment.

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 pension 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 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 Clinics – NP and FU – face to face, video or telephone

Planned outpatient care may be delivered by face to face, video or telephone appointments. Clinics may be provided by a sole consultant or with a team including trainee doctors, nurses and AHPs. If trainees are present, time for training needs to be included.

Clinic time should include time to read letters and patient records in preparation for a consultation and predictable admin time after the consultation to request investigations or treatments and to dictate and sign summaries and letters. The use of electronic patient records and formal consent processes often add to the time that is required. Time may be required to prepare clinics or to debrief afterwards, particularly when working in a team.

The time required for appointments will necessarily vary but is likely to be 45–60 minutes for a NP consultation and 15–30 minutes for a follow-up visit. These times include predictable clinic admin, which can be scheduled outside of the programmed clinic time (approximately 1–1.5 PA in addition to 0.5–1 PA unpredictable admin as described in section 3.5). An indication of the number of new patients and follow-up appointments in a clinic should be included in the job plan.

There is no evidence that telephone or video appointments are faster than face to face appointments for a given problem or patient. Non-face to face appointments should be offered as part of patient choice but are not a way to see more patients in the same time. Consultants undertaking virtual consultations are advised to keep up to date with current and evolving guidance (e.g. GMC guidance) on such activity from appropriate professional bodies.

5.2 Radiotherapy – contouring, peer review, patient review etc.

Contouring time should be protected from any other activity including patient reviews. A suitable quiet environment should be provided for contouring with all appropriate information available. The time required for contouring depends on the tumour site and workload. Time is also necessary to review and sign off plans and to look at on-treatment imaging when required.

Radiotherapy peer review should be included in job plans in addition to contouring time. It may be in the form of a peer review meeting or ad hoc peer review of contours. For most consultants with a significant radiotherapy practice this will be one-two hours per week.

On-treatment patient reviews should usually be carried out by specialist radiographers or nurses. It can be helpful to meet with teams carrying out reviews on a weekly basis in tumour sites where there are more significant side effects of treatment, for example, head and neck (H&N). Such a meeting is likely to take 30–60 minutes per week for each tumour site.

The RCR conducted a contouring times survey in 2021. The results of this survey will be published by summer 2022 and should be referenced then.

Example calculation

A consultant provides radiotherapy contouring for 100 H&N patients annually. The median time to contour and peer review contours for each patient is 90 minutes. Total 9,000 minutes annually.

In addition, that consultant provides peer review to 100 other contours from colleagues in the team with each review taking 20 minutes. Total 2,000 minutes annually.

So, the total time required for contouring and peer review of head and neck cancer is 11,000 minutes.

One DCC PA = four hours = 240 minutes. Assuming an annual working time of 42/52 weeks, this is 10,080 minutes.

The consultant required 11,000/10,080 PA of job plan time each week – 1.1 PA

5.3 SACT – prescribing, patient review

Routine patient review before each cycle of SACT delivery should be carried out by chemotherapy or specialist nurses, or by pharmacists rather than by oncologists. Doctors should provide clinical leadership to those teams, for example, by writing and agreeing clear protocols for dosing or by having DCC time for team huddles to discuss patients.

If SACT services are organised so that a patient group is always treated on the same day of the week, chemotherapy clinics might be scheduled at the same time, so doctors are available to see people to assess the response and discuss changes in treatment. Chemotherapy clinics can therefore be part of a follow-up clinic service and the time required will be similar to other follow-up appointments.

Chemotherapy prescribing may also be carried out by pharmacists but is often performed by doctors. Prescribing should ideally be done in time set aside in a job plan and would usually comprise 0.25–0.5 PA per week. Some of this work may also be timetabled as predictable admin.

5.4 Brachytherapy

This should include times in theatres, contouring, reviewing plans etc. Time should be calculated on an individual basis according to workload and complexity in a similar way to the calculation for radiotherapy above.

5.5 Molecular radiotherapy

Separate job plan time may be needed for any regular activity not included in clinic time – eg supervision of administration of radionucleotides.

5.6 MDT meetings

Clinical oncologists are usually core members of more than one 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. Where large MDTs have rotational attendance, this should be reflected in pro-rata job plan time. Time allocated should be consistent between clinicians attending the same MDT. MDT leads may need extra time to prepare for meetings, but this should be included as SPA time (see below).

