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Clinical Radiology
The Royal College of Radiologists

A guide to job planning in clinical radiology

Faculty of Clinical Radiology

Contents

Foreword

The Royal College of Radiologists (RCR) would like to thank and acknowledge the contribution to this important publication of the Faculty of Clinical Radiology, the Professional Support and Standards Board and, in particular, the individual contribution of Dr Mark Callaway.

The RCR considers it timely to present this update of its previous guidance on job planning, originally released in 2000, although realising that this may need to be revised in the near future following the recent announcement that negotiations are to take place on the consultant contract in England and Northern Ireland.

It is important that in this interim period the RCR continues to support the job planning process by keeping its guidance refreshed.

This paper therefore represents the current College advice. It replaces the previous guidance *Guide to Job Descriptions, Job Plans and Work Programmes in Clinical Radiology* published in 2000, which has now been withdrawn. Separate advice has also published by the British Medical Association (BMA) and it is suggested that clinical radiologists also consider the BMA advice[1] when drawing up their job plans.

This guidance forms part of a group of documents to assist radiologists in ensuring they have a realistic job plan that reflects, as far as possible, their full contribution to patient care. The other two documents are *Clinical Radiology Workload: guidance on radiologists' reporting figures*[2] issued in 2012, and *Cancer Multidisciplinary Team Meetings – Standards for Clinical Radiologists*,[3] which is currently being updated. Clearly we are aware that if substantial changes are made to the contract, then further revision of this guidance may be required.

Dr Pete Cavanagh
Vice-President, Clinical Radiology
The Royal College of Radiologists

1. Introduction

1.1 A job description is the basis of the contract between a consultant and the employing authority. There are two distinct employment contracts in England:[4,5]

- The pre-2003 national consultant contract – a small number of consultants appointed before 1 November 2003 retain this contract but it is not on offer to new appointments[4]
- The 2003 consultant contract[5] – the vast majority of consultants and all new appointments are employed under this contract. The latest update of these terms and conditions of service was in March 2013.

Separate contracts exist for consultants in Northern Ireland,[6,7] Scotland[8] and Wales[9] which, although similar, have some specific differences.

- In Scotland since 1 April 2004, all new NHS consultant posts (including locums) are appointed to the 2004 consultant contract.[8] Consultants in post before 1 April 2004 can move to the 2004 contract or stay on the pre-2004 contract.
- All consultants in Wales transferred to the new contract with the amendment agreed with the Welsh Government in December 2003.[9]

It is acknowledged that this guidance pertains particularly to the 2003 Consultant Contract (as amended), which is only applicable to consultant clinical radiologists practising in England. However, the principles of this job planning guidance are designed to apply to the whole of the UK.

The contract is based on programmed activities (PAs). One PA is regarded as the equivalent of a period of four hours. Three types of contract are possible: whole-time (a minimum of ten PAs per week), part-time (nine PAs or less per week) and honorary.

1.2 The job plan is a detailed description of the duties and responsibilities of a consultant and of the facilities available to carry them out. It incorporates a work programme. A job plan has to be agreed by the chief executive of the trust and should be reviewed annually. This role of agreement and review is usually delegated by the chief executive to a senior clinical manager, usually the medical director, clinical director or service lead. The purpose of review is to ensure that the job plan continues to accurately reflect the skills of the clinical radiologist and the clinical and imaging needs of patients. It presents an opportunity for individuals and departments to identify workload pressures to their managers, and is therefore of considerable importance.

2. A job plan for a consultant clinical radiologist

2.1 Job plans are agreed in conjunction with the medical director, clinical director or lead clinician/head of service, taking into account the departmental workload. For a normal full-time working week (40 hours), the balance of 7.5 sessions for direct clinical care (DCC) activities and 2.5 sessions for supporting professional activities (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 demonstrated outcomes. Additional sessions must be negotiated, if required, to provide the necessary service. Each session or 'programmed activity' 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 situation are discussed in 2.10 below.

2.2 Job plans need to be negotiated individually. For established consultants, this is on the basis of proven activity from a diary review. New consultants will need to negotiate a preliminary estimated sessional work plan which will 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.

