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Clinical Oncology
The Royal College of Radiologists

Guide to job planning in clinical oncology, Third edition

Faculty of Clinical Oncology

Contents

1. Introduction

Since the introduction of the new consultant contract in 2003, annual job planning has become an established aspect of consultants' working lives. There is variability in the approach by different organisations, most notably with allocation of supporting professional activities (SPA) time. Many organisations have moved to group and/or annualised job plans. The terms and conditions of the consultant contract are currently under negotiation but, given the rapidly evolving evidence base in the management of malignancy, combined with significant changes in working practices due to the increased utilisation of skill mix, a review of the College guidance on this was felt to be timely.

While this publication addresses the specific issues for clinical oncology, the British Medical Association (BMA) has published updated guidance on consultant job planning which provides more detailed information on the process in general; these two documents should be read in conjunction.[1] There is also guidance from the Department of Health about the process of job planning within the framework of the consultant contract.[2] Both of these organisations recommend that job planning should be based on a diary review of activities over a period of at least one to three weeks, but longer if activities occur with less frequency.

It is acknowledged that this guidance pertains particularly to the 2003 consultant contract (as amended), which is only applicable to consultant clinical oncologists practising in England.[3] Separate contracts exist for consultants in Scotland, Wales and Northern Ireland which, although similar, have some specific differences.[4–6] The principles of this job planning guidance are designed to apply to the whole of the UK.

The Faculty of Clinical Oncology previously updated this guidance in 2012 to take account of the significant changes in work patterns and pressures in the lives of many clinical oncologists since 2006. The impact of these changes and pressures has continued over the past three years, with significant increases nationally in the delivery of advanced radiotherapy techniques. With the sustained evolution of radiotherapy technology, the accepted paradigm of radiotherapy planning will continue to shift, further than occurred with the implementation of conformal radiotherapy at the end of the last century. This is partly presaged in the national Radiotherapy Board document *Intensity-modulated radiotherapy in the UK: Current access and predictions of future access rates*.[7]

In response to these changes, the Faculty of Clinical Oncology produced a document looking at the future of clinical oncology over the next five years.[8] A key theme of this document is the shortfall in current workforce available to deliver an excellent clinical oncology service to all patients nationally. While the Faculty is actively seeking to expand the workforce by increasing training numbers it is likely, in the current economic climate, that this gap may not be completely bridged. In turn, this will further drive changes in clinical practice via skill mix and extended roles for other healthcare professionals.

The RCR continues to recognise the importance of quality, safety and clinical governance. Electronic systems, whilst undoubtedly contributing to patient safety, do increase the time taken by clinicians to perform routine tasks. Patients expect to experience excellent communication, especially around informed consent and potential entry into clinical trials. Media exposure of new drugs and treatment technologies increases the time required for effective consultations. Clinical oncologists have the ability to communicate effectively with patients about their diagnosis and prognosis, as well as to enter into a meaningful patient-centred dialogue around treatment options, including risk–benefit analysis. The patient experience is prioritised in the peer review standards and in the national cancer strategy.[9,10] In the past, some trusts have put a heavy emphasis on cancer waiting times, with pressure on clinicians for greater output at the expense of quality. However, in the wake of the Francis report the quality of care has been re-emphasised.[11] Since 2012, revalidation has been implemented with increased emphasis on reflection and quality improvement activities. This underlines the importance of protected time in the job plan to undertake meaningful SPAs.

In response to feedback, this guidance contains 'idealised' job plans for a number of tumour sites. A range of potential annual new patient numbers is

also included but these are only indicative and must be interpreted with caution and knowledge of local implementation of skill mix and support from other members of the team, including trainees.

This version of the job planning document has been updated to reflect the changing nature of oncology practice. It replaces *Guide to Job Planning in Clinical Oncology* (which has now been withdrawn).

2. Job plan for a consultant clinical oncologist

Job plans are agreed in conjunction with the medical director, clinical director or lead clinician/head of service, taking into account the departmental workload. Many departments have moved to job planning on a departmental level; this allows increased transparency of workload between clinicians and also facilitates cross-cover during periods of leave. This is increasingly important in the context of delivering timely care. It also allows departments to ensure that SPAs – for example, training and quality improvement – are appropriately identified and supported by using consultant skill mix to its best advantage. For a normal full-time working week (40 hours) the balance of 7.5 PAs for direct clinical care (DCC) activities and 2.5 programmed activities (PAs) for SPAs is suggested. However, this is not a universal allowance and the job planning process should identify the activities undertaken in these sessions, which should link to demonstrable outcomes and the clinician's personal development plan. The minimum number of SPAs required to support an individual's revalidation is 1.5 per week. Other activities – for example, educational supervision – should attract SPAs in addition to this. Additional PAs must be negotiated, if required, to provide the necessary service. Each PA should, on average, occupy four hours per week, except in Wales where a session is 3.75 hours. Increasingly, consultants work on a part-time basis and the special job planning considerations for this are discussed below.

