The Report and Recommendations of the Clinical Oncology and Medical Oncology Closer Working Group

JULY 2023

I. SUMMARY: CLOSER WORKING AND A PROPOSED JOINT FACULTY FOR CLINICAL ONCOLOGY AND MEDICAL ONCOLOGY

Background - building a shared future for Clinical Oncology and Medical Oncology

Following the General Medical Council's (GMC's) review of the Shape of Training, representatives of the Association of Cancer Physicians (ACP), The Royal College of Radiologists (RCR) and the Royal Colleges of Physicians (RCPs) began in 2019 to explore the benefits - to patients, the NHS and to clinicians – of closer working between the two specialties of Clinical Oncology (CO) and Medical Oncology (MO) and to explore possible new arrangements to achieve this.

After wide ranging analysis and consultations, the Closer Working Group (CWG) formed the view in March 2022 that a new Joint Faculty be established for the two specialties, hosted within the RCR. A detailed analysis was undertaken of the key areas of risk – financial, operational and governance - associated with implementation of the above recommendations and how these risks could be mitigated. This indicated some potential barriers to moving forward immediately including:

a) the scale of funding needed to deliver a vote of the CO and MO memberships and the long-term financial impact on the RCR of implementing a new Joint Faculty
b) the challenges and costs of transferring responsibility and powers for training for MO from the RCP to the RCR
c) uncertainties around the successful delivery of a convincing vote with adequate turnout of the CO and MO memberships, and of the College's Clinical Radiology (CR) membership, given the financial risks identified
d) uncertainty about the likely immediate uptake of FRCR by consultant medical oncologists who wished to join the Joint Faculty
e) uncertainty whether or not the Privy Council would accept the recommendation for a new Joint Faculty.

Taking account of all the preceding work and the challenges outlined above, the CWG concluded in March 2023 that it was <u>not</u> viable to move forward with the proposal for a new Joint Faculty for the two specialties of CO and MO within the RCR at this point. However, there remained support for a Joint Faculty as a key aim for the future, if the barriers to progress outlined above could be addressed.

This process has resulted in **recommendations for change now and a template for future changes** – summarised below and included in full in Section III of this report.

Recommendations for change now:

i) ***Immediately*** *the chairs of the RCR's CO Faculty Board[1] and ACP Executive should convene and lead jointly a committee of CO and MO to take forward Closer Working, the implementation of these recommendations and proposals on the key issues identified in this report. These include shared strategy, workforce planning and training. It should report on progress to the members of the two specialties and appropriate stakeholders.*

ii) ***As soon as possible*** *there should be a new Joint Faculty for the two separate specialties of CO and MO, hosted in The RCR to support closer working and provide future flexibility. Its name should be chosen in a survey of members.*

iii) ***As soon as possible****, there should be a Joint Oncology Training Board overseeing the two existing separate CO and MO Specialty Training Committees.*

A future Joint Faculty

The CWG agreed a template for the development of the new Joint faculty which it believes will be appropriate for its future development:

i) The new Joint Faculty should be outward-looking and have strong links with the community of physicians in the RCPs and the other specialties and professions which play important parts in cancer diagnosis and care in the UK and globally.

ii) CO and MO, as separate specialties within the new Joint Faculty, should have equal input and roles in its leadership, governance and organisation, equal support and access to infrastructure and equal input into the development of its shared values and culture.

iii) The ACP should become linked to The RCR through the new Joint Faculty with an appropriate

[1] From 1 September 2023 the RCR will be making a number of changes to its internal governance structures. Future discussions around closer working between CO and MO will be led by the Chair of the CO Faculty Leadership Team. See also note 3.

Memorandum of Understanding.

iv) The governance arrangements for oncology in the RCR and the relationship of the new Joint Faculty to the Faculty of Clinical Radiology should be sustained as at present with the continuation of roles and positions on the main bodies, except that positions in the new Joint Faculty would be shared between CO and MO.

v) The change of the Faculty of CO in the RCR into the new Joint Faculty (including necessary Charter changes) should be done with minimal disruption to the RCR's existing arrangements and with input and agreement from the Faculty of Clinical Radiology.

vi). The support for the new Faculty should encompass the needs of CO and MO. Recognising that some modest increases in staff numbers is likely, these costs should be offset by additional subscription income to the RCR.

vii) General Medical Training and the MRCP (UK) examination would remain the route by which future clinical oncologists and medical oncologists arrive at specialty training. Within the new Joint Faculty, future developments in all aspects of training including examinations will be the responsibility of the Specialty Training Committees for CO and for MO overseen by the Joint Training Board.

viii) Both CO and MO should have appropriate post-nominal letters which reflect the standing of the individual specialists, and MO and CO should have same rights and franchise within the RCR and new Joint Faculty.

The CWG wishes to make two additional comments which fall outside its remit but which it feels should be noted in the development of closer working.

The landscape of organisations which exist to promote wider collaborations among cancer care and research bodies is cluttered and not all are fully functional. In particular, the Joint Collegiate Council for Oncology (JCCO) is widely perceived not to function effectively. The CWG recommends that the RCR and RCP, working closely with the relevant specialties and other bodies, should review the landscape and either update or integrate the work of the several bodies, particularly the JCCO**.**

The CWG noted that the two specialties of CO and MO have markedly different arrangements and levels of uptake of their respective specialist organisations. CO draws comprehensive support for its specialist activities from the RCR. Almost all CO trainees and consultants take advantage of this arrangement. MO draws its specialty support from the ACP. Almost all MO trainees take advantage of this but the uptake by consultants is less complete. The relatively low subscriptions of the ACP together with the relatively low level of consultant membership limits the support that the ACP can deliver for MO specialty activities. These disparities weaken the position of MO and make it harder to develop balanced joint working between MO and CO.

II. BACKGROUND

1. A Closer Working Party sets out a strategy; a Closer Working Group develops an implementation plan

1.1 Closer Working Party

Following the General Medical Council's (GMC's) review of the Shape of Training, a Closer Working Party (CWP) was convened by the Association of Cancer Physicians (ACP), The Royal College of Radiologists (RCR) and the Royal Colleges of Physicians (RCPs) in 2019 to explore the benefits to patients and the wider NHS of closer working between the specialties of Medical and Clinical Oncology (MO and CO).

