Trainee Consultant and Consultant Radiographer 2022/23 Survey

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SoR
THE SOCIETY OF RADIOGRAPHERS

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Executive summary

During the period December 2022 to March 2023, the Society of Radiographers (SoR) facilitated a survey of trainee consultants and consultant radiographers, the third time SoR had surveyed the group since 2018. The aim of the original 2018 survey had been to identify consultant radiographers' scope of practice and pay banding, and to explore factors associated with consultant practice. The 2022/23 survey results presented in this publication provide updated information and data to track trends and developments in the intervening period. Participants were recruited from SoR trainee consultant and consultant radiographer networks. Recruitment was online via the SoR consultant radiographer workspace. There were 94 responses to the survey. The response rate was therefore 64% of network members.

Findings of note were:

- Participants were located across the nations of the United Kingdom (UK), although there were no responses from the Channel Islands or Isle of Man.
- The majority of consultant radiographers (98%) worked solely in NHS public practice.
- 62% of participants worked in diagnostic radiography and 38% worked in therapeutic radiography services.
- The majority (72%) of trainee posts were graded at Agenda for Change (AFC) band 8a. The majority of consultant posts were banded at AFC 8b (63%), with a range between 8a and 8d.
- The highest percentage of therapeutic radiographer consultants worked in therapeutic breast services (29%).
- The highest percentage of diagnostic imaging radiographer consultants worked in diagnostic breast imaging (53%).
- 78% of participants had a job plan agreed with their employer and 9% were in the process of negotiating a job plan with their employer.

The SoR Consultant Radiographer Advisory Group (CRAG) has authored guidance for the support of new and established radiographer consultant roles: Consultant Radiographer – Guidance for the Support of New and Established Roles (second edition) | SoR

All trainee consultant and consultant members are encouraged to join the SoR consultant network. Prior to the development of new roles, managers and practitioners are also encouraged to contact pande@sor.org to arrange support for the development of trainee posts, job descriptions and job plans.

Introduction

This was the third survey of trainee consultant and consultant radiographers facilitated by SoR, with contributions from an online community of trainee consultant and consultant radiographers. This document presents descriptive results. The survey was intended to provide an overview of trainee consultant and consultant radiographer roles in the UK in 2022. The data that the participants provided presents a snapshot of training, roles, pay banding, intention to retire and range of practice.

Background

Trainee and consultant radiographer clinical practice may consist of a myriad of elements, for example:

- Direct patient contact, including clinic sessions;
- Examining patients; undertaking imaging tests on a one-to-one basis;
- Portal imaging review;
- Discussing sensitive news and shared decision making with people;
- Reporting and administrative work associated with sessions;
- Active participation in or chairing multi-disciplinary team meetings where patient diagnosis and treatment is discussed;
- Case discussion on individual examinations/therapeutic radiation fractionations;
- Support and advice to other staff, including supervising other practitioners while they are providing direct patient care;
- Advice to carers;
- Collaboration and discussion with colleagues to enhance an individual patient's journey;
- Arbitration of cases and/or Serious Case Review.

The role of a consultant radiographer is thus variable, but the common thread is that all practitioners are members of teams in clinical imaging and radiotherapy departments. They work to innovate, motivate, and influence local, national and international agendas.

The SoR facilitates a consultant radiographer network and provides a forum for consultant radiographers to develop and share the requisite skills, evolve best practice, promote innovations, and overcome barriers through discussion and shared knowledge. Fundamental to the group are four core elements of the consultant role:

- Expert clinical practice;
- Professional leadership and consultancy;
- Education, training and development, practice and service development;
- Research and evaluation.

Members of the SoR consultant radiographer network are proactive in their education and training roles; many regularly speak at national and international conferences, provide articles for publication in a wide range of journals and publications, act as expert witnesses, advise government groups, and so on. The action of members inherently raises the profile of consultant radiographers and, more widely, Allied Health Professionals (AHPs).

Through the 2022 survey, the SoR sought to provide evidence of the breadth of practice. This was achieved by asking participants questions about scope of practice, pay banding, job plans, etc. The survey also invited participants to describe any changes to their job role and scope of practice during the 2020 - 2022 period.

Method

The original 2018 survey questions were developed in consultation with SoR professional officers and CRAG. Following a pilot with three practitioners in 2018, the original survey was open from the last week in April to the first week in November 2018, a six-month period. Online SurveyMonkey® software was used to collect data in that instance. The 2020 and 2022 surveys were a repeat of those questions but were performed using online Alchemer® survey software, in line with SoR principles for participant anonymity. Alchemer® software automatically generated a descriptive report in the form of the graph and bar chart diagrams that are presented in the results below.

Participants

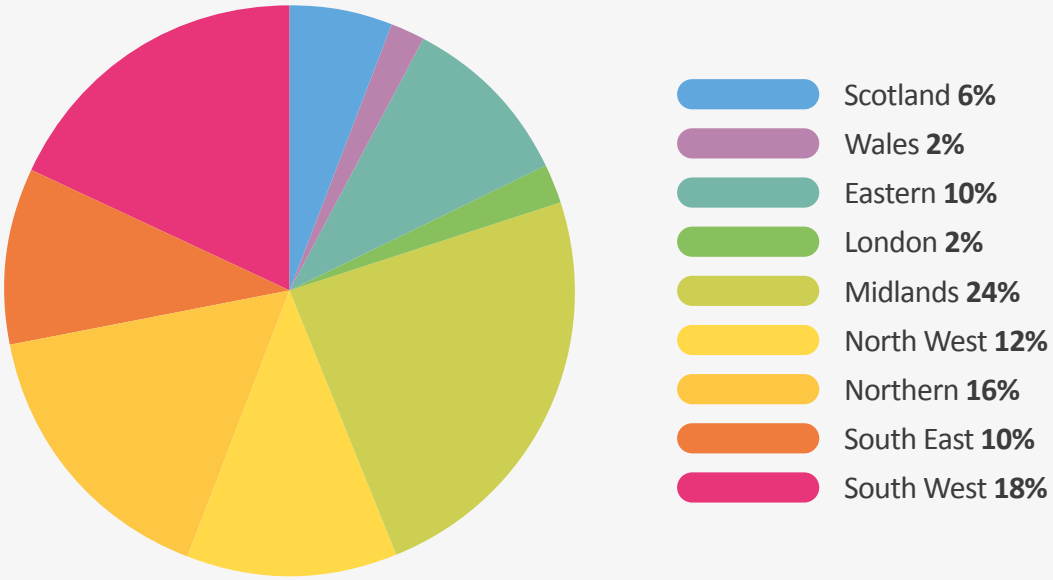
The survey was open to all members of the trainee and consultant radiographer network. In December 2022, the network had 147 members with access to Synapse; 94 members responded to the survey.

Results

Response statistics for the trainee consultant and consultant radiographer 2022/23 survey.