The RCR recommends that all MDTs should review their ways of working in light of the NHS England and NHS Improvement MDT guidance to ensure that MDT discussions genuinely add value to patient care and that decision-making can be protocolised where possible. Remote attendance should be facilitated where possible, particularly when clinical oncologists are part of MDTs in different hospitals.

5.7 Inpatient and planned on-call work – different models

There are many different models for management of oncology inpatients so time in job plans for inpatient care will vary. This can depend on inpatient numbers, whether there are dedicated oncology beds and admission pathways.

Many hospitals have a system of one consultant on call who provides clinical leadership and review of inpatients both during the week and out of hours. Pressures on urgent care usually mean a twice daily board round of all patients and a prompt review of acute admissions as a minimum. Most routine DCC is usually cancelled during this time on call. This is easier when there is sufficient tumour site cross-cover so that outpatient or peripheral hospital pathways are not significantly impacted. Other hospitals offer separate tumour site specific and AOS ward rounds though this means clinicians often switch between inpatient and outpatient work during the week.

If clinicians or teams manage their own inpatient caseload separate to the on call or AOS service, dedicated regular ward rounds each week might be included in a job plan. The time required for these will depend on patient numbers, tumour type and whether patients are admitted under oncology or other teams but is likely to be 15–30 minutes per patient.

For an on-call system, the RCR recommends:

- The job plan is clear which routine clinical activities are cancelled and which continue so that time is not double-counted. This is easiest when e-job planning software is used so that annualised time can be calculated
- Time allocated depends on number of consultants on the rota
- Out of hours DCC work is calculated at one PA = three hours.

Example 1

A consultant provides on-call cover for a week at a time on a 1:10 rota. This covers AOS consultant support, review of new admissions and management of all inpatients under the oncology team. Their usual job plan is 10 PA (eight DCC and two SPA).

- Monday to Friday this involves cover from 0800–1800 with all routine DCC activity cancelled. SPA activity continues, assuming there will be some quieter time when on call to achieve this.
- On a non-on call week, there would have been eight PA (32 hours) DCC work and two PA (eight hours) SPA.
- On call there are still eight hours of SPA but 42 hours (10.5 PA) of DCC work.
- Weekend cover is premium DCC time and involves ward work from 0800–1700, so a further six PA.
- Total on call time is 16.5 DCC PAs in a week but on a 1:10 rota. So, job planned on call time should be 1.65 PA.
- The job planned time for routine DCC should be reduced to take account of the one in 10 weeks when clinics, contouring etc are not carried out.

Example 2

A consultant provides on-call cover for a week at a time on a 1:13 rota. This only covers telephone advice and weekend ward rounds. No routine clinical work is cancelled while on call.

- Monday to Friday there are 30-minute phone calls in core hours and 15 minutes in premium time each day.
  - Total 0.625 + 0.42 PA in that week
- At weekends (premium time) there are ward rounds for three hours each day and 30-minute phone calls per day
  - Total 2 + 0.33 PA over the weekend
- Total PA while on call = 3.375. Annualised in a 1:13 rota = 0.25 PA in a job plan.

5.8 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. For clinical oncologists this is usually telephone advice so is calculated at category B rates.

5.9 Summary of suggested times for DCC

NP appt	45–60 minutes including preparation and direct (predictable) admin time.
FU appt	15–30 minutes including preparation and direct (predictable) admin time.
Unpredictable patient admin	0.5–1 PA per week for a 10 PA job plan.
RT contouring	Pending RCR data – see above.
RT peer review	Where there are formal peer review meetings this is likely to be a minimum of one hour per week for each major tumour site.
RT patient review etc	Mainly supervision of radiographers etc. 30–60 minutes per tumour site per week.
MDT meetings	Pro rata. Does not include MDT lead role. Consider team job planning to ensure consistency.
IP reviews and on call	Depends on ward cover model (see examples in text).

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

The wording in the model contracts for England and Northern Ireland state that job plans 'will typically include an average of 7.5 programmed activities for direct clinical care duties and 2.5 programmed activities 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 additional responsibilities.

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, appraisal and standard department meetings (consultants meeting, governance meetings, morbidity and mortality (M&M) meetings and so on). This should include time for some standard service improvement, quality improvement/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.