After detailed analysis and consultations (summarised in Figures 1 and 2 and shown in more detail in Appendix A), the CWP highlighted the complexity and sensitivity of the challenges faced in delivering useful changes to the modern practice of oncology in the UK and that considerable benefits could come from closer working.

Figure 1. Options explored to support closer working (see also Appendix A)

- No change – retain Joint Collegiate Council for Oncology (JCCO)
  - Current JCCO not decision-making, not influential
  - Sends a negative message to the GMC
  - Opportunities to improve training and care will be lost
- Joint Collegiate Council for Oncology strengthened or re-fashioned
  - Does not respond sufficiently to training expectations at GMC
  - Re-name to Inter-Collegiate Oncology Standing Committee?
  - Builds on current governance structures but would require some additional resource and review of scope of authority

- Joint Intercollegiate Faculty
  - Complex relationships between Colleges and an unbalanced infrastructure for oncology between the parent Colleges
- Single joint Faculty
  - Effective vehicle for joint working, but needs one host college
  - Preferred solution of RCR CO Faculty Board and ACP Executive Committee
- Separate College of Oncology
  - Substantial logistic and fiscal challenges
  - Fails to maintain the oncology-focused support and infrastructure enjoyed by CO in the RCR

Figure 2. Areas where joint working is desirable

- *Education, training, CPD*
  - Undergraduate education
  - Specialty recruitment
  - Curriculum development and oversight
  - Shared training in cancer biology and medicine
  - Assessment of progress, competency
  - New consultant support
  - Access to learning
  - Publications
- *Strategy and policy*
  - Policy development
  - Political access/influence
  - National cancer strategies
  - Academic strategies
  - Workforce planning
- *Clinical and academic practice*
  - Protocols and guidelines
  - Support to colleagues in their practice
  - Support for colleagues' wellbeing
  - National audit/quality improvement
  - Academic meetings and research planning

It agreed that considerable organisational change was required to facilitate closer working. The most feasible and effective way forward would be a new Joint Faculty comprising the two separate specialties, hosted in a single Royal College, and opening the ACP to members from both specialties.

The CWP recommendations were supported by the CO Faculty Board of the RCR and the ACP Executive Committee, by the ACP Trainees Sub-Committee, the RCR's Oncology Registrars' Forum and by the memberships of CO and MO in surveys conducted by the RCR, ACP and RCP London (RCPL). Both specialties wished to remain as separate entities, in keeping with the international approach to non-surgical oncology.

1.2 Closer Working Group

A Closer Working Group (CWG) was convened with the remit to explore implementation of the new Joint Faculty. Comparisons were made across the RCR, RCPL and ACP of key elements of their current infrastructure relevant to CO and MO. The CWG then undertook a comprehensive examination of the constitutional, governance, management, infrastructure and financial implications of establishing this new single Faculty. It worked closely with the specialties and all the parent Royal Colleges (the RCR and the three Royal Colleges across the UK which are responsible for MO at present).

The two specialties of CO and MO have distinct but overlapping clinical roles with different histories, organisational features and governance frameworks. However, there has been for some time close multi-disciplinary working at an operational level and excellent working relationships. Their parent Royal Colleges – the RCPs and the RCR - provide infrastructure and support which is very different in its scale and nature. The main functions that the RCR Faculty of Clinical Oncology oversees for CO are performed by the ACP for MO. Only the oversight of MO training sits under the RCPs.

The initial exploration of closer working and closer alignment in training in CO and MO resulted in a common first year of training in both specialties, implemented in August 2021. In the CWG, the two specialties and other stakeholders have continued this work to strengthen and facilitate closer working in order to:

- Improve the quality and efficiency of cancer care and patient outcomes in many areas including Acute Oncology (AO).
- Strengthen both specialties by working together and providing a robust, flexible framework for future developments in cancer care.
- Have a stronger joint voice for the two specialties together, increasing their influence for the benefit of services and patients.

2. The case for change – why and why now?

There are a number of significant potential benefits – for patients, for oncology and for healthcare services more widely – of creating a new single Faculty for CO and MO which have been set out in the recommendations of the CWP (summarised above). The modern approach to oncology in the UK which the CWP and CWG sought to strengthen and facilitate is summarised in Figure 3.

Figure 3. The Modern approach to Oncology in the UK

- Increasing emphasis on cancer-specific rather than treatment modality-specific expertise.
- Non-surgical oncology is contributing substantially to the current improvements in cancer outcomes and the patient experience of modern cancer practice. 50% of Systemic Anti-Cancer Treatments for solid tumours is delivered by MO and 50% by CO.
- UK oncology has an internationally respected and influential patient-centred approach and high levels of patient engagement.
- The traditional emphasis and success of cancer research in MO is now increasingly found in CO and in shared projects.
- There is harmonious multi-specialty team working in oncology practice:
    - Joint working in clinics
    - Acute Oncology (AO) services
    - Research and development.
- There is increasing emphasis on common training in early years through Oncology Common Stem (OCS) year and shared assessment approaches in the new CO and MO curricula.
- CO and MO share incentives for change and closer working:
    - Shared aims in quality assurance and improvement to further improve outcomes and "bridge the gap" to the best results in comparable countries
    - Need for effective professional advocacy on improving cancer outcomes to NHS/government
    - Need to make common cause for workforce expansion
    - Need to improve skill mix and productivity
    - Need for effective collaboration with other professional groups
    - Opportunity to work together to deliver AO services and thus make a substantial contribution to overall NHS acute services.

Perhaps less well noted previously, in addition to the benefits, are some potential threats to the future of the two specialties which could be mitigated through closer working and the creation of a single Faculty. Discussions with the GMC's Curriculum Oversight Group (COG) in 2019/20 were clear in their focus and desire for stronger unification of the two non-surgical oncology specialties, in line with the ethos of the Shape of Training review. During the discussions on Shape of Training it became clear that the current arrangements for non-surgical oncology training and practice were viewed negatively by the GMC COG. The successful introduction of the common first year into the specialty training of CO and MO has substantially reassured critics of the relationship between the two specialties. However, there remains a need for careful ongoing review of the ways in which the two specialties cooperate in the delivery of high quality and efficient care.