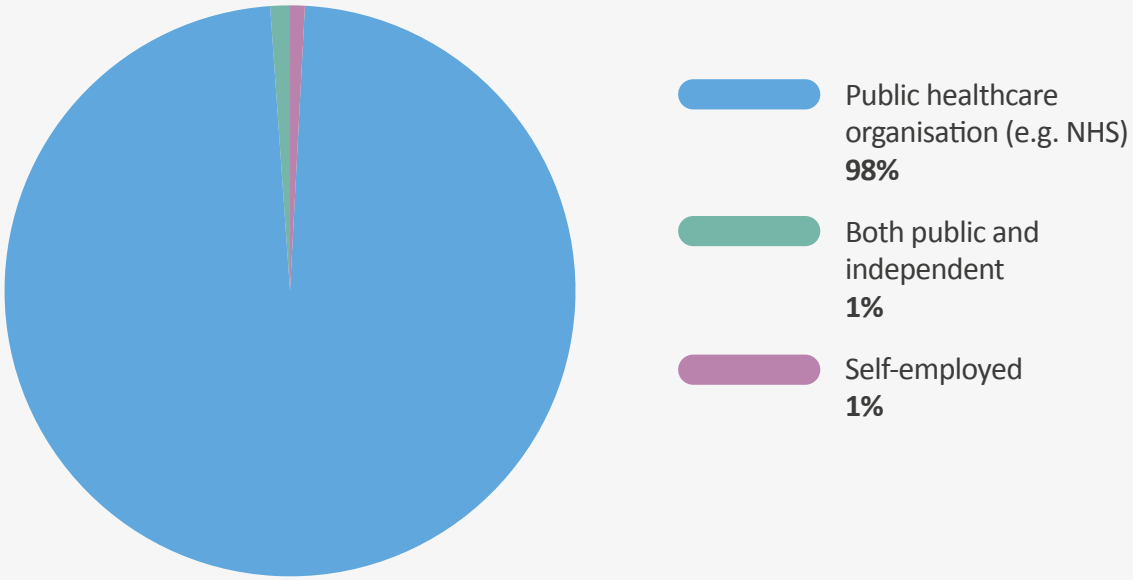
	Percent	Count
Complete	84%	79
Partial	16%	15
Disqualified	0%	0
	Totals	**94**

1. Participant geographic work region



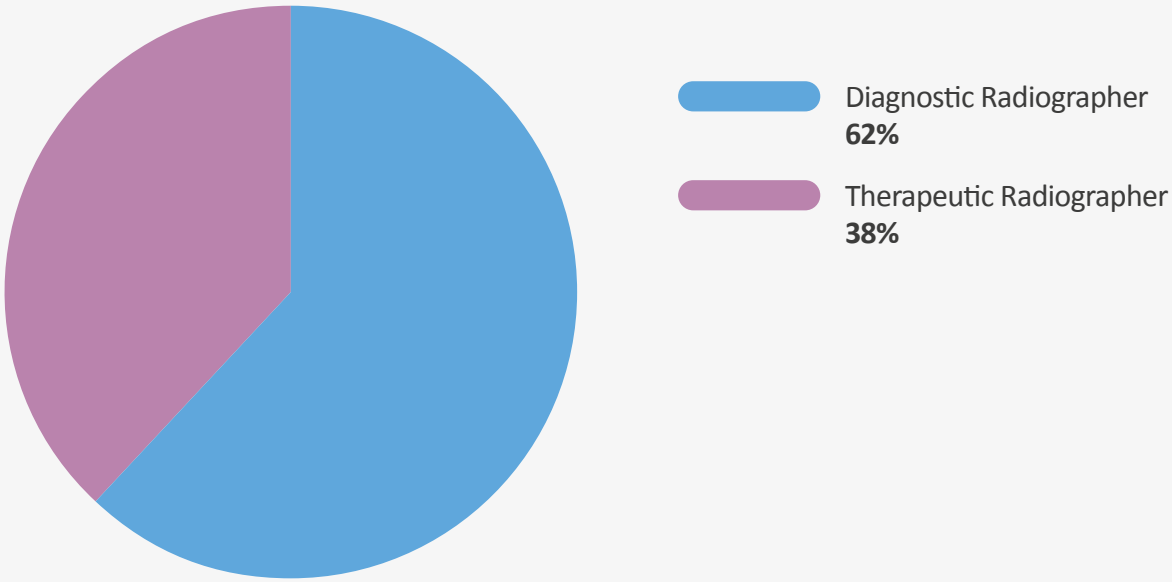
Value	Percent	Count
Scotland	5.6%	5
Wales	2.2%	2
Eastern	10.0%	9
London	2.2%	2
Midlands	24.4%	22
North West	12.2%	11
Northern	15.6%	14
South East	10.0%	9
South West	17.8%	16
	Totals	**90**

2. Participant employment sector/s



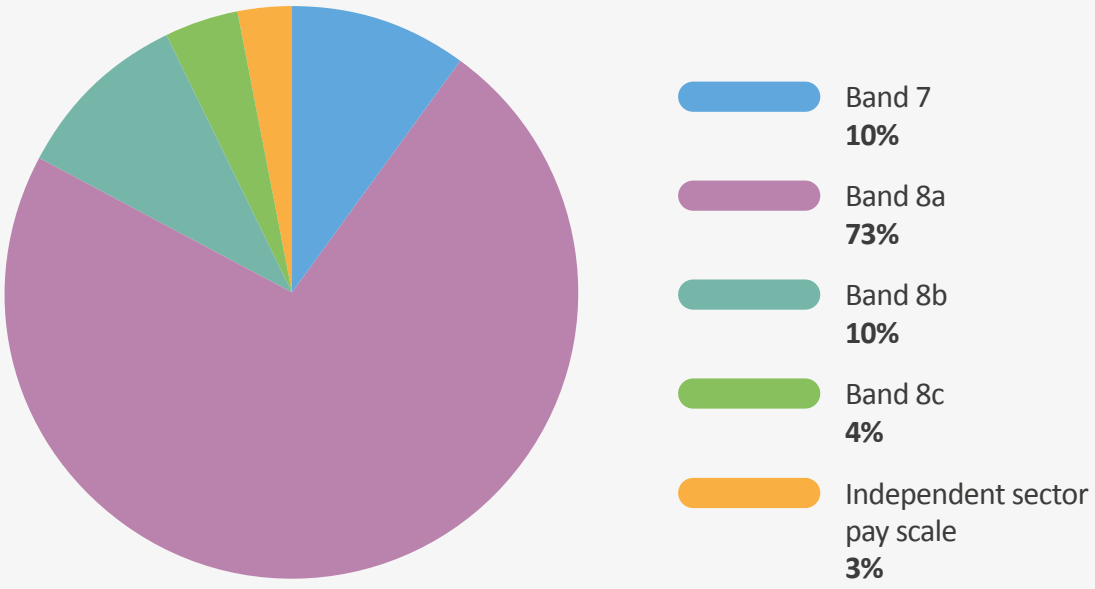
Value	Percent	Count
Public healthcare organisation (e.g. NHS)	97.8%	88
Both public and independent	1.1%	1
Self-employed	1.1%	1
	Totals	**90**

