Consultant radiographer Position Document

Four key “pillars” of Consultant practice:

- Clinical expertise
- Professional leadership & consultancy
- Education, training and development
- Service development and research

Background

The role of the Consultant Practitioner is not a new concept. There has been a steady increase in the past decade in the number of posts created. To date there are 71 Consultant Radiographer posts registered with the Society of radiographers. Posts have evolved in response to a number of drivers, mainly the need to address service demand, radiology workforce shortages, improve access to and coordination of services, and delivery of seamless patient care [(1),(2),(3),(4)].

It appears that the growth in Consultant Practitioner roles has been accompanied by a growth in the lack of clarity and debate about the definition of the role.

The role was proposed and described by the Department of Health in 2000 [(5)] who stipulated that the 4 core domains the role must encompass were expert clinical practice; professional leadership & consultancy; practice and service development, research and evaluation; and education and professional development.

Increasing demands for the skills and expertise of consultant radiographers are demonstrated across a number of patient care pathways ranging from health prevention and promotion, to detection and diagnosis. The Strategic Health Authorities Allied Health Professional Leads (SAHPLE) commissioned project identified clinical pathways that demonstrate how the efficacy of these roles has made a significant difference to the clinical outcomes for patients. This has been achieved by proactively addressing inefficiencies, supporting initiatives and service redesign which is evidence based, driving innovation to benefit patient care, which all address the Quality, Improvement, Productivity and Prevention (QIPP) agenda.

The Department of Health Advance Letter [(6)] stated that the first purpose “expert clinical practice” was to be central to the role of the consultant AHP. The three

supporting functions were considered “essential”, but it was considered that these elements could be “weighted” according to local need.

In a climate of increased efficiency, productivity, budget constraints and cost saving efficiencies the principal of the role is constantly under threat as the three supporting functions are often compromised to deliver on clinical pressures. For long term sustainability of the Consultant Radiographer role it is imperative that all 4 components of the post are seen as equal and symbiotic, and that delivery of the clinical aspect in solitude is detrimental and non- conducive to innovation and evolution of services.

It is essential that as consultant radiographer roles evolve and progress they are acknowledged as a professional not as a semi-professional role. This will be achieved by accentuating autonomy within the four pillars effectively, and attaining SOR accreditation.

Key function: Clinical expertise

Objective	Measures/ Demonstrated by/ examples	KSF dimension
Maintain existing clinical practice	Patient management (highly complex cases)	**2, 5**
Audit of practice relating to competency/workload	Information Technology statistics Peer review Mentor review	**2, 5**
Further develop clinical skills	Undertake post graduate module or Written and completed an in-house training programme	**2, 4**

Expert Clinical practice

The evolution of the Consultant Radiographer role has extended the clinical career pathway further, from the development of Clinical Specialist roles and Advanced Practitioners over the past decade. Consultant Radiographers work at the highest degree of professional autonomy demonstrating advanced knowledge, skills, and experience within their specific clinical speciality. These attributes are considered a prerequisite for the post. By definition the role is patient focused and has a requirement for complex clinical caseloads, which encompasses the need for advanced assessment, clinical reasoning, knowledge and clinical decision making in order to provide an expert clinical service.

The SOR 2010 document "An evaluation of the impact of implementation of consultant practitioners in clinical imaging" [(7)] provides evidence of how these posts have facilitated increased capacity and patient throughput, improved use of medical staff time, increased flexibility in response to demand and most notably with no compromise to the quality of service delivered. Conversely, the role has facilitated the "gold standard" for double reporting to be attained within certain fields of diagnostic practice and the introduction of radiographer led procedures, such as vaginal vault brachytherapy insertions, previously undertaken by an Oncologist.

The DOH dictates that the clinical practice domain should account for 50% of the role. As Consultant radiographer roles are usually developed to meet a specific service need, the perception is that there appears to be no issue with the volume and level of clinical practice undertaken. Conversely, it appears that excessive clinical workload levels are having a detrimental effect on the ability to deliver on the further fundamental "pillars" of the role. In 2008 the Society and College of Radiographers commissioned research examining the scope of radiographic practice. The subsequent report [(8)] endorsed this fact where it was commented that there were "*particular concerns that workload levels made it difficult for consultants to comply with requirements to undertake research …….engaging with all of the 'four pillars' to a meaningful extent."*

The need for an agreed job plan for any Consultant role is essential to prevent this from happening.

Analysis of patterns of work may demonstrate that expert practice is afforded the highest priority in terms of time spent on this aspect of the role. However, the diversity of the role necessitates that consultants' will perform multitasking as there is an interrelationship of tasks within and between pillars (Figure 1) [9].