3. Risks and challenges of the proposed new Joint Faculty

The CWG identified the following risks of action:

- *Reputational risk* - to either or both specialties (and their members) and to any or all of the parent Colleges and the ACP if they attempt change but fail to deliver changes which are expected to bring benefits to patients and the NHS.
- *Finances and resources* – there would be financial risks to all parent Royal Colleges in terms of potential loss of income or potential requirement to provide additional infrastructure and support for a larger Faculty/membership.

The CWG also identified the following risks of inaction:

- *Loss of opportunities* - to improve patient care, NHS services and patient outcomes.
- *Reputational risk* - if the specialties or Royal Colleges are seen to fail to adequately attempt to deliver the changes which they have recognised are likely to bring benefits to patients, the NHS and to both non-surgical oncological specialties.

- *External intervention* - might force the specialties into changes which are not well thought out and prove to be divisive and difficult to implement.

Consideration was given to the following challenges:

- Changes must maintain the identity of the two specialties as physicians who focus on the care of cancer patients, the individual skills and strengths of both specialties, and their close collaborative working patterns with other physicians and the many other specialities which are involved in the diagnosis and treatment of cancer.
- As well as strengthening the two specialties, the new Joint Faculty must be able to bring its collective strength to bear on the pressing need to improve cancer outcomes in the UK and contribute actively to developing cancer strategies and the recovery of cancer services following the COVID-19 pandemic.
- Despite the support of the leaderships and senior committees of CO and MO, medical and clinical oncologists would have to be sufficiently convinced of the benefits to support the proposed changes and for medical oncologists to join the new Joint Faculty.
- There may be a negative financial impact on Colleges that lose a portion of their membership – and therefore a portion of their income – and also on the College that hosts the new Joint Faculty, with the need to provide support and services for a larger membership, with some new governance structures. It is recognised that finance alone should not influence decision-making. However, it must be staged and mitigated.
- The capacity, organisation and resourcing of the new Joint Faculty within the host College must be minimally disruptive, fully resourced and acceptable to College members and Faculties and some changes to its overarching governance framework would be needed.
- The ACP as a joint Learned Society, with freedom to undertake activities through its own organisational and legal framework, would have to adapt its role to new circumstances and ensure alignment with new Joint Faculty activities.
- The greater alignment of training pathways, accreditation and national specialty recruitment is a substantial change which may make existing trainees feel uncomfortable and which requires careful consultation, consideration and planning.
- Equity for CO and MO must be established through changes in organisation and structures within the new Joint Faculty.

In the light of these risks and considerations, a detailed analysis was undertaken of the key areas of risk – financial, operational and governance - associated with implementation of the above recommendations and how these risks could be mitigated. This indicated some potential barriers to moving forward immediately including:

a) the scale of funding needed to deliver a vote of the CO and MO memberships and the long-term financial impact on the RCR of implementing a new Joint Faculty
b) the challenges and costs of transferring responsibility and powers for training for MO from the RCP to the RCR
c) uncertainties around the successful delivery of a convincing vote of the CO and MO memberships, and the outcome of a vote of the College's Clinical Radiology (CR) membership, given the financial risks identified and the possibility of a low voter turnout
d) uncertainty about the likely immediate uptake of honorary FRCR by consultant medical oncologists who wished to join the Joint Faculty
e) uncertainty whether or not the Privy Council would accept the recommendation for a new Joint Faculty.

4. Lay and patient representatives' comments

The CWG consulted two experienced lay and patient representatives, who are familiar with the specialties of CO and MO through working with the RCR and RCP, for their views on a new Joint Faculty hosted by a single Royal College. Their response is summarised here:

This is a sensible way forward – the lay and patient representatives felt that, to most patients, 'a cancer doctor is a cancer doctor'. There is likely to be little appreciation and understanding among patients/the public that there are two specialties now – this seems a strange distinction and reflective of how fragmented the NHS can seem. A single Faculty for CO and MO is a sensible way forward. It has the advantage of greater simplicity, with a single subscription. The current separation between ACP and RCP can be confusing. Transition could be difficult – anticipate some possible resistance from medical oncologists who wish to preserve their position as 'physicians' – but this could be addressed by transitional arrangements and would lessen over time, with each generation of new trainees. The new Faculty will eventually become the norm.

Is wider consultation needed with patients/the public? – the lay and patient representatives advised that the question of a single Faculty was not salient to the patient. Patients are more concerned about improving cancer services. Decisions about a single new Faculty are a matter for the professions and they should 'just get on with it' as it makes sense. While there is value in co-production, any patient consultation would be challenging. There are a large number of cancer-related patient groups/charities but these are only a sub-set. Over-communication by email is resulting in consultation fatigue. If attempted, consider paper-based communications (these are more 'visible' now that postal communications have reduced) but be mindful also of costs and environmental impact.

III. THE DELIVERY OF CLOSER WORKING AND A FUTURE NEW JOINT FACULTY

The CWG recognised at the outset that delivering a new Joint Faculty as recommended by the Closer Working Party would be a complex task, with many stakeholders and interests. Taking account of all the preceding work and the challenges outlined above, the CWG concluded in March 2023 that it was not viable to move forward with the proposal for a new Joint Faculty for the two specialties of CO and MO within the RCR at this point. However, there remained support for a Joint Faculty as a key aim for the future, if the barriers to progress outlined above could be addressed.

The CWG therefore made recommendations for a staged approach to the challenges:

i) Immediately the chairs of the Faculty Board of Clinical Oncology[2] and the ACP Executive Committee should convene and lead jointly a standing committee of CO and MO to take forward Closer Working, the implementation of these recommendations and proposals on the key issues identified in this report. These include shared strategy, workforce planning and training. It should report on progress to the members of the two specialties and appropriate stakeholders.

ii) As soon as possible there should be a new Joint Faculty for the two separate specialties of CO and MO, hosted in The RCR to support closer working and provide future flexibility. Its name should be agreed following a survey of members.

iii) As soon as possible, there should be a Joint Oncology Training Board overseeing the two existing separate CO and MO Specialty Training Committees.