3. Participant's regulated title



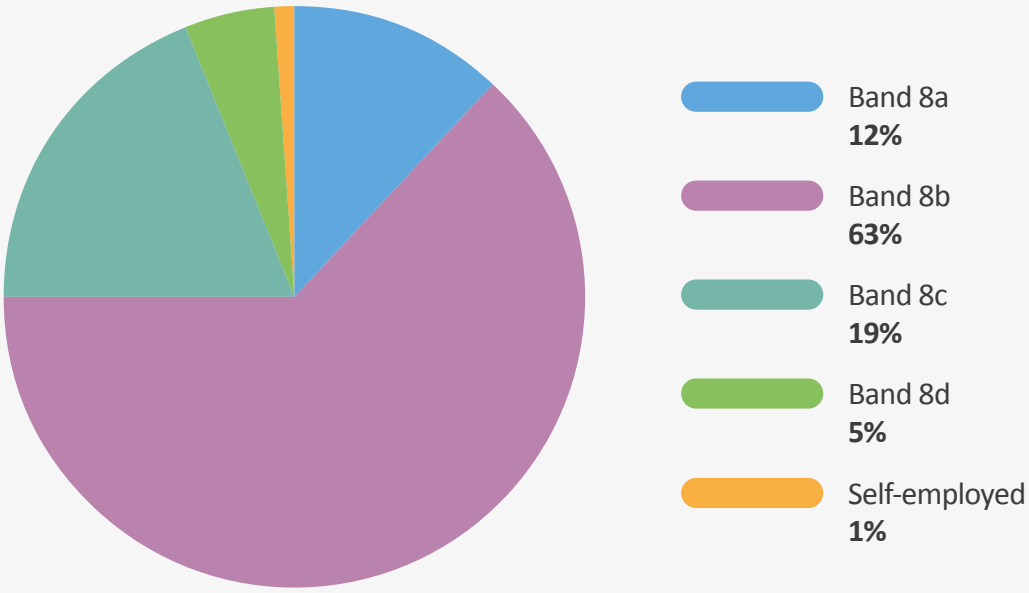
Value	Percent	Count
Diagnostic Radiographer	61.8%	55
Therapeutic Radiographer	38.2%	34
	Totals	**89**

4. For respondents who are trainee radiographers, what is your AFC banding?



Value	Percent	Count
Band 7	10.3%	3
Band 8a	72.4%	21
Band 8b	10.3%	3
Band 8c	3.4%	1
Independent sector pay scale	3.4%	1
	Totals	**29**

5. For full consultant participants (who have completed training/ preceptorship), what is your AFC banding?



Value	Percent	Count
Band 8a	11.5%	9
Band 8b	62.8%	49
Band 8c	19.2%	15
Band 8d	5.1%	4
Self-employed	1.3%	1
	Totals	**78**

6. Please tick your areas of practice

Value	Percent
Therapeutic Gynae-oncology	2.2%
Therapeutic Breast	28.3%
Therapeutic Head and Neck	6.5%
Therapeutic Lung	4.3%
Therapeutic Neuro-oncology	2.2%
Therapeutic Palliative Care	15.2%
Therapeutic Technical / Treatment Specialist	2.2%
Therapeutic Urology	4.3%
Therapeutic Prostate	15.2%
Therapeutic Colo-Rectal	2.2%
Therapeutic Brachytherapy	6.5%
Therapeutic Late Effects	2.2%
Therapeutic Information and Treatment Review	4.3%
Other - please provide a description	26.1%

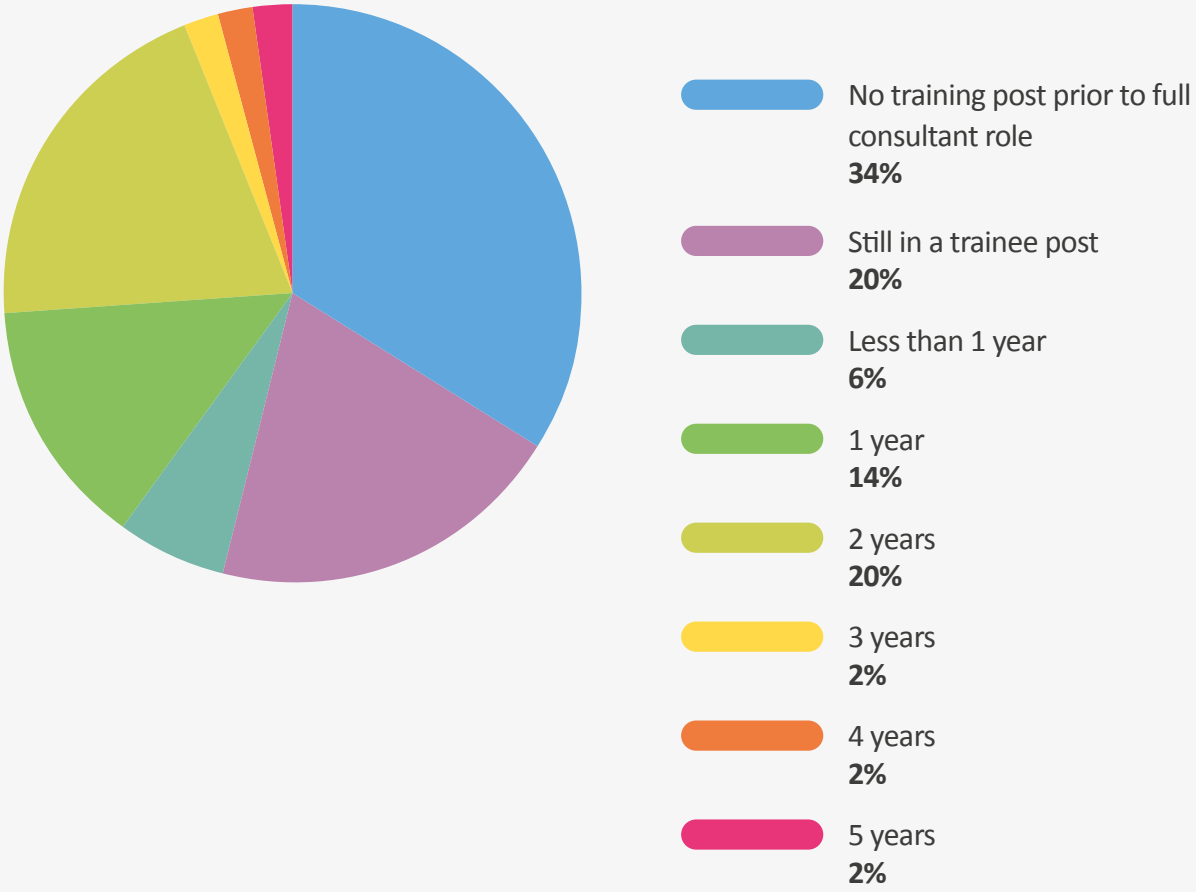
Diagnostic breast
Consultant Research Radiographer, Head of Radiotherapy Research and Development
I'm a diagnostic radiographer
Interventional radiography
Molecular radiotherapy
Research and innovation
Ultrasound interventional
Upper GI
Diagnostic

7. Please tick the boxes that apply to your practice

Value	Percent
Diagnostic Breast Imaging	52.8%
Diagnostic Ultrasound	24.5%
Diagnostic MR	1.9%
Diagnostic CT	7.5%
Diagnostic DXR	1.9%
Diagnostic Gastrointestinal Imaging (Fluoroscopy)	7.5%
Diagnostic Interventional Imaging and Procedures	15.1%
Diagnostic Paediatrics	17.0%
Diagnostic A&E Trauma / MSK	17.0%
Diagnostic A&E Chest	17.0%
Diagnostic A&E Abdomen	15.1%
Diagnostic Primary Care MSK	17.0%
Diagnostic Primary Care Chest	17.0%
Diagnostic Primary Care Abdomen	15.1%
Diagnostic Secondary Care MSK	20.8%
Diagnostic Secondary Care Chest	17.0%
Diagnostic Secondary Care Abdomen	15.1%
Other - please provide a description	9.4%