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

6.2 QI/service development projects

Many consultants will have roles leading large, complex projects such as implementation of a new service like SABR. 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 re-appraised 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, radiotherapy lead or SACT lead. The table below suggests time for each role and expectations of the 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 and 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 cancer care depends upon appropriately trained and validated practitioners. All doctors have a responsibility for teaching and training,[4] 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 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.[5] 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.

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 office/deanery 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 web pages. As for 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 are 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.[5] 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

Participating in nationally adopted clinical research trials is a standard part of a clinical oncologist job plan. Many clinical oncologists will be local principal investigators for clinical trials or will support research by sitting on trial management groups etc. This time is usually included as part of core SPA time.

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 (online training every three years, approx. one-two hours).

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 – includes: ▪ standard department meetings (consultants meeting, 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.

Oncology 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, head of RT etc). 2–4 PA depending on department size and devolved roles (RT lead etc).
RT head of service / lead	Clinical leadership of the radiotherapy service. May be included in the CD role in smaller departments. If separate, 0.5–1 PA This is a delegated role within Employers Procedures and IR(ME)R regulations.
SACT lead	Clinical leadership of the SACT service. May be included in the CD role in smaller departments. If separate, 0.5–1 PA.
AOS lead	Clinical leadership of acute oncology. Usually at least 1 PA though may be less if some work covered by CD. See RCR AOS document.
Governance lead	0.25–1 PA
Audit and QI lead	0.25–0.5 PA
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.
Cancer research lead	To lead the research strategy of a department 0.5–1 PA.
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.
Hospital cancer lead	Commonly also involved in diagnostics and performance. Usually at least 1 PA.

Cancer Alliance or ODN roles	Depends on the role.
Educational roles	
Clinical supervisor	0.25 SPAs per week per trainee.
Educational supervisor	0.25 SPAs per week per trainee to a maximum of three-four 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 five trainees for which the tutor has responsibility.
Juniors educational lead	0.5 SPA for IMT/Foundation level doctors.
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 five days leave per year is required to provide externality for ARCPs and attend meetings supporting this part of the role.
Training programme director	1 SPA per week for training programmes up to 30 trainees; 2 SPAs per week for training programmes from 30 to 50 trainees.
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

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 including new and follow up clinic numbers at all geographic sites, SACT courses prescribed and number of radiotherapy patients for each tumour site (radical and palliative). Information on the staffing levels in each multidisciplinary team 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 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 oncologist, the radiotherapy lead should also be involved in job plan reviews for clinical oncologists to ensure that the requirements of the radiotherapy 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 expect to take on this role at some point in their career for doctors and other AHPs who are at different points in training including ward-based (tier 1) doctors 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. It can be helpful for lead roles and their succession planning to 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 commitments and travel times. Timings can be agreed and disseminated at the start of a department's job planning cycle. Time for clinical admin should either be included in clinic time, or explicitly included outside of clinic time, to meet the recommendations for time for new and FU patients.

New consultant job plans should be clear about the number of new patients to be seen in a post per outpatient clinic, and this should be reviewed annually with the consultant to ensure that individual consultants do not become overburdened by increasing demand without pro-active planning to ensure sustainable service delivery.

7.4 Resolving disputes

Consultants may use this RCR, BMA[6] 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.

It should be noted that the consultant contract has a number of rules in relation to job plan negotiation. Examples include: a doctor working a 10 PA contract cannot be forced to reduce hours below that if they do not wish to. The first additional PA above 10 should be offered to the hospital before undertaking private practice.

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.

References

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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 oncology.

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 oncologist in day-to-day practice. The job plans cover the variation in current consultant practice between those who are working in a 'clinical oncology' model as well as those working in the less common 'radiation oncology' model.

A number of assumptions have been made in the development of these, in addition to those outlined in this guidance. The new patient numbers represent a guide to what might be achievable for a clinical oncologist of average productivity who is supported by exemplary skill mix (outlined below). They are indicative only and need to be interpreted in the context of local issues including support, skill mix and requirements to train. SPA allocations of greater than 1.5 SPAs will decrease potential new patient numbers.