The CWG worked through the issues presented by the challenges of developing the new Joint Faculty and unanimously agreed a template which can be the basis of the future Faculty at an appropriate time.

The new Joint Faculty would bring the two specialties closer together, facilitating and strengthening their work. The strengths and distinct characteristics of each specialty would contribute to their shared development. This closer working, underpinned by a single governance framework in a single host college and a single high-quality, equitably-shared infrastructure, would remove barriers to any future changes which new Joint Faculty members and Fellows may wish to bring about, in response to developments in healthcare, cancer sciences and patient needs. CO and MO working together in a closer framework could - and would have a responsibility to - improve cancer services further and contribute importantly to NHS acute care through AO services.

In developing its recommendations and a template for the future Joint Faculty the CWG considered in some detail:

[2] See notes 1 and 3

1. Choice of Host College

Although the available evidence suggested that both specialties supported a single Joint Faculty, perhaps unsurprisingly, initial preferences expressed by CO and MO memberships through surveys were for the new Faculty to be hosted by their respective parent Colleges. However, the CWG recommended that the RCR should be the host Royal College because of the scale and quality of the support RCR already provides to CO, paid for through RCR subscriptions, which could be extended to the two specialties and be hosted in a single UK-wide Royal College.

The RCR Faculty of Clinical Oncology already supports CO to deliver high quality oncology care and provides an increasingly loud and influential voice for the specialty. The CO Faculty is outward looking, has a track record of working collaboratively with all the other specialties and professions involved in managing patients with cancer and is represented on all relevant external groups. A Joint Faculty would build on these strengths and enable MO to benefit from this track record of focussed commitment to oncology.

CO, through the existing Faculty of Clinical Oncology, has equal representation to the Faculty of Clinical Radiology throughout the RCR, including on Council and the Senior Leadership Team, giving CO a highly valued, secure and sustainable role in the leadership and governance of the College. The provision of support and resources for non-surgical oncology provided through the RCR are comprehensive and of high quality, and are described in detail below. CO has a unique role in the provision of radiotherapy and links through the RCR to other relevant professional groups which are closely involved in radiation-related activities.

The provision of support and resources for MO within the RCPs is different in nature from that provided to CO by the RCR, in that it covers general internal medicine and the RCPs' support over 30 other medical specialties across three separate Royal Colleges. Support for specialist oncology activities is less substantial and most specialist oncology support for MO is provided by the ACP, funded through membership subscriptions, as is the case for all of the RCPs' medical specialist societies. Individual Fellows and members may take RCP leadership roles by election. The RCPs retain collaboration with medical specialties through their Joint Specialty Committees, including the Joint Specialty Committee for Medical Oncology (JSCMO).

The leadership of CO was unanimous that it would not be wise to forego its role and support from the RCR by moving CO to a different College, and preferred the RCR to be the Host Royal College for the new Joint Faculty. MO members on the CWG and the ACP Executive accepted this view as reasonable, evidence-based and cancer patient-centred, and not simply the consequence of tradition. Surveys suggested that, while the membership of MO overwhelmingly supported the new Joint Faculty, currently they would, on balance, prefer to remain with the RCPs as the Host College. If the vision and benefits of closer working were to be delivered, a compromise was needed on the choice of Host College. The Executive Committee of the ACP expressed a willingness to compromise. Unanimously but cautiously, it felt that it would be acceptable for the Host Royal College for the new Joint Faculty to be the RCR, reflecting the interests of patients, the quality and value of the RCR support to the existing Faculty of Clinical Oncology, the willingness of the RCR to welcome MO and provide it - within the new Joint Faculty - with support and status equal to that provided to CO.

MO and the ACP were very mindful of the important contributions made by the RCPs to the development of MO in the UK. They emphasised their wish to seek agreement with the RCPs about changes and future relationships, and the importance of the role of the RCPs in future contributions to cancer strategy.. Individual Royal College affiliation and the payment of subscriptions for eligible individual members and Fellows would remain a matter of personal choice, as it is now.

The CWG did not envisage any changes to the name of the RCR as a consequence of the inclusion of MO in the new Joint Faculty. However, consideration would need to be given to the name of the new Faculty. The following were suggested:

- Faculty of Oncology (FO)
- Faculty of Cancer Medicine (FCM)
- Faculty of Cancer Medicine and Oncology (FCMO)
- Faculty of Clinical and Medical Oncology (FCMO)
- Faculty of Oncologists (FO).

Opinion was divided among CWG members on these alternative names but there was clear recognition that care would be needed to ensure acceptability both among other medical Royal Colleges that have members engaged in oncological activities and by the Privy Council.

2. Governance and Leadership

The CWG recognised the substantial challenges involved in creating a governance and leadership framework for the new Joint Faculty. Within the RCR, the new Faculty would be a Faculty of the RCR, as defined in the RCR's Royal Charter. It would replace the existing Faculty of Clinical Oncology and operate in parallel with the Faculty of Clinical Radiology. However, the new Faculty would include two distinct specialties, unlike the

existing Faculty, and provision would be required to ensure that both are satisfied with the arrangements. The arrangements for leadership of the new Joint Faculty would be a key determinant of acceptability to CO and MO and of the success of the venture. They would have to demonstrate equity between the specialties. They would also have to cause minimal disruption to existing RCR arrangements, be acceptable and agreed by the RCR and its Faculty of Clinical Radiology (CR).

RCR Council would continue to be the Trustee Body with responsibility for oversight of both Faculties - the Faculty of CR and the new Joint Faculty that would replace the current Faculty of CO. The make-up of Council would be largely unchanged, with equal representation from radiologists and oncologists (both clinical and medical oncologists would be eligible to stand for election to Council). Senior Officers of the new Faculty would retain their seats on the Senior Leadership Team of the RCR. The ongoing RCR Governance Review was not expected to alter principles of equality and representation of its two Faculties and so would not alter the position of the new Joint Faculty[3].