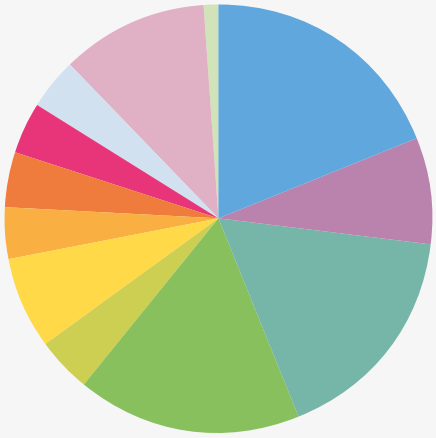
I also report Breast MR
Interventional radiography
Post-mortem and forensic imaging
Research and innovation
Post-mortem imaging

8. Number of years working as a trainee consultant practitioner prior to full consultant post?



Value	Percent	Count
No training post prior to full consultant role	34.1%	28
Still in a trainee post	19.5%	16
Less than 1 year	6.1%	5
1 year	13.4%	11
2 years	19.5%	16
3 years	2.4%	2
4 years	2.4%	2
5 years	2.4%	2
	Totals	**82**

9. Number of years working as a consultant radiographer



Still working in trainee post **19%**

Less than 1 year **8%**

2 years **17%**

3 years **17%**

4 years **4%**

5 years **7%**

6 years **4%**

7 years **4%**

8 years **4%**

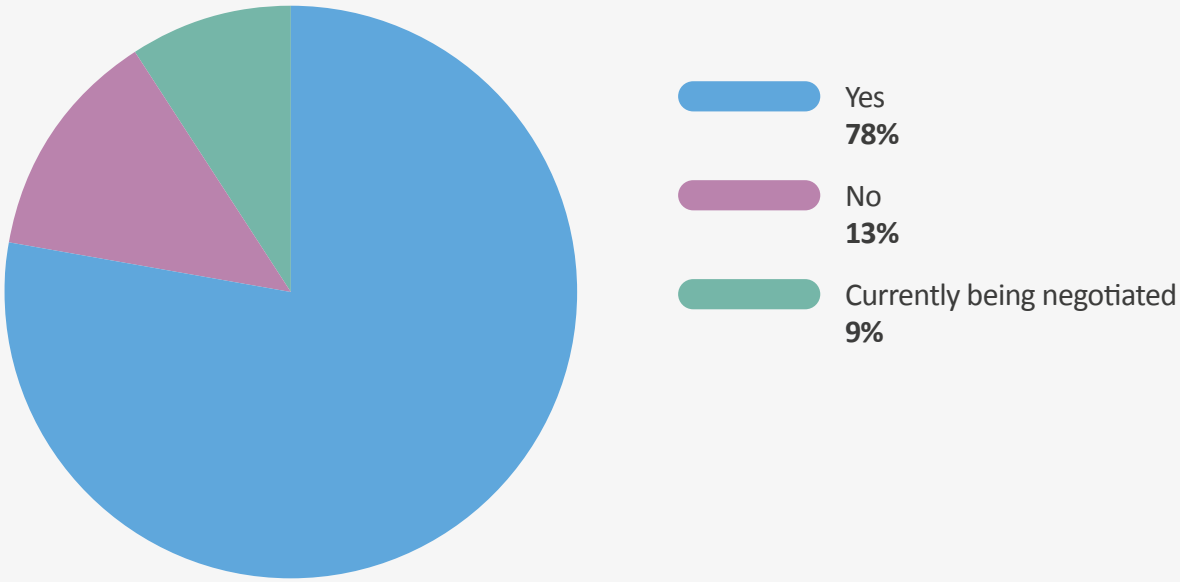
9 years **4%**

11 - 15 years **11%**

16 - 20 years **1%**

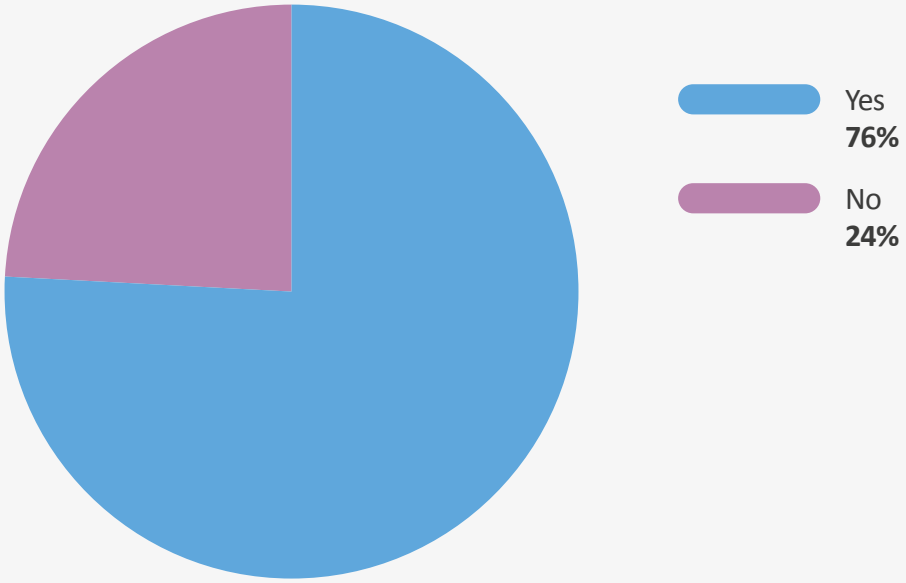
Value	Percent	Count
Still working in trainee post	19.5%	16
Less than 1 year	8.5%	7
2 years	17.1%	14
3 years	17.1%	14
4 years	3.7%	3
5 years	7.3%	6
6 years	3.7%	3
7 years	3.7%	3
8 years	3.7%	3
9 years	3.7%	3
11 - 15 years	11.0%	9
16 - 20 years	1.2%	1
	Totals	**82**

10. Do you have a job plan?



Value	Percent	Count
Yes	78.2%	68
No	12.6%	11
Currently being negotiated	9.2%	8
	Totals	**87**

11. If you have a job plan, are you generally able to work to it?



Value	Percent	Count
Yes	76.0%	57
No	24.0%	18
	Totals	**75**

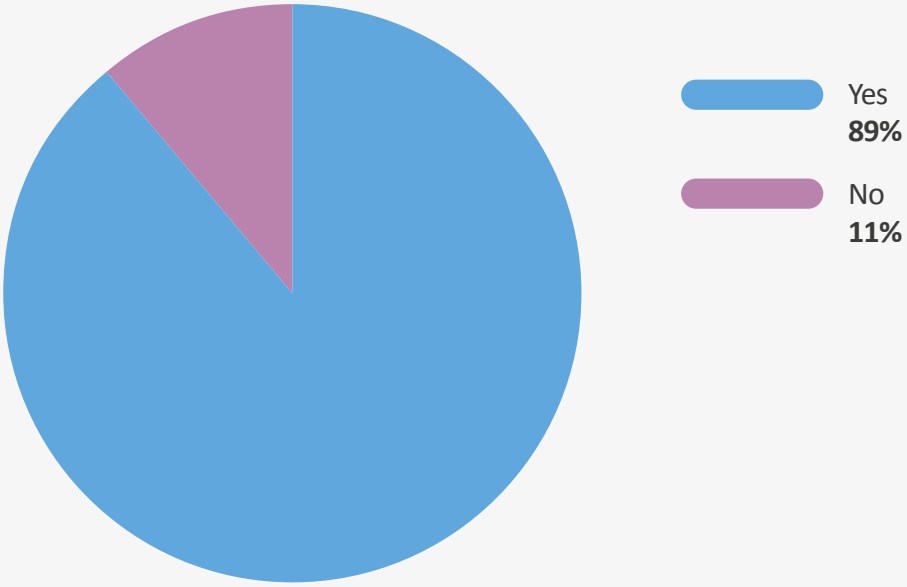
12. When do you plan to retire?