For established consultants, job plan negotiation occurs on the basis of proven activity from a diary review. New consultants will need to negotiate a preliminary estimated sessional work plan which will then be subject to annual review. The amount of time which will need to be allocated for each activity will be modified by the following factors:

- Whether the post holder is responsible for systemic therapies, including chemotherapy and biological therapy, chemo-radiation and/or for radiotherapy alone
- The number of areas of site specialisation being undertaken by the consultant (see below)
- The balance of advanced radiotherapy techniques, such as image-guided radiotherapy (IGRT) and stereotactic ablative radiotherapy (SABR) and radiographer/physics led skill mix support included in the post, including radiographer led breast prescribing and outlining of organs at risk (OARs) by non-medics
- The amount and nature of consultant cross-cover in terms of site-specific teams. This includes internal cover within a centre, but increasingly may include routine cross-cover between different centres to support management of rarer tumours in times of annual leave or sickness. It can also be used to facilitate site-specific clinician peer review of radiotherapy volumes, which is an important aid to improving radiotherapy quality assurance. Novel information technology (IT) solutions can support this
- The extent of participation in clinical trials. This involves longer consultation times and/or extra subsequent consultations to ensure adequate clinical trial governance and fully informed consent, as well as mandated routine follow-up by the clinician
- The proportion of patients for who English is not their first language or who require the involvement of other support staff such as social workers
- The extent of skill mix which has been implemented across the department in radiotherapy planning, treatment verification, 'on-treatment' review, systemic anti-cancer therapy (SACT) supervision and follow-up and triage of unwell patients
- The level of secretarial and clerical/administrative support available, including electronic systems – whilst these improve patient safety, they increase the time taken to perform tasks. Consideration should also be given to the the availability of increasingly complex image sets, often from remote trusts, which require review
- The level of senior non-consultant medical staffing, for example, specialty registrars and specialty doctors, both in terms of service support and time required for training supervision. This is increasingly important with the regulation of trainers by the General Medical Council (GMC)

- The amount of time spent travelling, which will depend on the number and geography of sites which the consultant must visit (see below)
- The on-call commitment, which will be affected by the level of junior staffing and the size of the department
- The commitment to acute oncology services, including triaging of unwell patients and the number and location of inpatients for who the consultant is responsible

The delivery of routine seven-day services
It is recommended that a clinic session of 60 minutes should typically be allowed for each new patient (to include 15 minutes for administration time per patient). Longer times may be required in complex cases.

For subsequent consultations, 30 minutes should be allowed. This takes into account former patients re-presenting with complex problems and assumes the discharge from follow-up of uncomplicated well patients. Routine long-term follow-up is no longer viewed as a necessary part of clinical practice. The exceptions to this are where follow-up improves outcomes or adds value, for example, by avoiding inpatient admissions. (Other methods of obtaining clinical outcome data should be sought and implemented to make sure that this is not lost with the reduction in long-term follow-up.) Subsequent consultations, therefore, often include patients with significant problems requiring clinical management. For such patients, 30 minutes should be allowed as a minimum (to include 10 minutes administration).

Day care/ward work: prescription of chemotherapy and informed consent for chemotherapy and radiotherapy may be undertaken at subsequent consultations in outpatient settings or in a day-care chemotherapy unit. Thirty minutes should be allowed for assessment and chemotherapy prescribing (including 10 minutes administration time). It is envisaged that skill mix will result in most chemotherapy delivery being supervised by nurses, pharmacists and radiographers. Clinical oncologists will move toward reviewing the patient at decision points only.

Good practice suggests that consent for chemotherapy and radiotherapy treatments should not be routinely undertaken in the first consultation. All necessary documentation should be completed in a second, subsequent appointment of 30 minutes (including 10 minutes administration time). It is envisaged that consent will increasingly be delegated to suitably qualified associated healthcare professionals (AHPs) working to protocol within a wider multiprofessional team.

Functions relating to radiotherapy planning, delivery and treatment verification must be allocated adequate time within the job plan. This should include time set aside for target volume localisation and also a weekly team quality assurance planning/treatment review meeting. The latter will vary depending on tumour site and the complexity of technique employed. In the future, much of the OAR localisation will be undertaken by dosimetrists or radiographers. Highly protocolised therapies will be delivered by suitably skilled AHPs working to a competency framework within the greater multiprofessional team. On-treatment review of patients will be delegated to a team of AHPs including nurses, radiographers and pharmacists.