Arrangements at Faculty level would need to ensure both MO and CO had equitable representation at RCR Council and Senior Leadership Team at all times. Both medical and clinical oncologists would be eligible for the roles of RCR President (when this is an oncology President), RCR Medical Director Membership and Business, and Vice President for the new Joint Faculty and its Faculty Officers.

At present the two Faculties within the RCR (CR and CO) are each led by a Vice-President of the RCR, supported by two Medical Directors (Education and Training, and Professional Practice) who are elected by the Faculty members. These three Faculty Officers sit on the Senior Leadership Team and Council of the RCR. The RCR is a charity and these Faculty Officers are charity trustees with the responsibilities that go with such roles. It was not proposed that this should change, except for the introduction of appropriate arrangements to ensure equitable representation for CO and MO in these roles, using rotations and shared leadership roles.

A Faculty Board would manage the affairs of the new Joint Faculty and be responsible for agreeing and implementing policy relating to the Faculty. The Board would have a number of designated places allocated specifically to equal numbers of elected CO and MO representatives. The membership of the existing CO Faculty Board within the RCR has a number of categories including elected members, co-opted members, links to devolved nations' Standing Committees and cross-representation from other committees and boards. These would be reviewed to ensure appropriate links to reflect the needs of the new Joint Faculty with its two specialties. There new Joint Faculty Board would need to be established early in the process of developing the new Joint Faculty.

There would be CO- and MO-specific issues to address separately. These may include the "politics/diplomacy" of the roles of the individual specialties in the RCR, specific issues within training and examinations, or relationships with international bodies such as the European Society for Medical Oncology and European Society for Radiotherapy and Oncology. These might be addressed by subsidiary Joint Faculty Board groups ("the Board CO group and the Board MO group") consisting of those Board members who represent each specialty on the Board, with additional members as needed. These CO- and MO-specific groups would report to the full Joint Faculty Board.

The new Joint Faculty Board would oversee subsidiary bodies which would relate to both CO and MO to manage areas of work, such as specialty training and professional practice. It was anticipated that these would be similar to those in the existing Faculty of Clinical Oncology (see Section 3) but with the modified role and remit, and chairmanship and membership, needed to equitably incorporate the needs of MO.

The ACP would continue as an oncology Learned Society, affiliated to the new Joint Faculty but with distinct and independent retained structures and functions. This model is usual among clinical medical specialties. It would provide a continuation, for as long as members wished, of an organisation which has been central to the development of MO in the UK but which would become open to MO and CO to join. As governance arrangements matured and members became comfortable with new arrangements, it was envisaged that the new Joint Faculty might take on much of the work of the ACP. That would be a matter for agreed evolution among members.

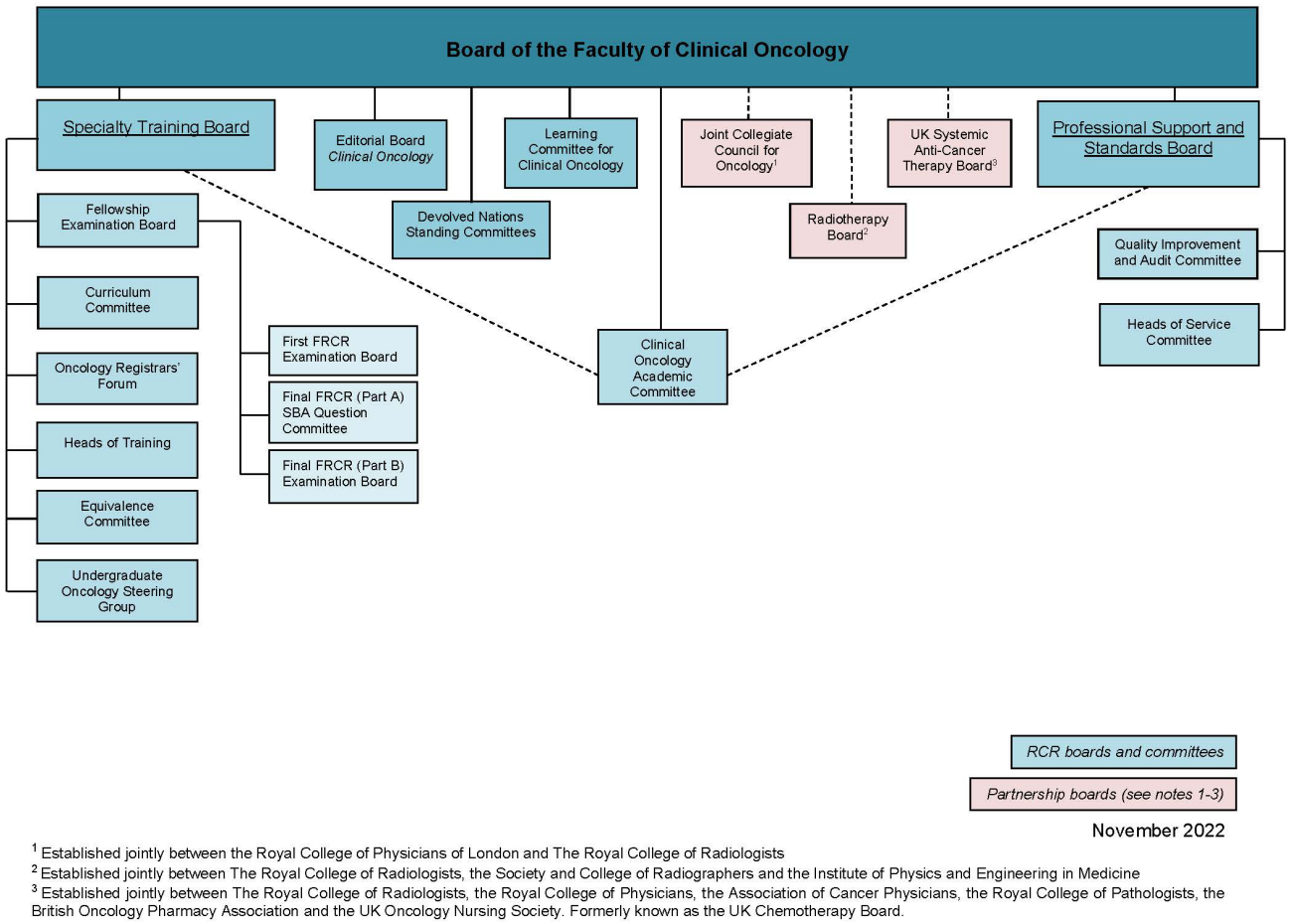
The CWG proposed the introduction of an equitable model for the shared leadership of the new Joint Faculty and its key Boards and Committees, including equal representation of both specialties on those bodies. This arrangement introduced the additional expertise of the new specialty (MO) to those bodies and also reassured both specialties that their interests would always be represented at leadership level. Suitable arrangements for election/appointment would be needed and could be reviewed over time.