Response ID	Response
6	2050
8	60
9	55
10	2028
11	65
12	7 years
13	27 years to go!
15	Not until able to! Aged 67 unless it changes
16	I don't
17	6-7 years
18	60
19	2040
20	Not planned
21	In many years
22	2023
23	65
24	60
25	2046
26	65
27	60
28	67
29	5-7 years
30	2035
31	4 years' time
32	15 years' time
33	2037
34	In 8 years
35	68
36	2032
37	2057

Response ID	Response
38	?
40	65
41	At retirement age
42	ASAP
43	2037
45	5 years
46	2031
47	Not sure
48	8 years' time
49	Next 10 years
50	10 years
51	67 years
53	60
54	60
55	2038
56	2026
57	2043
58	2026
61	Whenever it is financially viable for me to do so
62	18-20 years from now
63	2039
64	Around 60/65 years old
65	2024
66	Have retired and returned
67	60
69	5 years
70	60
71	2032
72	Age 60
73	67
74	2046

Response ID	Response
75	Dec 2023
76	67
77	60s
79	2040
80	Within next 7 years
81	Unsure
82	Not in the foreseeable future
83	5 years
84	68
85	2 years
86	No idea!
87	60
88	2026
89	60
90	N/A
91	In 10 years
92	Retirement age 65
93	2024
94	68
97	20 years
98	65
99	55

13. Do you plan to remain in the role of consultant radiographer until your retirement?



Value	Percent	Count
Yes	89.4%	76
No	10.6%	9
	Totals	85

14. If you are considering a change from consultant role, can you provide some information to help us understand why - eg family commitments, stress, change of career?

Response ID	Response
6	Change of career
8	No
11	May wish to change roles
13	Promotion and need for a pay rise
15	I would like to do an alternative career outside of the NHS, alongside my current job, but am not sure how feasible this is. Just for a change in role and work. I am quite happy in my profession
20	No progression opportunity from entry-level practice and pay band
21	I am seeking a similar role elsewhere
22	I am retirement age and have elderly relatives I need to help
26	n/a
33	Stress, career change
37	Role suits family life currently, current uncertainty in the way we are accredited/ HEE/SoR guidance differences takes more time than my actual job role
46	n/a
51	n/a
54	Stress
57	Unable to adopt flexible hours in role
62	Want to continue to progress, possibly to professorial role
71	Stress
72	Stress, new post, lack of support, isolation in role
80	Stress and change of career
98	Development/management - Role development to support further appointments to these roles
99	Stress and family commitments

15. A rough estimate of your time percentage spent on 1) Clinical Practice; 2) Consultancy and Strategic Leadership; 3) Education; 4) Research and Service Evaluation.

Response ID	Response
6	Clinical practice 70%, Leadership 20%, Education 5%, Research 5%
8	Clinical practice and leadership 70%, Education and research 30%
9	1. 90% 4. 10%
10	Clinical Practice 60%, Leadership 20%, Education 10%, Service evaluation 10%
11	1. 70% 2 10% 3. 10% 4. 10%
12	80% clinical, 20% the rest
13	50%, 10%,10%, 30%
14	Clinical practice 60%, Education/research 40%
15	Majority is clinical practice. I might have an afternoon available for non-clinical work, but this is mainly used to catch up on my personal audits etc. We do have trainees through the department, so I can combine clinical with teaching in that way. So I suppose 80% clinical most weeks, 10% education
16	1. 10% 2. 25% 3. 25% 4. 40%
17	1. 70% 2.10% 3. 10% 4.10%
18	1. 60% 2. 5% 3. 10% 4. 25%
19	1. 60% 2. 10% 3. 10% 4. 10%
20	DCC 60%, Education 10%, Consultancy and Strategic Leadership 20%, Research and Service Evaluation 10%
21	1. 45% 2. 40% (Leadership, management and service management) 3. 5% 4. 10%
22	Clinical practice: 8 sessions, but within that I am constantly teaching breast ultrasound/interventional/image interpretation. Leadership: 1 session but also leading the way forward with new innovation and equipment throughout the week. Education (as above). Research/service evaluation: 1 session.
23	1. 70% 2. 10% 3. 10% 4. 10%
24	1. 60% 2. 5%-10% 3.15% 4.10%-15%
25	Clinical 65%, Consultancy etc 20%, Education 5%, Research 10%
26	1. 70% 2. 10% 3. 10% 4. 10%
27	At the moment due to staff shortages I spend all my time on clinical practice
28	1. 40% 2. 25% 3. 30% 4. 5%
29	65%, 5%,15%, 15%

Response ID	Response
30	Clinical practice 60%, Consultancy/leadership 10%, Education 15%, Research 15%
31	1. 75% 2. 10% 3. 10% 4. 5%
32	1. 70% 2. 10% 3. 10% 4.10%
33	1. 50% 2. 10% 3. 35% 4. 5%
34	Clinical practice 75%, Leadership 5%, Education 15% (In addition, 40% of my clinical work is educational), Research 5%
35	Trainee role: 20% study, 70% clinical, 10% other
36	1. 30% 2. 20% 3. 20% 4. 30%
37	Clinical practice 0.5-0.7 depending on week, Consultancy 0.2, Education 0.2, Research 0.1
38	90% clinical, 10% all others
40	Clinical 60%, Leadership 10%, Education 10%, Research 20%
41	Clinical 50% moving to 70% once apprenticeship complete, Leadership 10%, Research 10%, Education 10%
42	Clinical practice 60%, Leadership/consultancy 15%, Education 20%, Service evaluation/research 5%
43	80% clinical, 20% 2, 3 and 4
45	Clinical 50%, Research 15%, Education 15%, Leadership 20%
46	Clinical Practice 60%, Consultancy & Strategic Leadership 20%, Education 10%, Research/audit 10%
47	1. 50% 2.10% 3. 30% 4.10%
48	Clinical practice 50%, Consultancy and strategic leadership 10%, Education 30%, Research and service evaluation 20%
49	Clinical practice >50%, Consultancy and leadership 25%, Education 12.5%, Research and service evaluation 12.5%
50	1. 70% 2. 15% 3. 10% 4. 5%
51	1. 55% 2.15% 3. 20% 4.10%
52	1. 40% 2. 30% 3. 20% 4. 10%
53	Clinical practice (Reporting) 80%, Education 10%, Leadership 5%, Research 5%
54	1. 60% 2. 10% 3. 15% 4. 15%
55	50%, 15%, 15%, 20%
56	Currently have a 2-year secondment to university 2 days per week, clinical academic research post 1. 50% 2. 10% 3. 5% 4. 35%
57	Clinical 80%, Leadership 5%, Education 10%, Research 5%