- The number of reporting sessions designated within the job plan, and the number of clinical and radiological meetings the consultant is required to attend.
- Allowance for clinical interruptions needs to be made. This may take the form of a 'consultant of the day' role or 'hot-desking' within some departments but fulfils an important role in providing integrated clinical radiological services. The department should strive to protect the time of the consultants that are not in this role.
- If a radiologist has an interventional workload, time for assessing the imaging, planning the intervention and 'consenting' the patient is required. It may be necessary to provide and support outpatient clinics.
- Patient care and clinico-radiological team working are greatly enhanced by multidisciplinary team (MDT) meetings. Their application has extended from oncology to other patient groups such as those with stroke, rheumatology, and so on. Some MDT meetings will require considerable preparation time, others much less.
  The appropriate number of participating radiologists will vary according to case mix, multi-site teleconferencing, and so on. Each MDT should have at least two radiologist members to ensure cross-cover for periods of leave. Radiologist members of an MDT should aim to attend all meetings unless they are on leave. This is necessary for feedback on complex imaging, and prevents deskilling in the management of less common diseases.
  Each radiologist should participate in at least one MDT meeting per week. The number of MDT meetings that should reasonably be attended by an individual radiologist will vary depending on their case mix, the need for clinical feedback, other service demands, and the availability of other radiologists in the same sub-specialty.[10]
- Cross-cover of consultant leave should be factored into job plans, based on an annual commitment of 40 weeks. Time needs to be allowed not only for reporting the extra examinations, but for the increased clinical enquires resulting from a reduction in staff.
- Some allowance should be made in an individual's job plan for unpredicted workload, particularly with regard to emergency interventional procedures. Adequate provision for cross-covering emergency work needs to be factored into the overall working of a department

and may require a team approach to both daytime lists and on-call provision.

- The on-call component of the job plan needs to be assessed regularly. The on-call expectations of most departments continue to increase as the expectation for the availability of imaging on a 24/7 basis continues to increase. These annual changes need to be reflected in robust and up-to-date job planning.
- On-call rotas should be formalised, with no dependency on ad hoc rotas or informal rotas. If a department cannot provide a formal rota, the organisation has to clearly define the alternatives and support different ways of working via job planning. This may require developing an integrated approach with other neighbouring organisations.
- Some departments perform routine imaging 'out of hours' and at weekends. Adequate cover to report this routine, often unsupervised, imaging needs to be built into the overall job planning of the department. Radiologists should not be required to report elective imaging during on-call hours. Contractually, radiologists are required to deliver emergency radiology when on call, not elective outpatient reporting and scanning.
- The amount of skill mix within a department needs to be considered, with regard to appropriate delegation, adequate time for supervision, review and delegation. This needs to be factored into an individual's job plan.
- The level of secretarial and clerical/administrative support available needs to be considered.
- The level of specialty registrar staffing – both in terms of service support and time for training input – should be taken into account.

2.3 No recommendation regarding absolute reporting numbers can be made other than to refer to the recent guidelines on workload.[2] The workload achievable is very variable within a single department as well as within an organisation. Individual job planning should strive to identify the activities per session and weight accordingly. A consultant providing a 'hot seat' service is likely to be constantly interrupted and will have low reporting numbers for that period, but will have provided an invaluable service to those patients discussed, whereas a consultant who is in a 'reporting-only' environment will report far more examinations per unit time. It is important that the approach to job planning is standardised within a single organisation.

2.4 Time should be made available for all members of the department to attend departmental discrepancy meetings. These should be regularly timetabled and attendance should be recorded.

2.5 A typical job plan will include an average of 7.5 PAs of DCC and 2.5 PAs of SPA per week (see 2.1 above). However, if a consultant's job requires more supporting professional activity, or includes additional NHS responsibilities or external duties, this must be reflected in the job plan either 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. This could take place as part of the annual appraisal process or ideally, separately, especially if there are particular issues or problems that need raising and addressing relating to job plan pressures or changes.

2.6 All clinical care, including administration and travelling related to 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 or teaching should be counted as an SPA, 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 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.