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. Electronic systems, while increasing safety, can also increase the time taken to perform tasks.
3. Patient pathways will continue to be streamlined by ongoing review.
4. More common tumours will be treated in district general hospitals (DGHs)/cancer units, so travel time will need to be factored into job plans.
5. Management of rarer tumour types will be centralised with less travel time required.
6. Remote supervision of SACT prescribing for common tumour types in DGHs/cancer units will need time recognised in job plans.
7. A significant proportion of SACT delivery will be supervised directly by autonomous nursing/pharmacy staff and clinical oncologists will increasingly only review patients at decision points.
8. It is expected that skill mix will continue to evolve to enable consultants to work at the top of their licence. This may include (but is not limited to):
   - Nurse/AHP led SACT supervision
   - Radiographer/AHP/nurse led on-treatment review clinics
   - Radiographers performing all routine image verification
   - Consent being delegated to suitably qualified AHPs
   - Further implementation of the four-tier radiographer structure with increased radiotherapy prescribing delegated to competent radiographers
   - Organs at risk (OAR) outlining mainly being completed by dosimetrists/physicists/autosegmentation software
   - Acute oncology type services being provided by nurse specialists.

Assumptions regarding future developments:

1. Data systems will support collection of clinical outcomes and toxicities so clinicians can appropriately reflect on the patient impact of new techniques without being required to perform routine follow up.
2. Data systems will support automated recall of patients requiring diagnostic tests during their follow-up period.
3. We expect there to be an evolution of models of follow up, following completion of active treatment including patient directed follow up where appropriate. This should be accompanied by end of treatment consultations, as well as provision of written end of treatment summaries for the patient.

Head and neck radiotherapy and chemo radiotherapy, urology radiotherapy only

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Follow-up clinic H&N MDT	H&N on treatment MDT Chemo supervision H&N complex follow up	Urology New patients Complex follow up	Urology follow-up clinic	RT planning Urology MDT
PM	H&N new patient clinic	RT planning Peer review	Predictable admin	Unpredictable admin SPA	SPA

Breast radiotherapy and SACT, and colorectal radiotherapy and chemo radiotherapy

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Predictable Admin Ward round	Breast MDT Breast new patient clinic	Breast clinic (SACT and complex follow up)	Colorectal MDT Colorectal NP clinic	SPA Unpredictable admin
PM	RT planning Peer review	pred admin	SPA	Colorectal complex follow up Unpredictable admin	RT Planning

Upper gastrointestinal (UGI) and hepato-pancreato-biliary (HPB), (radiotherapy and SACT)

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	UGI MDT UGI new patient clinic	HPB MDT HPB new patient clinic	HPB complex follow-up clinic chemo supervision	RT planning Peer review	SPA
PM	Complex UGI follow-up clinic Chemo supervision clinic	Predictable admin	Unpredictable admin	SPA	RT planning

Neuro LTFT

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	RT planning	MDT RT Peer review	New patient clinic Predictable admin	SPA	
PM	SPA	Unpredictable admin RT planning	Complex follow up Unpredictable admin	Predictable admin	

Lung (radiotherapy and SACT) and acute oncology

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	MDT New patient clinic	Chemotherapy supervision Acute oncology	Acute oncology	RT planning	SPA
PM	Complex follow up	SPA	Ward round Unpredictable admin	Predictable admin	Peer review RT planning

Staff and associate specialist (SAS) grade

LTFT SAS doctor (RT) – 6 PAs, three days a week

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	New patient Clinic	Complex follow-up clinic SPA	MDT RT on treatment reviews		
PM	RT Planning Peer review	SPA	Predictable and unpredictable admin		

Full time SAS doctor (RT) – 10 PAs

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	New patient clinic Complex follow up (Tumour type 1)	On treatment reviews Complex follow up (Tumour type 2)	New patient clinic (Tumour type 2)	MDT (Tumour type 1) Peer review (Tumour type 1)	SPA
PM	RT planning (Tumour type 1)	SPA	Peer review RT planning (Tumour type 2)	Predictable admin	MDT (Tumour type 2) Unpredictable admin

Appendix 2
Induction checklist

Induction checklist applies to home and peripheral trusts.