As stated above, a typical job plan is expected to include an average of 7.5 PAs of DCC and 2.5 PAs of SPA per week, however, 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 direct care or the payment of additional programmed activities or both. This should be set out clearly at the job plan review, which should take place separately from the annual appraisal process. Job planning should occur at least annually or more frequently if there are particular issues or problems that need raising and addressing by either the clinician or clinical manager during the appraisal cycle.

Time spent travelling to and from clinics and multidisciplinary teams meetings (MDTMs) in hospitals other than the base hospital or main cancer centre is clearly 'unproductive' and should be kept to a minimum. This should be borne in mind when a job plan is created. 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. Time allocated for travelling between hospital sites for clinical commitments should be treated as DCC. Video-conferencing is recommended and should increasingly be used where an MDTM is the sole reason for travelling. Rationalisation of MDTM attendance should be actively encouraged.

No recommendation is made about the precise numbers of new patients per year that should be seen by an individual consultant due to the differences between jobs in terms of complexity of treatments and variation in the support and input from other members of staff. Attached in Appendix 1 are some 'idealised' timetables which illustrate the components required in a job plan. Indicative numbers have been included but should be interpreted in the context of local departmental issues as outlined in above.

It is recommended that a consultant should normally undertake no more than two broad areas of site-specialist practice. In larger centres and for those working less than full time (LTFT), it is recognised that single site specialisation can occur. Clearly, some site specialisations have wider sub-divisions that each may have separate MDTMs and clinics. Therefore, this guidance needs to be flexibly interpreted within the mix of common cancers, rarer cancers and regional services, volume of activity and range of shared team and multi-professional working. However, it seems unlikely that a clinician can remain up to date across too wide an area of practice.

All clinical care, including administration and travelling it, should be included in the DCC element of the job plan, which should not normally exceed 7.5 PAs. Other activities such as audit, quality improvement, teaching and so on, should be counted as SPAs, although work done as a clinical director, audit lead, clinical tutor and so on should be classified as an additional NHS responsibility. These and external duties, such as work done for The Royal College of Radiologists (RCR), should be reflected in the job plan by a reduced DCC component, the payment of extra PAs or both, subject to the agreement of both parties.

The consultant has no obligation to work beyond the basic working week of 10 PAs for a full-time post. For most clinical oncologists this will be 40 hours (37.5 in Wales), but it could be less if activity is done in 'premium time' (outside Monday to Friday, 7 am to 7 pm). This is becoming increasingly common due to the commitment to acute oncology services and the routine delivery of seven-day services. For those consultants who constantly work in excess of their contracted PAs, as supported by a job planning diary, either a reduction in workload or an increase in PAs should be sought. If agreement cannot be reached in consultation with their departmental manager then mediation should be undertaken. In any event, no consultant should work more than 48 hours for their trust, which is the limit under the European Working Time Directive, unless they have decided to sign an opt out.[13]

There is no requirement under the 2003 contract to work more than 10 PAs if a consultant wishes to do private practice.[3] However, one of the criteria for pay progression is that a consultant should accept any extra paid PAs, if offered, before doing private work. If he/she is already doing 11 PAs in a full-time post, this does not apply. A consultant may decline any offer of an extra PA and do private work, but this will risk pay progression. Any private work undertaken in a self-employed capacity does not count towards the 48-hour limit for the purpose of the Working Time Directive.[12]

The individual process of appraisal, which may be a requirement of alterations to the job plan of an individual consultant, will obviously affect other members of the department, and a mechanism should be in place for appropriate review of departmental workload and working within teams. In many cases, good clinical managers would look at team job plans, including both clinical oncology and medical oncology, to ensure clinical continuity and consistency, as well as parity of workload.

Less than full-time (LTFT) working needs special consideration, particularly where the consultant is only working clinically for a few PAs per week. The SPA allocation required for individual revalidation is identical to those colleagues working full time. This may be in the setting of an academic post in which there is a small service commitment or where there is a major managerial role. Alternatively, some consultants choose to work only 1–2 days per week. Working in this way raises a number of issues around responsibility for, and continuity of, patient care. All consultants should have clear arrangements for cross-cover and this is particularly important for those consultants working clinically LTFT.