[3] In May 2023 members and Fellows of the RCR voted in favour of changes to the governance structures of the College. These would affect the role and membership of RCR Council, the CO Faculty Board, the Senior Leadership Team and the CO Leadership Team.

3. Organisational Support, Finance and infrastructure

The support given to CO by the RCR and its development to include MO would be an important part of the planning for the new Joint Faculty. The existing RCR Faculty of Clinical Oncology has the support of a large organisation with around 100 staff, including direct access to a substantial and high-quality building in Lincoln's Inn Fields, London, including a designated Members Room. While almost all RCR staff work across the two existing Faculties of CR and CO (and this would continue as the most efficient approach), a dedicated Executive Officer supports the CO Faculty's Officers on a day-to-day basis, provides the secretariat to a number of key Boards and Committees, and maintains links with other teams within the RCR to support the strategic work of the Faculty. In other areas of the RCR, staff are dedicated to key areas such as exams, training, professional practice, audit, academic research and professional learning and development, as well as core functions such as membership and communications. Within these areas, staff provide support to Boards and Committees specifically for the CO Faculty, as illustrated in Figure 4.

Figure 4. The RCR arrangements for the existing Faculty of Clinical Oncology



[1] Established jointly between the Royal College of Physicians of London and The Royal College of Radiologists
[2] Established jointly between The Royal College of Radiologists, the Society and College of Radiographers and the Institute of Physics and Engineering in Medicine
[3] Established jointly between The Royal College of Radiologists, the Royal College of Physicians, the Association of Cancer Physicians, the Royal College of Pathologists, the British Oncology Pharmacy Association and the UK Oncology Nursing Society. Formerly known as the UK Chemotherapy Board.

The CWG anticipated a likely need for a small expansion of staff numbers overall within the RCR, particularly if delivering exams for MO in the future, in order to ensure that the strength and depth of support currently provided to the CO Faculty was maintained for a new and larger Joint Faculty containing two specialties rather than one. However, the number of committees and workstreams to be serviced was not expected to expand significantly, rather their scope/remit would be broadened. Communications and infrastructure support (eg. press/media, HR, IT, Facilities and Finance functions) would continue to be provided to the new Joint Faculty by the central RCR teams, as happens now for the CO and CR Faculties. The provision of resources to support necessary expansion would be an important factor in the success of the new Faculty and should be offset as far as possible by subscription and training fee contributions from new MO members and Fellows.

Effective financial arrangements would be critical to the success of the new Faculty and they must:

- Allow the funding of the extended functions and activities of the new Joint Faculty.
- Provide for a level of support to the new Joint Faculty which is comparable, allowing for its increased size and activities, to that currently provided for the RCR Faculty of Clinical Oncology.
- Avoid sudden changes which would place any of the parent Royal Colleges at risk.

This would require a staged transfer of subscriptions and examination fees over several years.

4. Training, Examinations, Professional Practice and Support

For a new Joint Faculty to be established and succeed, it is the longer-term management of training and examinations that, although critically remaining clearly distinct between the specialties, would need to be aligned within the Host College such that trainees applying to either specialty in the future would, by default, become members at the time of entry into specialty training.

Based on experience with the successful but informal collaboration during the 2021 curriculum revision process, a structure with common over-arching policy/oversight directing and being advised by specialty-specific elements was envisaged. This would encourage increased commonality where appropriate, avoid unwarranted duplication and variation, improve efficiency and drive innovation. The changes proposed were substantial but justified by the benefits for patients and the specialties.

At present, entry into CO and MO specialty training is possible following successful completion of both a foundation programme and a core Internal Medicine Training (IMT) programme, and possession of the MRCP (UK) exam - which is normally a pre-requisite for recruitment into higher specialty training. IMT is managed by the JRCPTB. The RCR recruits specialty trainees in CO and leads, supports and educates those in clinical oncology. The JRCPTB oversees the recruitment of specialty trainees in MO.

MO training is overseen by the JRCPTB, supported by the MO Specialty Advisory Committee (SAC). The Chair of the SAC is a constitutional member of both the ACP Executive Committee and the RCP JSCMO. The assessment programme includes a Specialty Certificate Examination (SCE) run by the MRCP (UK) office. Trainees are required to enrol with the JRCPTB and may also choose to join one of the parent RCPs as a collegiate member. Medical oncologists are awarded MRCP (Medical Oncology) on completion of the SCE and Certificate of Completion of Training (CCT). FRCP is conferred following a nomination or application via the annual census, to consultants of at least 2 years duration who have made a significant contribution to their specialty in service or research. Subscriptions are paid annually and many MO (and some CO) hold the FRCP, which confers rights within the RCPs.

CO training is overseen by the RCR. The assessment programme includes FRCR Examinations. Trainees are required to enrol with the RCR. They acquire “Fellow” status during training, on completion of the exam. After training, most choose to remain as Fellows of the RCR. FRCR is a requirement for award of CCT and subscriptions are paid annually. The status of Fellow gives voting and representation rights in the RCR. The award of “Fellowship without Examination” is possible by the RCR via a nomination process.