2.7 The consultant is under no obligation to work beyond the basic working week of ten

PAs for a full-time post. For most clinical radiologists, 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). If a consultant's job plan is in excess of ten PAs, they should be recompensed for those additional hours. If the trust declines to pay for that extra work, the BMA Central Consultants and Specialist Committee (CCSC) recommends that the doctor does not work them. In any event, no consultant should work more than 48 hours per week for their trust, which is the limit under the European Working Time Directive,[11] unless they have decided to sign an 'opt out'.

2.8 There is no requirement under the 2003 contract to work more than ten PAs if a consultant wishes to do private practice. However, one of the criteria for pay progression is that a consultant should accept an extra paid PA, if offered, before doing private work. If they are 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, private capacity does not count towards the 48-hour limit for the purpose of the European Working Time Directive.[11]

2.9 Alterations to the job plan of an individual consultant may affect other members of the department. A mechanism should be in place for review of departmental workload and optimal team working. Team job planning may be appropriate.

2.10 Part-time working needs special consideration, particularly where the consultant is only working clinically for a few PAs per week. 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 one to two 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 part-time consultants, who 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 who spend 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 challenges of the wide range of clinical scenarios that may present to the on-call consultant clinical radiologist.

3. On call for out-of-hours emergency work

There is no single solution which will deliver safe sustainable 24-hour radiological services for all settings.[12]

Radiologists and the other staff required for the 24-hour provision of radiological services must have adequate rest periods to assure patient safety during on-call hours and the next work session.[12]

The Working Time Regulations (1998)[13] implement the European Working Time Directive (1993)[14] into UK law. The original Directive, Directive 93/104/EC was enacted in UK law as the Working Time Regulations, which took effect from 1 October 1998.

Article 10(1) states that, 'An adult worker is entitled to a rest period of not less than 11 consecutive hours in each 24-hour period during which he/she works for his/her employer'.[13]

Article 11(1) states that, 'An adult worker is entitled to an uninterrupted rest period of not less than 24 hours in each seven day period during which he/she works for his/her employer'.[13]

Unless there are exceptional circumstances (for example, those working limited hours – see 2.10 above), all consultant clinical radiologists are expected to take part in departmental on-call commitments for delivery of out-of-hours emergency work. The content/intensity of work while on call will depend on local practice (for example, ward rounds, acute radiological arrangements, and so on).

The following paragraphs (3.1 to 3.3) are found in Schedule 8 (On-call rotas) in the *Terms and Conditions for Consultants*.[5]

Adequate provision should be made for the 'on call' to cover colleagues' leave, and this additional commitment needs to be factored into the on-call rota. As per the European Work Time Directive, 11 hours of continuous rest in a 24-hour period is required.[11]

3.1 Duty to be contactable

3.1.1 All radiologists on call should be immediately contactable. Subject to the following provisions, the consultant must ensure that there are 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.

3.1.2 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:

- There are arrangements for messages to be taken if the employing organisation tries to contact the consultant during such an interval
- The intervals in question have been agreed with the employing organisation in advance and clearly recorded
- The consultant can and does respond immediately after such an interval.

3.2 High frequency rotas

3.2.1. Where a consultant or consultants are on a rota of one in four, 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.

3.2.2 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 can be made

locally. A consultant will be resident during an on-call period only by mutual agreement.

3.3 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 one in four, or more frequent; his or her on-call duties have been assessed as falling within category B described in Schedule 16;[5] 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'.[5]

Large radiological 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

4.1 Direct clinical care (DCC)

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.[15] 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; multidisciplinary team meetings about direct patient care; and administration directly related to the above (including but not limited to referrals and notes).

A DCC for a clinical radiologist might include activities such as:

- Reporting of all forms of imaging investigations
- Discussing clinical cases and advising on the next most appropriate diagnostic investigation
- Reviewing imaging in the clinical context to establish a diagnosis; this may be imaging performed in the radiologist's hospital or imaging from another centre
- Participating in clinical radiological meetings
- Preparation and review of imaging for cancer MDT meetings
- Documentation by supplementary reports or addendums after an MDT meeting or following discussion with a clinician colleague
- Discussing and reviewing difficult cases
- Supervising registrars and/or radiographers
- Double reporting for peer review
- Quality control, designing protocols for imaging and maximising image quality
- Discussing potential interventional procedures with clinicians
- Discussing potential interventional procedures with the patient; either in an outpatient environment or on the wards
- Obtaining 'informed consent'
- Supervising radiographers, double reporting or discussing and reviewing difficult cases
- Attending departmental discrepancy meetings.