Consultants working LTFT should be working within defined site-specialist teams. Employing organisations should ensure that all consultants in the team have time for providing cross-cover within their job plans. There may be issues for the individual around revalidation and subsequent re-entry into full clinical practice, but this is up to the

individual to anticipate. Consultants working less than one day per week in clinical practice should not participate in on-call rotas as they may not be fully equipped to deal with the challenges of the wide range of clinical scenarios that may present to the on-call consultant clinical oncologist.

3. On call

Unless there are exceptional circumstances (for example, those working limited hours – section 2), all consultant clinical oncologists are expected to take part in departmental on-call commitments. The content/intensity of work while on call will depend on local practice (for example, ward rounds, acute oncology arrangements, extended working day and so on).

The following paragraphs are found in Schedule 8 (on-call rotas) in the CCSC publication *Terms and Conditions for Consultants.*[3]

'Duty to be contactable

- *Subject to the following provisions, the consultant must ensure that there are clear and effective arrangements so that the employing organisation can contact him or her immediately at any time during a period when he or she is on call.*
- *The only exception to this requirement is where a consultant's on-call duties have been assessed as falling within category B described in Schedule 16 and the employing organisation and the consultant have agreed in advance that the consultant may arrange short intervals during an on-call period when it will not be possible for him or her to be contacted straight away. In these circumstances, the consultant must ensure that:*
  - *The intervals in question have been agreed with the employing organisation in advance and clearly recorded*
  - *There are arrangements for messages to be taken if the employing organisation contacts the consultant during such an interval*
  - *The consultant can and does respond immediately after such an interval.*

High-frequency rotas

- *Where a consultant or consultants are on a rota of 1 in 4 or more frequent, the employing organisation will review at least annually the reasons for this rota and for its high frequency and take any practicable steps to reduce the need for high-frequency rotas of this kind. The views of consultants will be taken into account.*
- *Where unusually a consultant is asked to be resident at the hospital or other place of work during his or her on-call period, appropriate arrangements may be agreed locally. A consultant will only be resident during an on-call period by mutual agreement.*

Private professional services and fee paying services

- *Subject to the following provisions, a consultant will not undertake Private Professional Services or Fee Paying Services when on on-call duty. The exceptions to this rule are where:*
  - *The consultant's rota frequency is 1 in 4 or more frequent, his or her on-call duties have been assessed as falling within the category B described in Schedule 16, and the employing organisation has given prior approval for undertaking specified Private Professional Services or Fee Paying Services;*
  - *The consultant has to provide emergency treatment or essential continuing treatment for a private patient. If the consultant finds that such work regularly impacts on his or her NHS commitments, he or she will make alternative arrangements to provide emergency cover for private patients.'*[3]

Large oncology centres may choose to have a first and second consultant on call and duties and supplements will have to be negotiated with the trust.

4. Definitions

Direct clinical care (DCC)

Direct clinical care refers to work directly relating to the prevention, diagnosis or treatment of illness that forms part of the services provided by the employing organisation under section 3(1) or section 5(1)(b) of the National Health Service Act 1977.[13] This includes emergency duties (including emergency work carried out during or arising from on call), operating sessions including preoperative and postoperative care, ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, public health duties, MDTMs about direct patient care and administration directly related to the above (including but not limited to referrals and notes).

DCC for a clinical oncologist might include activities such as:

- Seeing new patients and those attending subsequent consultations which may be undertaken at the centre, in satellite units or in the district general hospital setting
- MDTMs
- Radiotherapy planning – this is a multi-step process involving localisation, plan review, verification review and dose prescription. Adequate time should be allocated within sessions or accommodated flexibly within the job plan. It is imperative that the complexity of different site-specific practices is taken into account in the allocation of time
- Supervising patients undergoing radiotherapy, including managing toxicity, dose modifications and assessments
- Assessment of patients and prescription of systemic therapy including chemotherapy
- Managing toxicity of systemic therapies, including dose modifications
- Theatre sessions – required for brachytherapy, examination under anaesthetic and intraoperative radiation therapy
- Supervising, assessing and prescribing unsealed source therapies for patients
- Ward rounds – effectively supervising acutely ill inpatients and facilitating early discharge where possible
- Inpatient referrals – assessment of patients admitted under other medical specialties. This is a common component of clinical oncology practice which can amount to the equivalent of a new outpatient consultation with the same administrative burden
- Acute oncology – this is an essential component of clinical oncology practice and includes the management of acutely ill patients with side-effects of radiotherapy, chemotherapy and metastatic spinal cord compression, and new cancer patients presenting for the first time as an emergency. The National Peer Review Programme manual for cancer services suggests that acute oncology consultant ward rounds will take place twice a day.[14] These rounds may take place out of standard hours, especially the late afternoon or evening round. This should be counted as DCC time, annualised depending on the rota frequency and added into the job plan.
- Administration directly related to patient care; for example, patient correspondence, subsequent phone calls, review of results and completion of diagnostic requests, completion of benefit application forms, hospice and palliative care assessment and referrals, radiotherapy planning/booking forms and so on
- Travel between hospitals required to perform clinical duties.