Response ID	Response
61	1. 75% 2. 5% 3. 10% 4. 10%
62	1. 10-20% 2. 20-30% 3. 10-20% 4. 30-60%
63	Clinical practice 60%, Consultancy and strategic leadership 20%, Education 10%, Research and service evaluation 10%
64	Clinical practice 60%, Leadership 10%, Education 10%, Research 20%
66	1. 60% 2. 20% 3. 10% 4. 10%
67	Most of my time currently is spent on clinical practice. It has been this way since the start of the pandemic
69	Clinical practice 70%, Leadership 5%, Education 20%, Research 5%
70	1. 75% 2. 15% 3. 5% 4. 5%
71	1. 90%, others variable
72	1. 75% 2. 15% 3. 5% 4. 5%
74	1. 70% 2. 5% 3. 15% 4. 10%
75	1. 75% 2. 5% 3. 10% 4. 10%
77	1. 85% 4. 15%
80	1. 80% 2. 10% 3. 5% 4. 5%
81	1. 70% 2. 20% 3. 10% 4. 0%
82	1. 70% 2. 10% 3. 5% 4. 15%
84	1. 50% 2. 15% 3. 10% 4. 25%
85	75% clinical, 25% on 2, 3, 4
86	My post is split 50:50 between PhD research and consultant training. But my education and leadership tends to relate to my research. So... 50% Clinical practice, 10% Leadership, 15% Education, 25% Research
87	1. 85%, often more 2. 5% max 3. 5% max 4. 5% max
88	1. 65% 2. 10% 3. 15% 4. 10%
89	1. 40% 2. 40% 3. 10% 4. 10%
91	Work 32 hours. 2.5 days clinical, 0.5 admin, 1 day study including SPA/study time whilst a trainee
92	1. 85% 2. 5% 3. 5% 4. 5%
93	30%, 30%, 20%, 20%
94	1. 60% 2. 10% 3. 10% 4. 20%
96	1. 50% 2. 10% 3. 20% 4. 20%
97	Clinical 80%, all others 20%
98	80% Clinical, Leadership 15%, Education 5%, Research - Have a plan to increase this due to additional resource in the team
99	1. Clinical practice 80% 2. Consultancy and strategic leadership 5% 3). Education 10% 4. Research and service evaluation 5%

16. If you have barriers to spending time in any of those four core domains of consultant practice, what are they?

Response ID	Response
6	Lack of time; I undertake a lot of personal time doing research
8	Lack of staffing
10	Pressure on Clinical Practice demands
11	High clinical workload. Just completing training. Working 0.6 WTE - lack of funding to increase my hours
12	Clinical necessity; lack of desire to be involved in research
13	As per job plan
14	Time and quantity of clinical patients
15	Staff A/L or sickness at the moment. We are looking into a research role in the unit which I may apply for - this would be 0.5 session a week. We need another radiologist to backfill current clinician who has been promoted
16	I think I do too much management and not enough research and true leadership
17	Pressure of clinical workload eats into the time available
20	Service and staffing pressures
21	Not enough opportunities/support to expand my current clinical practice. Leadership and management challenges often take priority and come with little recognition. Unable to find time at work for 3) Education; 4) Research and service evaluation
22	The huge clinical workload expected of me to keep up with the 2ww
23	Too much clinical work
24	Clinical practice workload fluctuations (in referrals)
25	Staffing
26	At the minute just experience, as fairly new in post I am concentrating on the clinical and still building the contacts for the other three. I anticipate they will all increase in workload in the coming 6 months
27	Staff shortages
28	Too much to do, such that activities bleed into much of my free time. A lot of pressure to complete the trainee period in 12 months, including qualifying as an independent prescriber. It's a lot of work, and as a trainee, I have to bias a lot of time in favour of Education. The reality of the 30% I have quoted, is 30% of employed hours. That is easily doubled, or more, but hours devoted outside of work
29	Clinical workload takes priority
30	Doesn't seem to be opportunities for education involvement - currently investigating this

Response ID	Response
32	Time to develop changes. Hospital has other priorities
33	Too much clinical and teaching required for the others
34	Leadership - overlap with HOD. Research - time
35	Seen by colleagues/managers as a mostly clinical role
36	Staffing shortages
37	Research - time available. Role includes operational responsibility which is unpredictable in time required. Staff shortage/sickness - often leads to covering extra clinical work taking time away from other domains
38	Clinical demand
40	Time constraints, personal preference to undertake patient-facing clinical work in face of waiting times
41	Always clinical pressure or staff shortages when I have to cancel my admin time
42	Time
43	Clinical urgency, staff shortages
46	The sheer pressure of clinical workload is the biggest barrier to overcome
47	Small service means hard to share strategic leadership
48	Service demands
49	Clinical pressures - no cover for maternity leave requiring additional clinic cover
50	Work load pressures - expectation that clinical work comes first
51	Access to appropriate training - consultancy leadership as long waiting list
52	Last-minute urgent requirements both strategic and clinical
53	Pay is directly related to clinical work now so this must take priority over other domains
54	Clinical pressures
55	Clinical and managerial work taking up too much time
57	Clinical workload - radiologists working from home. Required on-site full time
62	Too much management/operational responsibilities to do quality research I want to do. Makes writing large grants very challenging
63	Time pressures

Response ID	Response
64	Clinical practice often prioritised to meet reporting demand, to the detriment of research time. We are a small reporting team of 5, so if a member of the team is off sick or on annual leave, the rest of the team inevitably picks up the workload so that a reporting backlog does not develop, and to ensure hot reporting services are maintained. Education opportunities and tasks ebb and flow, with some weeks and months being busier than others. Workloads then vary and on the weeks where there are more education tasks (ie trainee radiologist supervision, teaching sessions for other professionals), research time may be sacrificed. I work at a district general hospital and our reporting team is small, so leadership opportunities can feel limited. Funding available for service change and improvement is lacking, meaning opportunity to become involved in service change is also limited
67	Lack of staff
69	Protected time
70	Lack of staff
71	Departmental demand
72	Too much clinical work/waiting lists, not enough time, lack of department interest in research, lack of support in service evaluation within department and across other specialities
73	Staffing levels
74	Variability of role from day to day (palliative) meaning it is difficult to plan blocks of time for project work or commit to strategic meetings
75	Clinical workload
80	Understaffed department therefore increased demand for clinical practice required
81	Time, but also at present research is on hold until I finish my training in planning. I still take part in service evaluation
82	Clinical work very busy. Difficulty in getting time in the other 3 domains
84	Only that no one week is the same, as depending on different stages of different projects, my work plan is fluent to represent that. However, just because there is a sudden surge of work on the research front, doesn't mean that the clinical work lessens, so this increases hours worked and stress levels
85	Too much clinical component
86	I find it most difficult to dedicate time to research (which should be 50% of my job). It's the thing that can always be squeezed or dropped if something more pressing comes up
87	Staffing pressures in clinics. Additional hours and evening clinics to cope with demand make quality time for research virtually impossible
88	Excessive number of pt's that are breaching
89	Clinical workload
91	Access to research, particularly in the clinical area - trials