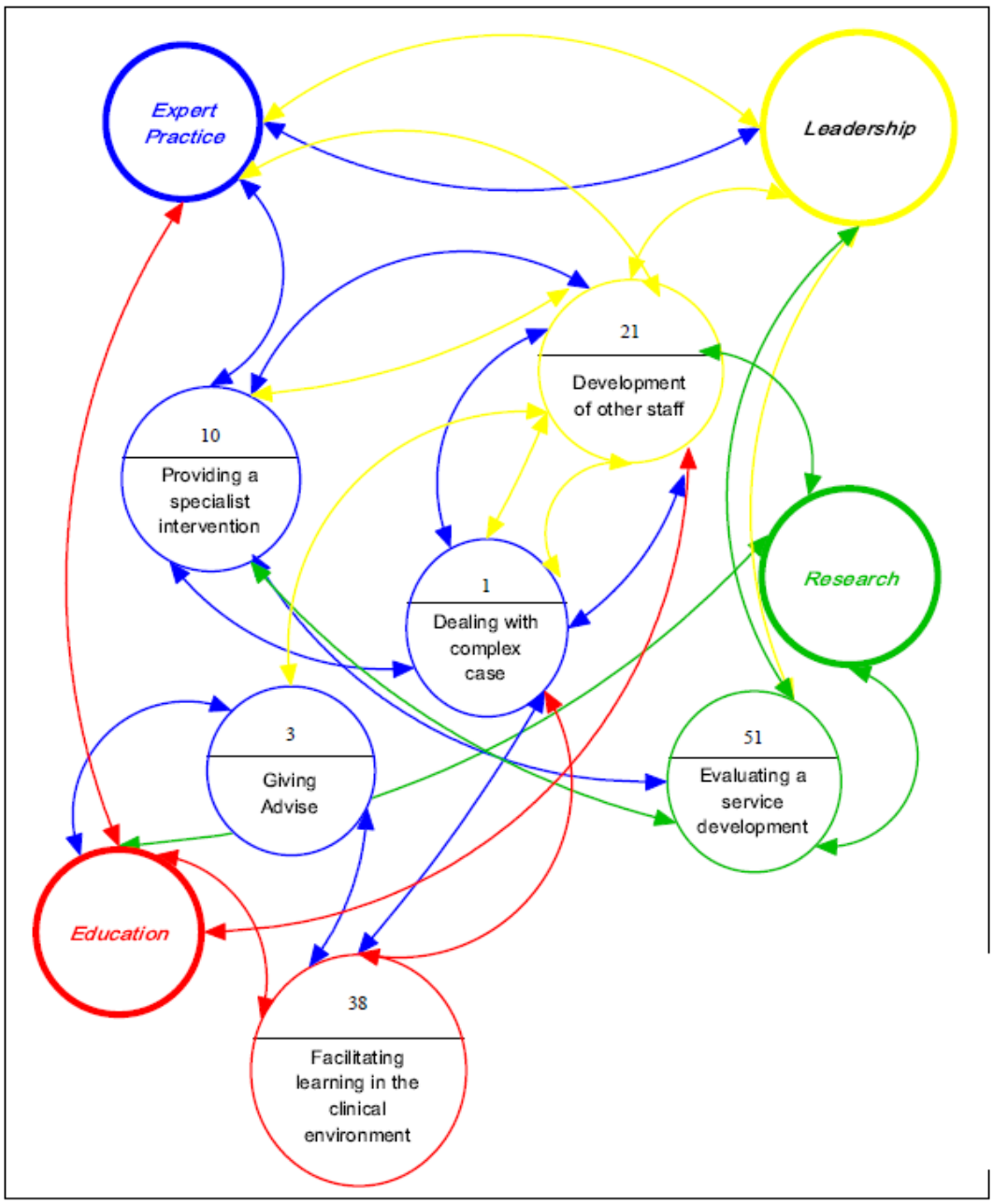

Figure 1. Example of Multiple Coding in Relationship to the 4 Pillars [9]

Another area of concern highlighted by the report [8] was whether there is 'added value' to be gained from implementing a consultant radiographer. The ultimate arbiter of any role will be – how effective is it in improving services for patients and service users? The research highlighted that opinions exist whereby consultant positions are perceived as high cost and bringing few benefits compared to an advanced practitioner. A pertinent statement from the report was *"An advanced practitioner can do nine or ten sessions a week and then if they become a consultant they go down to half that number of sessions and more salary ……. We would prefer an advanced practice specialist so at the end of the day we would still get seven or eight clinical sessions and they could have their CPD, but it bothers me that we pay [consultants] a big salary to do less."* - ***Diagnostic manager***

In a rapidly changing NHS with competing demands to demonstrate value for money and commissioning of services, it could be argued that a clinical specialist would provide the same level of care. However, although both levels of practitioner provide exemplary standards of clinical care, the added value of the Consultant is the ability to deliver a high level of functioning in all four pillars of the role, which on occasion is simultaneous. This has been evidenced through various examples where consultant radiographer roles have significantly added value and improved productivity locally particularly in relation to: supporting the delivery of performance targets; improving both workforce and service efficiency reducing waste; and significant re-development of existing services. These instances provide an indication of the complexity, breadth and depth at which Consultants' are operating.