Supporting professional activities (SPAs)

There are two types of SPA that underpin direct clinical care:

SPA – time required for an individual to comply with clinical governance and revalidation requirements, including mandatory training, audit, continuing professional development and appraisal. This should be a minimum of 1.5, and ideally 2.5, SPAs per week.

Other SPA activities required by, or agreed with, the employing organisation or which, if undertaken, should be justified at appraisal. These could include teaching and training, research, management, committees (local or national) and administration (not directly related to patient care). All of these

activities require documented output. Specific duties relating to the education and clinical supervision of trainees should also be included. This activity requires 0.25 SPAs per trainee per week allocated within the job plan.

Additional NHS responsibilities

Special responsibilities are those not undertaken by the generality of consultants in the employing organisation, which are agreed between a consultant and the employing organisation and which cannot be absorbed within the time that would normally be set aside for SPAs. These could include (but are not limited to) being a medical director, clinical director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, serving on ionising radiation medical exposure regulations (IRMER)/critical incident committees, ethics committees, drugs and therapeutics committees, acting as an undergraduate dean, postgraduate dean, clinical tutor or regional specialty adviser.

External duties

External duties encompass those not included in any of the three foregoing definitions and not included within the definition of fee-paying services or private professional services, but undertaken as part of the job plan by agreement between the consultant and employing organisation. These might include trade union duties, undertaking inspections for the Care Quality Commission, acting as an external member of an Advisory Appointments Committee, undertaking assessments for the National Clinical Assessment Authority, reasonable quantities of work for the Royal Colleges in the interests of the wider NHS, reasonable quantities of work for a government department or specified work for the GMC. This list of activities is not exhaustive.

Travelling time

Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other sites will be included as working time. Travel to and from work for NHS emergencies, and ‘excess travel’, will count as working time. ‘Excess travel’ is defined as time spent travelling between home and a working site other than the consultant’s main place of work, after deducting the time normally spent travelling between home and main place of work. Employers and consultants may need to agree arrangements for dealing with more complex working days. Travelling time between a consultant’s main place of work and home or private practice premises will not be regarded as part of working time.

5. Expectations of the employing organisation

It is noted that the employing organisation will expect the consultant to honour their contract. In general these expectations are likely to include:

Participating satisfactorily in the annual appraisal process and, ultimately, revalidation

Making every reasonable effort to meet the time and service commitments in the job plan

Participating satisfactorily in reviewing the job plan and setting personal objectives in conjunction with service objectives

Having met the personal objectives in the job plan or, where this is not achieved for reasons beyond the consultant's control, made every reasonable effort to do so

Having worked towards any changes identified in the last job plan review as being necessary to support achievement of the employing organisation's objectives

Having taken up any offer to undertake additional PAs that the employing organisation has made to the consultant in accordance with Schedule 6 of the Terms and Conditions of Service (Extra Programmed Activities and Spare Professional Capacity)[11]

Meeting the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 of the Terms and Conditions of Service (Provisions governing the relationship between NHS work, private practice and fee paying) and Code of Conduct for Private Practice.[3,15,16]

Approved by the Board of the Faculty of Clinical Oncology: July 2015

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Appendix 1. Idealised timetables for ‘pure’ site-specific clinicians

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 section 2 of 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, whilst increasing safety, also increase the time taken to perform tasks.
3. Patient pathways with continue to be streamlined by ongoing review and change implementation.
4. Most common tumours will be treated in district general hospitals (DGHs)/cancer units, so travel time will need to be factored into job plans.
5. Remote supervision of SACT prescribing for common tumour types in DGHs/cancer units will need time recognised in job plans.
6. 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 in their journey.
7. Management of rarer tumour types will be centralised with less travel time required.
8. Routine follow-up of patients not on active therapy will not be supported, except where specialist follow-up directly improves patient outcomes or adds value (for example, admission avoidance). However, it is likely to continue to occur in the context of clinical trials and the burden of trials work needs to be acknowledged, though this is difficult to alter.
9. Each department needs 0.5 SPAs per tumour site to per week ensure the process infrastructure to support ongoing review of protocols, quality assurance of techniques and ongoing quality improvement activity for example, new immobilisation techniques.
10. Every department needs at least 5 SPAs per week to innovate and implement new technologies in a rapid and responsive but controlled and safe fashion. It is likely these PAs will be attached to different clinicians (representing different tumour site groups) at different times, facilitating each service development in turn.