4.2 Supporting professional activities (SPAs)

According to the Academy of Medical Royal College's publication on *Supporting Professional Activities (SPAs)*,[16] SPA reflects time spent undertaking teaching, training, education, continued professional development (CPD) (including reading journals), audit, appraisal, research, clinical management, clinical governance, service development and so on; activities that are essential to the long-term maintenance of the quality of the service, but do not represent direct patient care.

SPAs should not include major additional NHS responsibilities such as those of a medical director or clinical director, training programme director or postgraduate dean. SPAs should not include agreed external duties such as acting as an examiner, peer assessor, or carrying out work, for example, for a medical Royal College, the Department of Health or the General Medical Council.

A contract that includes only 1.5 SPAs and 8.5 PAs would have no time at all for other SPA work, such as teaching, training, research, service development, clinical governance, and contribution to management. The Royal College of Radiologists considers 1.5 SPA is the minimum requirement to enable a consultant to provide evidence for enhanced appraisal and revalidation.

For the professional development of consultants in the NHS, 2.5 SPAs are important. It includes activities which are not related to direct patient care.

All radiologists should undertake activities such as:

- Formal teaching, tutorials/lectures for medical and non-medical staff
- Planning and undertaking CPD
- Journal reading
- Audit
- Service planning and development both internal in the radiology department and across the wider hospital/community
- Job planning
- Appraisal
- Revalidation
- Clinical governance
- Writing references/assessments for staff
- Participating in staff appointment/job descriptions
- Responding to complaints
- Reading and responding to emails on daily basis
- Communication with colleagues, managers and staff
- Participating in meetings with management and departmental meetings
- Trust-wide management meetings
- Mandatory training requirements by the trust.

It is important that some SPA time is provided during each day, the consultant works for the trust and should be distributed during the week.

Any additional SPA activity required by, or agreed with, the employing organisation or which, if undertaken, should be justified at appraisal. These could include teaching, research, management, committees (local or national) and administration (not directly related to patient care). All of the activities require documented output. Specific duties related to the education and clinical supervision of trainees should also be included. This activity requires 0.25 SPAs per trainee per week to be allocated within the job plan.

4.3 Additional NHS responsibilities

Specific 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 being a medical director, clinical director or lead clinician, or acting as a Caldicott guardian, clinical audit lead, clinical governance lead, or serving on an Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER)/critical incident committee, ethics committee, drugs and therapeutics committee, being an undergraduate dean, a postgraduate dean, a clinical tutor or a regional education adviser. This is not an exhaustive list.

4.4 External duties

External duties are 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 consultants and employing organisation. These might include trades 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 interest of the wider NHS, reasonable quantities for a government department, or specified work for the General Medical Council. This list of activities is not exhaustive.

4.5 Travelling time

Where consultants are expected to spend time on more than one site during the course of the 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

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

5.1.1 Participating satisfactorily in an annual appraisal process

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

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

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

5.1.5 Taking up any offer to undertake additional PAs that the employing organisation has made to the consultant in accordance with Schedule 6 (Extra Programmed Activities and Spare Professional Capacity) of the *Terms and Conditions of Service*[5]

5.1.6 Meeting the standards of conduct governing the relationship between private practice and NHS commitments set out in Schedule 9 (Provisions governing the relationship between NHS work, private practice and fee paying)[5] of the *Terms and Conditions of Service* and *A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants*.[17]

6. Expectations of radiologists from their employers

6.1 Job plans must comply with European Working Time Regulations, allowing for 11 hours continuous rest in a 24-hour period to allow radiologists to work safely.[13]

6.2 Adequate secretarial support staff should be provided to enable radiologists to deliver the workloads expected of them safely.

6.3 Access to clinical information such as laboratory results or pathology reports should be available with ease; that is, within one mouse click to allow radiologists to provide a high-quality report.

6.4 Adequate time to be provided in job plans to deliver the workload expected safely and without compromise on quality.

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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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