- ID badge and name badge
- IT requests and training including NHS email, NHS smart card, electronic medical records, radiology, electronic chemotherapy records, electronic prescribing, printer access, dictation/letter approval, electronic staff record, mandatory training, and access to shared drives
- Laptop/desktop with remote access including offsite trusts where available
- Attend Anywhere access
- Clinical workspace with support staff
- Admin workspace
- Radiotherapy planning and guidelines database access (access to competencies if a new tumour site or for trainee supervision)
- Inclusion on department and trust wide email distribution lists
- Secretarial/PA support at home and peripheral trusts
- On-call rota/leave records
- Leave request process
- Expense forms
- Door codes
- Uniforms/laundry
- Covid-19 swabbing and occupational health details
- FIT testing
- Bank/locum doctor sign up
- Honorary contracts
- Staff contacts list and timetables
- Revalidation/appraisal officer contact and setting up of electronic job plan and appraisal records
- Education centre contacts and access to supervisor training
- Support and wellbeing services.

Appendix 3
Competency assessment example from Lancashire Teaching Hospital NHS Foundation Trust

Radiotherapy planning and prescribing competency documentation	
Author	
Staff group relevant to:	Clinicians, consultant radiographers, advanced clinical practitioners
Name of site specialisation competency achieved	
Category of authorisation achieved (see Appendix 1)	
Date of competency assessment	
GMC/HCPC Number	
Staff name (please print	**Signature**
Supervisor's name (please print)	**Signature**
Clinical director's name (please print)	**Signature**

This competency covers the planning and prescribing of radiotherapy treatments within the site specialisation detailed above. It will be completed by all new employees during their induction stage and annually thereafter for radical treatment sites as part of the performance review process. For palliative treatments this competency will be completed only at the induction stage for all new employees.

A separate competency document will be completed for each site specialism.

By signing this competency the supervisor / clinical director are satisfied the individual has successfully completed the competency for planning and prescribing radiotherapy and that they are now competent to act as an IR(ME)R practitioner in radiotherapy for the category of authorisation achieved above.

Read relevant clinical protocols and list below:

Can you name any national documentation/legislation that has supported the production of these clinical protocols?

What are your responsibilities under the IR(ME)R Regulations?

Evidence of completion of E-Learning for Health IR(ME)R Training Modules, IR(ME)R Case based discussion with a MPE to explore your responsibilities under IR(ME)R and local IR(ME)R eLearning annually will be required. MPE to sign to confirm IR(ME)R training completed and individual responsibilities understood at the induction stage for new employees.

MPE name (please print)

Signature

MPE signature only required at initial induction phase not at annual review

Relevant training / clinical experience: detail any relevant experience gained

Radiotherapy experience:

Detail radiotherapy specific experience gained over the past 12 months

Concurrent SACT and radiotherapy experience (If appropriate):

Detail specific experience of delivering chemotherapy in conjunction with radiotherapy gained over the past 12 months

Feedback discussed with supervisor:

Detail any feedback and further actions required

Previous significant incidents discussed:

Refer to Incident Reporting Group for information if required

Target outlining supervision record

Detail below the patients planned under supervision or peer review. A minimum of five cases per tumour site are required.

Date	Patient No.	Supervisor	Comments

Table 1: Categories of authorisation

Category	Subcategory	Types of treatment
1a	Authorisation of the radiotherapy referral form	Palliative radiotherapy
1b	Authorisation of the radiotherapy prescription	
2a	Authorisation of the radiotherapy referral form	Radical radiotherapy utilising all non- specialised techniques (including VMAT, IGRT, IMRT etc.) appropriate to that sub site.
2b	Authorisation of the radiotherapy prescription	
3a	Authorisation of the radiotherapy referral form	Special techniques, such as: ▪ Stereotactic radiosurgery (SRS/T) ▪ Stereotactic body radiotherapy (SABR)

Competency document

Title: Radiotherapy planning and prescribing			Doc ref
Section: treatment planning		Implementation date:	
Type of document: competency document		Review period:	
Approval	**Signature**	**Print name**	**Date**
Approved by			
Approved by			

Reason for change

Issue number	Sec/para change	Change made	Date/initials
1	n/a	Initial issue	
2	Overview IR(ME)R	Add detail that competency to be completed once at induction for palliative treatment and annually for radical site specialisms. Include need to complete elfH IR(ME)R training, local eLearning and MPE discussion. Add MPE to sign to confirm IR(ME)R training completed and individual responsibilities understood.	
3	n/a	Update competency to include GMC/HCPC number and category of authorisation as a IR(ME)R Referrer / practitioner. Add specific information as to what the supervisor / CD is authorising when signing the document Appendix 1 added	

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