Assumptions regarding future developments

1. Skill mix will be increased in all areas over and above the current level. This includes (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/auto-segmentation software
   - Acute oncology type services being triaged by nurse specialists
2. Structured clinician peer review of radiotherapy planning volumes will be mandatory

3. IT support for remote working will be routine across trusts with multiple sites as well as across cancer centres and networks
4. Rationalisation of MDTM attendance will occur. MDTM discussion may be rationalised to include only those patients who, for reason of comorbidity or previous therapy, fall outside of protocol
5. IT solutions will further reduce the need to travel between sites
6. 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 perfom routine follow-up
7. Data systems will support automated recall of patients requiring diagnostic tests during their follow-up period
8. End of therapy interviews will become the norm with facilitated access back to the appropriate service for investigation of concern symptoms.

Idealised job plans by site-specialty

Breast (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	TRAVEL NEW PATIENTS/PROBLEM FOLLOW-UPS/CHEMO SUPERVISION (as before)	TRAVEL END OF THERAPY SURVIVIORSHIP INTERVIEWS TRAVEL	RADIOTHERAPY PLANNING (supervising radiographer led mark ups and complex patients)/PEER REVIEW	SPA
PM	NEW PATIENTS (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/inpatient [IP] review)	RADIOTHERAPY VERIFICATION (complex problems) SPA	NOT WORKED (LONG DAYS ELSEWHERE)

NEW PATIENTS PER YEAR = APPROX 250–300

Breast (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENTS (dictation time/treatment booking/scan requesting time included)	TRAVEL NEW PATIENTS/PROBLEM FOLLOW-UPS	TRAVEL POST-THERAPY REVIEW PATIENTS TRAVEL	RADIOTHERAPY PLANNING (supervising radiographer led mark ups and complex patients)/PEER REVIEW	SPA
PM	NEW PATIENTS TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING (as above)	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 300– 350

Breast (with development time)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	TRAVEL POST-THERAPY REVIEW PATIENTS/END OF THERAPY SURVIVIRSHIP INTERVIEWS	DEVELOPMENT TIME (RADIOTHERAPY [RT] OR SACT)	RADIOTHERAPY PLANNING (supervising radiographer led mark ups and complex patients)/PEER REVIEW	SPA
PM	NEW PATIENTS (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UP TRAVEL	DEVELOPMENT TIME (RT OR SACT)	ADMIN (queries about patients/results sign off/IP review)	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 150–180

Lower gastrointestinal (GI) (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	TRAVEL NEW PATIENTS/ PROBLEM FOLLOW-UPS/CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	LIVER METS MDTM/ CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENTS (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 250–300

Lower GI (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	TRAVEL PROBLEM FOLLOW-UPS	NEW PATIENTS/CHEMO SUPERVISION (CHEMORAD ONLY)/PEER REVIEW	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT CLINIC TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 300–350, IF DO CHEMORADIOTHERAPY = APPROX 280–320

Lower GI (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT CLINIC/CHEMO SUPERVISION (CHEMORAD ONLY)	TRAVEL PROBLEM FOLLOW-UPS	DEVELOPMENT TIME	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	SPA TREATMENT VERIFICATION (complex problems)	DEVELOPMENT TIME

NEW PATIENTS PER YEAR = APPROX 150–180

Upper gastrointestinal (UGI) and hepato-biliary (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL UGI MDTM NEW PATIENT CLINIC	TRAVEL NEW PATIENTS/ PROBLEM FOLLOW-UPS/CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	HEPATOBILIARY (HBP) MDTM/ CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 250–300

Upper GI and hepatobiliary (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL UGI MDTM NEW PATIENT CLINIC	TRAVEL PROBLEM FOLLOW-UPS	HPB MDTM/CHEMO SUPERVISION (CHEMORAD ONLY)/PEER REVIEW	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 300–350 PER YEAR, IF DO CHEMORADIOTHERAPY = APPROX 280–320

Upper GI and hepatobiliary (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT CLINIC/CHEMO SUPERVISION (CHEMORAD ONLY)	TRAVEL PROBLEM FOLLOW-UPS TRAVEL	HPB MDTM/SPA	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included) TRAVEL	DEVELOPMENT TIME	ADMIN (queries about patients/results sign off/IP review)	PEER REVIEW/ TREATMENT VERIFICATION (complex problems)	DEVELOPMENT TIME