Response ID	Response
92	Clinical demands, admin demands, access to funds for conferences, travel and accommodation, lack of exposure to higher management, locally/ nationally
93	Requirement to cover clinical sessions
94	My work week is fluid and amount of time I spend on each domain depends on what research/leadership/education projects I'm working on. Generally I would say I get a good balance across all 4 domains
97	Clinical commitment
98	Clinical demand is extremely high
99	Overbooked clinics, 2 weeks wait and backlogs, staff shortage, etc

17. What facilitates your spending time working across the four core domains of consultant practice?

Response ID	Response
8	Amount of clinical time
10	Having a job plan
11	As becoming more established I am being asked to do more teaching, etc
12	Personal choice
13	Requirements of the department
14	Job plan helps but clinics overbooked/stretched
15	Full level of staffing, discussion with peers and allocating time for non-clinical work. I have completed an evaluation on breast biopsies in the under 30yrs population - it took 1 year to get others to review images for it, though!
17	My job plan
18	Working from home one day a week
20	Dedicated role and management support
21	Time away from the workplace is the only time I get to realistically look into 3. Education and 4. Research and service evaluation
22	The only way I can do this is to have a session where there is not a clinical session taking place at all in the department, eg Friday pm
23	Very supportive management and oncologists. Links with Hertfordshire University Member of the Oncology research group. Links with breast services and Uni Portsmouth research team. Cancer Alliance
24	Flexible job plan, dedicating time at different points in the year to the various domains (prioritisation)
25	Job plan
26	Job plan helps, as do colleagues and supportive management who are aware of the need to fulfil all four domains, not just loading with more new patient appointments
27	Having the full complement of staff
28	I think that getting through the initial burden of education and training, as a trainee, will then allow a better spread across the domains. The research and service evaluation domain primarily has to take a back seat at present, if learning objectives are going to be met
29	Good job plan and supportive colleagues
30	Having a job plan
31	Research opportunities are limited
32	Multi-disciplinary approach to service development
33	Extra staff, support, time

Response ID	Response
34	My job plan
37	Agreed-upon job plan with protected time
40	Job plan and clinical consultant support
41	Agreed job plan with manager, framework of tasks that need completing before consultancy title (as per Hardy and Snaith)
42	Natural ability
43	My own time management
45	Job plan, support of manager, enthusiasm to keep up with all 4 domains
46	I have a good job plan, strong support from clinical oncologist colleagues and flexibility to manage my own priorities and workload
47	Agreed job plan, supportive team
48	Protected time agreed before taking post for dedicated research and reporting time
49	Occasional working from home to allow lack of interruptions and improve efficiency
50	Good job plan, regular reviews of balance
51	Protected SPA time. Access to research and ongoing projects within the department. Good time management and communication to update progress among colleagues. Funding for appropriate projects
53	As I have no other commitments and am essentially my own boss, I am now free to divide my time to each domain as I see fit
54	Management
56	Backfill for some clinical work to cover my university secondment
57	Workload changes in breast depending on the time of year - downtime at Christmas. Education - SLA with HEI therefore requirement for release. Research usually undertaken in own time
61	Reporting demand - minimal backlog; staffing levels - team of full-time reporters provides cover easily
62	I have built an excellent team who are proactive and enthusiastic
63	Job plan. Supportive management. Good team below me
64	Expert practice - great radiologist support. Radiographers at our trust report over 90% of plain film imaging, and radiographer development is promoted and supported by radiologist colleagues. Leadership - I am currently participating in a network leadership programme, which is providing opportunity to spend time with different leaders from different organisations and in different roles. Research - I completed my MSc last year, which provided great opportunity to learn about research methods and undertake a project. I'm in the process of writing project findings for publication, with support of my MSc supervisor who has significant research and publication knowledge and experience. I think this level of guidance and mentorship is essential. Education - having dedicated time and autonomy to undertake education is essential

Response ID	Response
66	My original consultant role was hosted by a university, seconded to two clinical depts that facilitated research and education. The clinical aspect is gained via NHS depts and the private sector
67	A full complement of available staff
69	Apart from clinical practice, a lot of my own time is spent on the other domains
70	Full-time hours, when fully staffed
72	My own perseverance in trying to achieve it all!
73	Radiotherapy manager
74	Flexible working hours, time spent working from or out of the department, eg library
75	Job planning helps
80	I am unable to work across all 4 domains as appropriate due to clinical needs of department
81	Action plan and my job plan. Regular meeting with my professional and clinical leads
82	A high proportion of time spent covering 2, 3 and 4 is by using my time
84	Being able to manage my own time, not being micromanaged, being trusted to work within my 4 core domains by different amounts throughout the year as need requires
85	Overtime
86	Proper planning and personal time management. Saying 'no' to things, which I rarely do!
92	MDT collaborations locally, connections with external agents which facilitate education and leadership opportunities, trials running in dept or local uni
93	Working from home
94	Workload management, ability to be dynamic in how I address my various tasks
96	My job plan and objectives from appraisal and discussion with my medical supervisors
99	Requesting allocated time SPA time. Extended working or working from home

18. Since your initial consultant post, have you extended your role / changed working practice? Can you tell us about that?

Response ID	Response
6	Role extension to include additional leadership/management responsibilities irrespective of no additional time
8	Yes extended into gynaecology lead
10	Yes, performing more complex interventional techniques and I am now the Clinical Director of Radiology
11	Just at the end of two years of training (part time), plan to increase complexity over time
12	Added breast MRI reporting
13	Expanded scope of role and responsibility
14	Stayed the same
15	This is my initial consultant post. Prior to this I was working as B8a. I am now involved in screening assessments. I was due to study breast MRI but that was withdrawn
16	Yes - my role in academic leadership has increased significantly as I am a co-lead of a doctoral academy. I also wanted to note in the training section - I did not do a training role (I think mine is the only role of its kind) but I did do training as a PhD - and I'd worked as a research rad for approx. 15 years prior with increasing levels of responsibility in advanced practice, research, education and leadership. This led to the creation of the post
17	Yes. I have extended into paediatric imaging, including SPA evaluation
19	No
20	No
21	No - and this is disappointing, there is no investment in my clinical skills since embarking on this role
22	I have studied breast MR and now also report breast MR in my normal job role. I have reported breast MR for the last 10 years
23	With prescribing I have increased my SOP to allow me to prescribe bisphosphonates so far
24	Yes, completed NMP (non-medical prescribing) qualification and expanded my clinical practice to include anti-cancer drugs
25	Yes, now report breast MRI scans and lead a breast imaging service independent from a consultant radiologist
26	Not yet
28	Still training, but definitely changed working practice from leading a dosimetry team to this much more patient-facing role. Certainly, it represents an extended role in terms of prescribing, non-medical referring, and radiotherapy (IR(ME)R) prescribing