From August 2021, there has been a joint first year of specialty training for CO and MO, with a common curriculum and programme of assessment for that year. However, trainees are still separately recruited into one of the two specialties. Training, including the Oncology Common Stem year, continues to be managed separately according to specialty, as above.

The length of training - five years for CO and four for MO - and the examinations sat by CO (FRCR) and MO (MO/SCE) are different in their nature and timing although both are very demanding. Training and exams in both CO and MO contribute to ensuring that the two specialties deliver excellent care to patients and satisfy the requirements of the GMC to award the CCT and to be included on the GMC Specialist Register. CO and MO exams are taken at different stages and have different content and structure. In some respects the FRCR presents a more intense experience for CO trainees, reflecting the craft nature of the specialty and the need to acquire and demonstrate new sets of skills for the safe and effective delivery of radiotherapy (for example, contouring and plan evaluation). The MO SCE was designed in a similar way to the many RCP-based SCE examinations and, while difficult and challenging, does not generate the same level of ‘burden’ on trainees during their training. However, MO trainees are actively encouraged to undertake higher research degrees which generate a substantial additional training duration.

The acquisition of voting rights and eligibility for leadership roles within the RCR is based on Fellow status, usually acquired by passing an FRCR exam. Under current governance arrangements, such opportunities are not open to those without FRCR. As such, in the longer term, the exam sat by MO trainees would have to be recognised by the RCR as being of equal standing with the FRCR.

Virtually all trainees in both CO and MO are eligible to become collegiate members of one of the RCPs on completing the MRCP (UK) exam. They can choose to subscribe and remain collegiate members. Those who remain members become potentially eligible for nomination to become Fellows of the RCP after two years as a consultant and pay a subscription to one of the RCPs. Many MO consultants become FRCP: a smaller proportion of CO consultants do so.

Initial work and transition to a new model for closer working should begin with a new Joint Oncology Training Board. It would oversee the training in both specialties and provide a forum for the development of future changes and, where appropriate, increased convergence in training. Separate specialty training committees would continue for each specialty, based on the existing arrangements.

Entry into CO and MO specialty training would continue to follow successful completion of both a Foundation Programme and a core IMT programme and possession of the MRCP (UK) exam. The CWG recommended that IMT before CO and MO specialty training would be managed by the JRCPTB, as it is now. This arrangement would continue during transition and thereafter in the long term.

Ultimately, within a future new Joint Faculty, all CO and MO specialty trainees would be required to join the new Joint Faculty for oversight of their specialty training in CO and MO, access to the e-portfolio, etc. Recruitment would still be into the two separate specialties, but aspects of this may be co-ordinated more closely than at present.

The new Joint Oncology Training Board would oversee the two specialty training committees which would remain responsible for all aspects of the curriculum and assessment/examination process, and define any need for change through curriculum review.

Through this training process, the award of FRCR status and appropriate post nominal letters to MO would become routine. The exact routes to FRCR status for CO and MO are likely to remain different. Though there may be some convergence of the specialty-specific examinations over time, these would remain tailored to the needs of the separate specialties and therefore there would continue to be differences in details and timing. The Joint Oncology Training Board would be able to develop plans for an equitable solution to the timing of allocation of Fellowship status.

Eventually, all newly appointed MO trainees would become members of the RCR, in the same way and with the same fee rates as CO trainees. The CWG recommended that all current in-post MO trainees at that point should become members of the RCR and no longer required to be linked to JRCPTB. Relevant e-portfolio content would be transferred to Kaizen (RCR training portfolio). The JRCPTB has a policy of charging a fixed fee for all trainees regardless of time in training – either four annual payments or a one-off payment. The RCR would honour this. The RCR could give MO trainees the option of becoming a subscribing member of RCR (consistent with the option they have now to become members of an RCP).

As arrangements are changed to bring MO training into the new Joint Faculty within the RCR, the criteria for the award of FRCR or for the provision of voting rights for trainees will need to be harmonised in such a fashion that they should carry the same rights for CO and MO including voting, for both specialties at a similar stage. In future, medical and clinical oncologists, would be eligible to join the new Joint Faculty at different categories of membership.

Holding a Fellowship and paying annual subscriptions is an option that is taken up by individuals and is not a requirement for ongoing membership of the GMC Specialist Register. Medical oncologists already on the GMC Specialist Register who wished to become full voting members/Fellows of the RCR to reflect the affiliation of their specialty would need to be awarded their full voting rights through an *ad hoc* process of “grand-parenting”. Mechanisms for Fellowship without exam are available but their use on a time-limited, “one-off” basis would have to be agreed by the CR membership.

A substantial degree of uptake of Fellowships in the new Joint Faculty would be key to its success and for it to become financially sustainable. This requires that it is attractive to established consultants, trainees and others. The benefits of the new Joint Faculty to promote developments of both specialties and to bring benefits to patients would be important factors. The excellent support provided to the new Joint Faculty as it replaces the Faculty of Clinical Oncology would also be crucial. As the new Joint Faculty increasingly provides training to CO and MO, the loyalties of newly accredited consultants to the Faculty and RCR would grow. However, especially in the early stages, post nominal letters would become an indicator of the standing of the Fellows as senior oncologists and should reflect the inclusion of MO who do not have a formal link to radiation-related activities. There could be several options for naming that may be considered such as an FRCR (Oncology).

Professional Practice and Continuing Professional Education would be central to the work of the new Joint Faculty. There are already excellent integrated working relationships between CO and MO in the delivery of cancer care in the UK. All patient management is done in consultation with other clinicians within the context of multi-disciplinary meetings and clinical networks.

At present, consultant appointments in both specialties receive advice from the respective Royal College representatives. In future, consultant appointment advice in MO and CO will be given by the new Joint Faculty.

The existing RCR CO Professional Support and Standards Board would take on a wider role and membership to include medical as well as clinical oncologists, to support practice, sustain high quality care standards and support professionals in their demanding roles. Much professional practice and policy work is already focussed on the overall delivery of cancer services and on systemic therapies as well as radiotherapy. In future there might be more focus on systemic therapies - eg. with guidance and audits and the role of clinical research in improving care. The provision of educational opportunities and resources for oncologists under the 'RCR Learning' brand would continue, encompassing the work of both CO and MO.