NEW PATIENTS PER YEAR = APPROX 150–180

Head and neck

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	ON/POST-TREATMENT CLINIC (complex problems)	RADIOTHERAPY PLANNING	PEER REVIEW/ TREATMENT VERIFICATION (complex problems)	SPA
PM	NEW PATIENT	RADIOTHERAPY PLANNING	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	SPA/CHEMO SUPERVISION FOR CHEMORAD

NEW PATIENTS PER YEAR = APPROX 200–250

Head and neck (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	PEER REVIEW/ TREATMENT VERIFICATION (complex problems)	SPA
PM	NEW/ON/POST-TREATMENT CLINIC (complex problems)	DEVELOPMENT TIME	RADIOTHERAPY PLANNING	SPA/CHEMO SUPERVISION FOR CHEMORAD	DEVELOPMENT TIME

NEW PATIENTS PER YEAR = APPROX 100–150

Central nevous system (CNS)

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	CHEMO SUPERVISION	VERIFICATION (complex problems)/ON-TREATMENT REVIEW	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT CLINIC	ADMIN (queries about patients/results sign off/IP review)	FOLLOW-UP CLINIC	RADIOTHERAPY PLANNING	SPA/PEER REVIEW

NEW PATIENTS PER YEAR = APPROX 250

CNS (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	CHEMO SUPERVISION/ ON-TREATMENT REVIEW	DEVELOPMENT TIME	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT CLINIC/FOLLOW-UP CLINIC	ADMIN (queries about patients/results sign off/IP review)	DEVELOPMENT TIME	RADIOTHERAPY PLANNING/ VERIFICATION (complex problems)	SPA/PEER REVIEW

NEW PATIENTS PER YEAR = APROX 150

Lung (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)/NEW PATIENTS	TRAVEL NEW PATIENTS	CHEMO SUPERVISION (FOR CHEMORAD)/ON /POST-TREATMENT REVIEW	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENTS (dictation time/treatment booking/scan requesting time included) TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/ VERIFICATION (Complex problems)	SPA/PEER REVIEW

NEW PATIENTS PER YEAR = APPROX 250–300

Lung (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW (dictation time/treatment booking/scan requesting time included)	TRAVEL NEW PATIENTS	CHEMO SUPERVISON (CHEMORAD)/ PEER REVIEW/ON/POST-TREATMENT REVIEW	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENTS TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/TREATMENT VERIFICATION (Complex problems)

NEW PATIENTS PER YEAR = APPROX 300–350

Lung (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM PROBLEM FOLLOW-UPS	CHEMO SUPERVISON (CHEMORAD) PEER REVIEW/ON/POST-TREATMENT REVIEW	DEVELOPMENT TIME	RADIOTHERAPY PLANNING	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included) TRAVEL	DEVELOPMENT TIME	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/ TREATMENT VERIFICATION (complex problems)	SPA/NOT WORKED (LONG DAYS ELSEWHERE)

NEW PATIENTS PER YEAR = APPROX 150–180

Genito-urinary radiation oncology (no brachytherapy)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT(dictation time/treatment booking/scan requesting time included)	TRAVEL NEW PATIENTS/ PROBLEM FOLLOW-UPS	CHEMO SUPERVISION (CHEMORAD)/ON-TREATMENT REVIEW/END OF THERAPY INTERVIEWS	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENTS TRAVEL	PROBLEM FOLLOW-UPS/POST-THERAPY REVIEW PATIENTS TRAVEL	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 250–300, DEPENDING ON TUMOUR TYPES TREATED

Genito-urinary (prostate) plus brachytherapy

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	TRAVEL NEW PATIENTS/POST-THERAPY REVIEW	THEATRE/ BRACHYTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	SPA
PM	NEW PATIENTS/ PROBLEM FOLLOW-UPS TRAVEL	PROBLEM FOLLOW-UPS TRAVEL	RADIOTHERAPY PLANNING/ CHEMOTHERAPY SUPERVISION	BRACHYTHERAPY REVIEW MEETING/ RADIOTHERAPY PLANNING	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 200–250

Genito-urinary (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	TRAVEL MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	TRAVEL POST-THERAPY REVIEW PATIENTS/ PROBLEM FOLLOW-UPS TRAVEL	DEVELOPMENT TIME	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENTS TRAVEL	DEVELOPMENT TIME	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 150–180

Gynaecology clinical oncology (no brachytherapy)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	NEW PATIENTS/ PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	CHEMO SUPERVISION (CHEMORAD)/ON-TREATMENT REVIEW	RADIOTHERAPY PLANNING/PEER REVIEW	SPA
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	CHEMO SUPERVISION	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING (as above)	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 220–280, DEPENDING ON TUMOUR TYPES TREATED (CERVIX, OVARY AND ENDOMETRIUM)