In some instances consultant radiographers' have been appointed instead of a consultant radiologist. The SOR paper [7] reported that service expansion had been achieved at less cost in these situations where there are easily identifiable cost savings evident from the difference in salary of an AFC band 8 comparative to a medical consultant. This is a fairly crude evaluation and the value of the post may be better analysed against impact on patient outcomes - in terms of faster diagnosis, shorter waiting times and treatment. Because of the diversity of the role, numerous evaluation strategies may have to be considered to demonstrate effectiveness and impact.

Key function: Professional leadership and Consultancy

Objective	Measures/ Demonstrated by/ examples	KSF dimension
Guide/advise on updates of local protocols in line with current best practice	-Review dept/trust protocols/policies -Partake in relevant meetings/working groups	**1,2,4,5**
Contribute to clinical governance	- Participate/Lead discrepancy meeting - Adverse incidents	**3,4,5**
Influence recruitment and retention	- Change in attrition - Empower others	**1,2,6**
Contribute to national guidance	-Respond to consultations -Volunteer to be a member of relevant working party	**1,5**
Develop/Maintain a national/international profile in radiography	-Conference attendance -Presenting at conferences/study days -Journal publications -Poster presentation	**1,2,4,5**

Professional leadership & consultancy

It is expected that Consultant radiographers are specialists in their clinical field conveying clinical leadership and strategic direction relevant to their specific region of expertise.

Clinical leadership has been a major political aim within the health service for the last 10 years, reinforced by the department of Health publications Making a Difference [(10)] and Shifting the Balance of Power [(11)]. Consultant posts provide a clinical career pathway in the NHS that are associated with the retention of clinical maturity and

excellence. This strengthens professional leadership by facilitating as a role model for senior staff, whilst developing and promoting the speciality. As a result this has an associated positive effect on the recruitment and retention of staff.

On a local level, it is perceived that consultants are exhibiting skilled leadership which is enabling individuals to negotiate the often complex process of working across professional boundaries and groups. This is demonstrated in various clinical examples where consultant practitioners' have primarily influenced the quality and experience of patient care through changing and challenging organisational and professional barriers that limit or inhibit effective service delivery.

The consultant role should be seen as entrepreneurial in that they can ensure strategic plans are translated into workable operational plans, identifying risks, critical success factors and evaluation measures. In these areas of activity there is evidence to show that post-holders have demonstrated high levels of engagement, high levels of expertise and clinical leadership.

It can be disputed that consultant radiographers lack managerial authority. Cook and Leathard [12] suggest that "effective clinical leaders adopt transformational leadership styles" and the consultant post offers the opportunity to innovate, inspire and motivate to encourage change. However, transformational leadership requires an environment that is supportive. Some of the difficulties identified in achieving this may be organisational barriers that inadvertently hinder individuals' leadership initiatives. Traditional structures and heavy clinical workloads have also been recognised as obstacles to establishing new specialist services which is also reported in other AHP consultant posts [13]. As leaders, consultant radiographers need support mechanisms and organisational infrastructures that will facilitate them in their duty. It will be up to individual NHS Boards to set out appropriate management and accountability arrangements to support the Consultant role, taking account of the senior level of these posts.

To substantiate the future of the consultant role it is essential that post holders capitalise on available opportunities that inter-professional and inter-agency working provides, so that they build their leadership capacity and start to influence key decision-makers who determine future commissioning of services. It is expected that

on appointment to these posts individuals will have presented and contributed to local and regional special interest groups/conferences, but with experience consultants should be disseminating to national/international professional conferences, actively becoming members of working parties/panels, and aim for a substantial contribution to scholarship and relevant publication.