In summary, the CWG recommendations for the template for the future Joint faculty are:

i) The new Joint Faculty should be outward-looking and have strong links with the community of physicians in the RCPs and the other specialties and professions which play important parts in cancer diagnosis and care in the UK and globally.

ii) CO and MO, as separate specialties within the new Joint Faculty, should have equal input and roles in its leadership, governance and organisation, equal support and access to infrastructure and equal input into the development of its shared values and culture.

iii) The ACP should become linked to the RCR through the new Joint Faculty with an appropriate Memorandum of Understanding.

iv) The governance arrangements for oncology in the RCR and the relationship of the new Joint Faculty to the Faculty of Clinical Radiology should be sustained as at present with the continuation of roles and positions on the main bodies, except that positions in the new Joint Faculty would be shared between CO and MO.

v) The change of the Faculty of CO in the RCR into the new Joint Faculty (including necessary Charter changes) should be done with minimal disruption to the RCR's existing arrangements and with input and agreement from the Faculty of Clinical Radiology.

vi) The support for the new Faculty should encompass the needs of CO and MO. Recognising that some modest increases in staff numbers is likely, these costs should be offset by additional subscription income to the RCR.

vii) General Medical Training and the MRCP (UK) examination would remain the route by which future clinical oncologists and medical oncologists arrive at specialty training. Within the new Joint Faculty, future developments in all aspects of training including examinations will be the responsibility of the Specialty Training Committees for CO and for MO overseen by the Joint Training Board.

viii) Both CO and MO should have appropriate post-nominal letters which reflect the standing of the individual specialists, and MO and CO should have same rights and franchise within the RCR and new Joint Faculty.

IV. PRACTICAL STEPS FOR IMPLEMENTATION

The next steps to take forward Closer Working are:

1) To finalise and publish this report with appropriate communications with stakeholders and members of the two specialties.

2) To convene the joint CO and MO committee under the joint chairmanship of the Chair of the RCR CO Faculty Board[4] and the Chair of the ACP Executive Committee.

3) The committee should take forward Closer Working and planning in the key areas identified. These include shared strategy, workforce planning and training. It should report on progress to the members of the two specialties and appropriate stakeholders.

4) The committee should continue working towards a new Joint Faculty for the two separate specialties of CO and MO, hosted in The RCR to support closer working and provide future flexibility. Its name should be chosen in a survey of members.

5) To continue towards a Joint Oncology Training Board, overseeing the two existing separate CO and MO Specialty Training Committees.

[4] See notes 1 and 3

APPENDIX A

Options explored by the Closer Working Party to support closer working between Clinical Oncology and Medical Oncology

The following is an extract from a Closer Working Party (CWP) working document dated January 2020. This sets out the six options considered by the CWP to facilitate closer working between the two specialties of Clinical Oncology and Medical Oncology:

'Options for Change

1. ***No change**. This risks sending a negative message to the GMC and health departments which will re-open the Shape of Training and Acute Unselected Take discussions. Opportunities to improve training and care will be lost.*
2. ***A strengthened JCCO**. While this could achieve some changes, it may not signal a sufficiently robust change to match our ambition or the requirements placed upon us.*
3. ***A re-fashioned JCCO** (re-named – eg Intercollegiate Oncology Standing Committee) this would be an efficient use of the current resource and governance structures already in place but re-energised for the modern cancer environment.*
4. ***A Joint Intercollegiate Faculty**. This version of a single Faculty could be a vehicle to achieve our ambitions and satisfy our critics. However, it might involve a complex set of relationships, organisational and fiscal, between our two Royal Colleges.*
5. ***A single autonomous Faculty in a Royal College with a reciprocal arrangement with the other Royal College**. This would be a vehicle for joint working and might be simple but might risk a sense of "loss" in one or both specialties.*
6. ***A separate new College of Oncology**. This may be ideal and could be an effective vehicle to signal powerfully the commitment to joint working. However, it is a huge logistic and fiscal exercise with profound governance challenges and might be better achieved in a step-wise fashion with complete commitment from all parties.'*

The following is an extract from the Minutes of the CWP meeting held in January 2020:

'In October 2019 the larger Working Party considered exploring options 4 (a joint intercollegiate faculty) and 5 (a single autonomous Faculty in a Royal College with a reciprocal arrangement with the other Royal College). At that meeting an Intercollegiate Faculty had been the more favoured option with some representatives concerned that a Faculty of Clinical and Medical Oncology within either Royal College could be negatively viewed as the 'host' specialty "taking over" and perpetuating a "sense of loss" amongst the reciprocal specialty membership.

However, on reflection, the representatives at this small drafting group meeting felt that the Intercollegiate Faculty option would not offer significantly more than the current JCCO structure and would not be able to achieve the group's ultimate aim of providing a single strong voice for non-surgical oncology with the gravitas desired. The group also noted the various challenging governance and financial implications of such a model which in itself, it was agreed, was extremely difficult to define.

Given that a separate College is felt to be a non-viable option at the present time, it was therefore concluded by the drafting group that a single autonomous 'Faculty of Clinical and Medical Oncology' housed within one of the current parent Royal Colleges would be the most effective vehicle to deliver on successful joint working and to empower the single voice of non-surgical oncology.

That view - a single Faculty for the two (separate) specialties, hosted in one Royal College as the simplest and most deliverable option - was subsequently fully endorsed by the CWP in July 2020 resulting in the recommendations noted in this report.

As detailed on page 3, a Closer Working Group (CWG) was established and tasked with:

- preparing a detailed plan for the New Faculty, including hosting and governance arrangements, management, infrastructure and finances;
- consulting stakeholders appropriately as needed to establish the acceptability and feasibility of the plan; and
- presenting the plan and its probable acceptability and feasibility, to the main stakeholders in appropriate forums.

It has discharged these duties and the results are set out in this report.