Gynaecology radiation oncology (brachytherapy)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM CHEMO SUPERVISION (CHEMORAD)/ON-TREATMENT REVIEW	NEW PATIENTS/ PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	THEATRE/ BRACHYTHERAPY PLANNING	BRACHYTHERAPY PLANNING/ SUPERVISION/ RADIOTHERAPY PLANNING	BRACHYTHERAPY PLANNING/ SUPERVISION/ RADIOTHERAPY PLANNING
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/PEER REVIEW	SPA	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 180–220

Gynaecology (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM CHEMO SUPERVISION (CHEMORAD)/ ON-TREATMENT REVIEW	NEW PATIENTS/ PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	DEVELOPMENT TIME	DEVELOPMENT TIME	RADIOTHERAPY PLANNING
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/PEER REVIEW	SPA	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 150–180

Skin (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM NEW PATIENT (dictation time/treatment booking/scan requesting time included)	NEW PATIENTS	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)/ON-TREATMENT REVIEW
PM	NEW PATIENT	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	RADIOTHERAPY PLANNING	SPA	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APROX 280–320

Skin (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM NEW PATIENT	NEW PATIENTS	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/ON-TREATMENT REVIEW
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	RADIOTHERAPY PLANNING	SPA	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 320–350

Skin (development time)

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM NEW PATIENT	DEVELOPMENT TIME	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	DEVELOPMENT TIME
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS/ON-TREATMENT REVIEW	RADIOTHERAPY PLANNING	SPA	SPA/TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 150–180

Thyroid

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM NEW PATIENT	NEW PATIENT	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)/ON-TREATMENT REVIEW
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	NUCLEAR MEDICINE/ FOLLOW-UP	SPA	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 300–350

Lymphoma (clinical oncology) – outpatient (OP) chemo only, inpatient (IP) chemo under haematologists

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM JOINT CLINIC NEW PATIENT	NEW PATIENTS/PEER REVIEW	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)/FOLLOW-UP
PM	JOINT CLINIC NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	RADIOTHERAPY PLANNING	SPA	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENT PER YEAR = APPROX 220–280

Lymphoma radiation oncology

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM JOINT CLINIC NEW PATIENT	NEW PATIENT/FOLLOW-UP	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	RADIOTHERAPY PLANNING/ON-TREATMENT REVIEW
PM	JOINT CLINIC NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	RADIOTHERAPY PLANNING/PEER REVIEW	SPA	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 250–300

Lymphoma (development) no chemotherapy

	Mon	Tues	Wed	Thurs	Fri
AM	SPECIALIST MDTM JOINT CLINIC NEW PATIENT	DEVELOPMENT TIME	RADIOTHERAPY PLANNING	ADMIN (queries about patients/results sign off/IP review)	DEVELOPMENT TIME
PM	JOINT CLINIC NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS	RADIOTHERAPY PLANNING/PEER REVIEW	SPA	SPA/ TREATMENT VERIFICATION (complex problems)

NEW PATIENTS PER YEAR = APPROX 150–180

Radiotherapy development (radiation oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM NEW PATIENT	RADIOTHERAPY PLANNING/PEER REVIEW	RADIOTHERAPY PLANNING	SPA/TREATMENT VERIFICATION (complex problems)	DEVELOPMENT TIME
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS/ON-TREATMENT REVIEW	ADMIN (queries about patients/results sign off/IP review)	SPA	DEVELOPMENT TIME

NEW PATIENTS PER YEAR = APPROX 150–200, DEPENDING ON TUMOUR SITE

Radiotherapy development (clinical oncology)

	Mon	Tues	Wed	Thurs	Fri
AM	MDTM CHEMO SUPERVISION (complex patients/meet with AHPs delivering care)	RADIOTHERAPY PLANNING/PEER REVIEW	RADIOTHERAPY PLANNING	SPA/ TREATMENT VERIFICATION (complex problems)	DEVELOPMENT TIME
PM	NEW PATIENT (dictation time/treatment booking/scan requesting time included)	PROBLEM FOLLOW-UPS/POST-THERAPY PATIENTS/ON-TREATMENT REVIEW	ADMIN (queries about patients/results sign off/IP review)	SPA	DEVELOPMENT TIME

NEW PATIENTS PER YEAR = APPROX 150–180, DEPENDING ON TUMOUR SITE

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The Royal College of Radiologists
63 Lincoln's Inn Fields, London WC2A 3JW
Tel: +44 (0)20 7405 1282
Email: enquiries@rcr.ac.uk **www.rcr.ac.uk**

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