Key function: Education training and development

Objective	Measures/ Demonstrated by/ examples	KSF dimension
Support the education of health economy staff at all levels	-Teaching -Assessment -Mentorship support -CPD programme	**1, 2, 5**
Facilitate advanced practice	Mentorship/supervision Journal club CPD programme	**2,5**
Collaborate with and contribute to Local HEI education	-Lecturing -Curriculum development -External examining Major review	**2**
Contribute to professional publications	-Publish in Journal article, National Press, Poster display -Journal review -Book review -Write chapter/text book	**1,2,5**

Education & professional development;

Defining the appropriate academic underpinning required for Consultant practice in itself has generated considerable debate. The principle is that the Consultant post-holder will have a Master's degree as supported by various authors [14]. It is considered that post-holders with such an underpinning will be more likely to progress, sustain and fully develop these roles. Where relevant to the expectations of the post, it has been debated that individuals should be pursuing doctoral level studies or equivalent activity to demonstrate sufficient independent academic learning. However, it is evident that this is not viable before the individual is appointed and therefore should not be deemed a prerequisite of employment. The failure to benchmark the level of academic development required at this level of practice and subsequently to prepare practitioners appropriately may adversely affect recruitment to new posts or succession plan for existing roles.

The nature of the Consultant post requires a commitment to lifelong learning and a portfolio that demonstrates responsibility for meeting their own development needs [6]. This is essential not only for the HCPC and SCoR accreditation but for the development of the profession.

The SCoR 2010 document *Education and Professional Development strategy: New Directions* [15] emphasises the pivotal role the Consultant should play in "enhancing the links between practice, professional bodies, and academic institutes". Although also specified in the DOH letter [6] and individual job descriptions involvement in education and training also appears to be variable at Consultant level. In reality, it appears that whilst the educational/training obligation is generally met at operational level, there does not appear to be a great deal of evidence to suggest influence at a strategic level. The reported education/teaching activities appear to predominantly be education of others within the clinical setting, with a smaller number of post holders broadening the scope of their influence by teaching on professional programmes in Higher Education Institutions (HEI). The purpose of the Consultant post is to work in partnership with clinical leaders, managers and educators to promote and facilitate positive learning environments/opportunities and influence the strategic development of organisational learning.

The SCoR document "Scope of Radiographic Practice 2008" [8] highlighted that some individuals perceive the education component of the role to be about "identifying training needs, and developing a culture that supports learning rather than the actual delivery". The report stated that this may amount to an individual's perception of compliance with the obligation to provide education and training. The impression is that actually some posts do not appear to match the components of the job as per job descriptions

If the Consultant role is to be respected in terms of delivery on education it is imperative to demonstrate a greater degree of contribution to educational policy for pre and post qualifying practitioners [6]. Not only does this have the potential to raise the profile of the local Trust as a centre of excellence for the delivery of education for radiographers, it will also promote local universities which may enhance recruitment of future students.

Publishing in professional journals needs to be forthcoming from the consultant group. This may be in various forms from local service developments undertaken, case studies, to single and collaborative research projects. It is important that education in specific areas of expertise are disseminated nationally and internationally by a greater commitment to lecturing/presenting at conferences.

Key function: Service development and research

Objective	Measures/ Demonstrated by/ examples	KSF dimension
Facilitate service redesign/improvement/resource management	-Integrate robust skill mix at all 4 tiers -Reduce stages in patient pathway -Develop greater multi professional working	**4,5,6**
Evidence based practice	Review imaging protocols Contribute to evidence base	**5**
Access to services	Contribute to relevant Multi-disciplinary team meetings Shorten waiting times	**4,5**

	Individuals service compared to others	
To take an active lead in clinical audit	-Undertake audit projects -Encourage /Support staff to develop skills in audit -Ensure audit outcomes are implemented	**1, 2, 4, 5**
To support a departmental research culture	-Establish relevant links to support culture -Assist staff wishing to undertake projects as required -Take and active role in relevant research projects	**2,4,5**

Research & evaluation.

The purpose of the Consultant post in the research domain is to make a significant contribution to the health research agenda by initiating, facilitating or undertaking appropriate high-quality research. This may take various formats from clinical audit, evaluating service developments, to collaborating with appropriate research partners. The prime importance is to develop a research culture within the radiography profession, acting as role models, and ensuring support for clinical research activity.

The strategy document “Developing the Role of the Clinical Academic Researcher in the Nursing, Midwifery and Allied Health Professions” [(16)] specifies that research is part of NHS core business and commissioners, providers and Higher Education Institutions (HEIs) should promote and use research to inform planning and provision.

It is acknowledged that the research sub-role remains the most difficult to achieve within the Consultant radiographer role. Post holders report that although this element is incorporated into their job descriptions it is the domain of least activity. It

mainly seems to be recognised through undertaking clinical audit activity, or as part of academic studies. In part this may be due to the complexity of the role, increasing workload pressures, a lack of research skills, but it may also be that research is not being recognised by Consultants and their mangers as a fundamental aspect of the role. Several studies have assessed what clinical staff perceive to be the barriers to performing and implementing research findings [17]. The common responses include: poor attitude towards research; lack of knowledge; insufficient time; lack of support from peers, managers and other health professionals; lack of resources and a resistance to change.

The 2008 SCoR document [8] highlighted that some post holders questioned what was expected by the term 'research' in the context of the consultant role. Actually, there appeared to be bewilderment on the exact definition of 'research' with individuals questioning if involvement in clinical audit was sufficient to fulfil the requirement. Audit is fundamental to reflective practice so that services can be re-designed and outcomes improved. This goes hand in hand with Research and Development as it helps to identify gaps in the evidence base.

The current philosophy of the National Health Service (NHS) with open accountability, cost effectiveness and efficiency has brought with it the requirement for a research-based healthcare culture. The literature review highlights that with regard to research, results are disappointing comparative to other AHP professions [18, 19, 20]. The impression is that Involvement in clinical research is minimal in diagnostic radiography but there are more reports of radiographer-led clinical research within radiotherapy [8].

Individuals express a desire to develop further in this area, but feel unprepared for their research role on appointment. Although there are a number of consultants with a master's degree, these individuals also report difficulty integrating research into practice, supervising and conducting research. It must therefore be questioned "Is the current training adequate for research skills required at this level"? Some authors [21] suggest an alternative would be to run specific doctorate modules in conducting and implementing clinical research for non-medical consultants.

Historically there have been debates regarding radiography as a “semi-profession” because the vast majority of its knowledge base was generated from research undertaken by others e.g. Medical practitioners and physicists. The Consultant Radiographer role is the prime resource to address statements that “More needs to be done by radiographers to make the profession truly professional” [17] and strive to maintain a professional status. More radiographer led clinical research will support Paterson's [22] view that “development and expansion of radiographic practice will only come about if research is recognized as a fundamental requirement of the professional role”.

There are some individuals already engaged in research, as demonstrated in peer reviewed
journals, but many more need to be pro-active. It is essential that Consultants come to see their practice as a valid source of research which will provide a foundation of theory and development of the knowledge base. Within these roles there is the opportunity to ensure that research is of high quality, cost effective and responsive to NHS needs. This will be achieved by building partnerships which link clinicians, professional bodies and academic establishments on a local, national and international level.

Conclusion

It must be stressed that consultant practitioners do not exist to simply substitute for medical colleagues. Paterson [23] and Law [24] forewarned of the potential risk that consultant posts will become “local solutions to local problems”. It is acknowledged that post holder’s may demonstrate a greater eminence in one specific domain e.g. education and teaching, but the requirement of the post remains that there must be evidence to satisfy all 4 components to some degree. This will be of greater significance when individuals apply for SCoR accreditation. Accreditation is not only important at an individual level, but department’s applying for ISAS accreditation may find this is a measurable performance against which compliance is assessed.

It may be that some members of the group will not be able to evidence all pillars of the role to achieve accreditation for Consultant status, although they may have an

abundance of evidence for clinical expertise. In a climate of financial constraints, Trusts have actively down-graded radiographer posts and there is nothing to suggest that the consultant post will be an exception to this if it is “deemed” to be a clinical specialist role. Members may have to be pro-active in negotiating new work plans to facilitate the full remit of the role.

It has been highlighted that the strategic role of the consultant practitioner in some cases is currently under-developed. The consultant group believe that it is essential the requirements of the role remain the same, with clear distinction between the positions of advanced and Consultant practitioner. If the title of consultant (which is not protected) is to remain, every opportunity should be grasped to prove its value and significance. In the long term a lack of Consultant posts may contribute to the de-skilling of the profession.

<u>Recommendations</u>

Trusts must carefully evaluate if it is a “true” consultant post or clinical specialist they require. Posts created without the full remit of the role are set to fail the individual

Individuals must be proactive at appraisals and address issues within personal job plans. The primary focus of a Personal Development Plan (PDP) is to enable the individual to effectively meet the demands of their current post, and support them in achieving their objectives

There is minimal published evidence demonstrating the cost-benefit and impact resulting from consultant radiographer posts. As a result, perceptions of the role are not always favourable. Further published evidence may assist with the introduction of more posts.

There appears to be a diversity of practice within the consultant role. Consultant training posts are strongly advised as a strategy to ensuring that individuals have appropriate support/skills and can demonstrate competency in all 4 domains of practice prior to appointment to a substantive post.

Consultants will need to utilise resources available to them e.g. Local research hubs to take forward collaborative research work with other AHPs and academic colleagues.

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