Response ID	Response
29	Moved from breast alone to breast nodes. Completed NMP
30	Yes. Now extended to include complex radiotherapy such as IMN radiotherapy - voluming and plan approval. Also, training up to undertake palliative field placement and prescription for brain and bone
32	As I have developed competence, I have taken on my own clinics and worked independently
33	Expanded team, trained several more reporters, extended scope of practice to take on all aspects of plain films. Apart from NAI cases, we are able to report all films. Hot reporting service. Teaching internationally
37	I have had to continue the work undertaken as a B7 advanced practitioner in one body site and take on another body site alongside existing work. Requirement to be part of more trust-wide boards/working groups, chairing shared decision-making councils
38	Added MRI breast reporting and became director of breast screening
40	No
41	Negotiated cross-sectional reporting skills to support my interventional planning and at the MDT
42	Greater element of consultancy
45	Increased scope of reporting practice - undergrad teaching now included
46	Role has expended to incorporate upper GI work and providing out of hours cover instead of clinical oncologists. I have also become audit lead for the clinical directorate and MSCC clinical lead for the trust
47	No
48	Began PhD study since starting post
49	Yes - increased departmental leadership/line management responsibilities have changed job plan considerably
50	No
51	No, still training
52	Intending to progress further into paediatrics - currently a lot of barriers
53	Yes, I now report neonatal/paediatric chest and abdominal x-rays
54	No
55	Not changed
56	Completed PhD, NIHR-funded. Now in 2 day per week secondment clinical academic research post
57	Not as such. Workload has increased. Pressure to keep up with service needs
61	Now report paediatric chest x-rays. Now do rad-led discharge. Now do HEI teaching as well as trust-based

Response ID	Response
62	Focus has been in team building and securing funding to do that from 6-13 in four years. Also on building PhD academy - so more supervision than hands-on innovation and research
63	No
66	Yes - into US-guided interventions, paediatric MSK ultrasound, training other HCPs in USGI, expert witness work
67	Since the pandemic working practice has needed to change. At our 1-stop clinic, the patients just used to arrive in the department. This is now regulated and the clinician phones the department for the patient to have an allotted time. We still see everyone at the clinic but it's more regulated by us. If we struggle for staff we will only see the patients who have clinical examination of E3 and above - this never happened pre-pandemic. Our afternoon appointments are more controlled too
69	I came into a new consultant post which has evolved over time. There were few guidelines and even less guidance on starting the post. The role has extended to include registrar teaching
70	Working more independently/autonomously
71	No
72	I am developing additional clinical skills that align with my current skillset. I am trying to remodel service pathways to make efficient use of resources and improve patient access, but it's an uphill battle
73	Added radical prostates, was originally palliative only but service needs
74	Have built up to working across whole of patient pathway from referral to follow-up
75	Breast radiology lead responsibilities. Breast MRI reporting
80	I did spend more equal time across all 4 domains of consultant practice. However, due to clinical needs/demands this has changed over time
81	Yes, take more part in MDT and they ask me for advice when Dr not present. Important though for me to set boundaries. Didn't realise how much autonomy that I would be given. Also able to request a vast amount of diagnostic imaging too
82	Yes. As gaining further knowledge and experience, more patients are referred to me for follow-up post treatment
84	Only in terms of treatment complexity, but this is due to change in RT indication rather than my role extending - ie it has had to extend in response to radiotherapy practices evolving
85	Increased clinical responsibilities
86	N/A - still training
87	Progressed to deputy director of large screening service - additional responsibilities associated with role
89	Helping to fill the gaps in the service due to lack of oncologist. Taking on radiotherapy for skin cancer under supervision

Response ID	Response
91	Currently in a trainee consultant post
92	In training - previously in advanced practice role in same field
93	Now have two junior consultant radiographers. Also deputy clinical lead for breast imaging within the trust
94	Yes, I have implemented many service and technical changes departmentally to ensure I still maintain technical and service leadership beyond what was in my original job plan
96	Yes, I have expanded my scope and developed new areas of practice
97	I also work as the director of breast screening for which I was upgraded from B8C to B8D. I am given approx. 1 PA per week for this. I count this work also under the 3 non-clinical arms of consultant practice. I have 1 PA of SPA that tends to be used for self-audit and teaching, etc. I have also undertaken breast MRI reading in the last 2 years
98	Service has now enabled direct and fast management of patients requiring palliative radiotherapy within the area
99	Yes, I have requested dedicated SPA time to enable me to focus on other domains of practice as the clinical aspect constantly dominates and makes it difficult to focus on developing other domains of practice

19. Considering changes to job roles and scope of practice in the last 2 years: Has your local service design changed? Did you learn new skills? Did your focus of work change?

Response ID	Response
6	
8	Yes, biopsy intervention, not as much management
10	I am now performing palliative domiciliary interventional scans as well as significant service redesign as the CD
11	Move towards telephone consultation for follow-ups. This is often preferable for patients as negates need to travel to come in. Pressures on the service have made things more clinically focused
15	The main change for me is involvement in screening assessment clinics. I am still predominantly clinical but would like to broaden my scope into research and education. The main change here is that our lead clinician is now clinical director for radiology which leaves us short-staffed in symptomatic clinics at times. We hope to gain a radiologist in the new year...
16	Yes to all
17	No
19	No
20	No, but I had 25 years of practice and cross-modality clinical practice with intervention skills as well as well-developed education and QI practice before achieving consultant post
21	No - and again this is disappointing
22	No change in service design in the last 2 years
23	Unable to comment as I have been in post 1 year
25	Yes - it is more resilient and I have a slightly more strategic focus
26	N/A, started within this
28	All the above, see answer to previous question. In our department, these are the first ever therapeutic consultant radiographer roles created. I work in a breast cancer specialist role, and my colleague in prostate. Alongside AHP role development, our roles have principally been created to address clinical oncologist recruitment and resource pressures
29	Pathway from referral to treatment streamlined. Probably best placed to do that as a radiographer due to overall knowledge of radiotherapy pathway. But otherwise, no
30	Local service has evolved so that I am lead for breast in my locality. This is due to shortage of clin oncs and our use of locums
32	I have new skills, but the service has not developed a workforce plan to include more consultant radiographers
33	Moved to GP-booked appointments for x-rays from walk-in. Focus moved to emergency work and IPs to aid patient flow and management

Response ID	Response
34	Learnt core biopsy and FNA
35	Increasing demand for symptomatic services. Lack of radiologists who previously did all VAEs, so now I'm training in VAEs (Stereo). Changed localisation method to RFID
36	Yes to both
37	Focus of work is currently seeming to be around the accreditation requirements across professions and trust. Less clinically focused than expected
40	Become more autonomous. Working has changed to a hub system. Working more in teams
41	Yes, created new lists for me. Yes, learnt new skills, focus has shifted from purely US-centred skills
42	Always seeking clinical challenges
43	Learnt more advanced interventional skills
45	Learnt new skills for increased scope of reporting. More focus on research as now PI for two studies
46	Medical staffing pressures meant that I took on upper GI work as back-up to a clinical oncologist as there was only single consultant site cover in that specialism
47	No
48	Started radiographer chest reporting service from scratch in recent previous post (only 2 months appointed in this one!!)
49	No
51	I'm in a new job and trust so can't comment on this
53	I learned new skills to expand the team's remit into paediatrics and built a business case to expand the team
54	Covid restrictions meant more focus on clinical workload due to staff absences. Not back where we need to be yet, developing treatment planning partial breast/depth dose SCF cals due to workload stresses within treatment and planning
56	Research skills developed through PhD. Focus of work - more strategic, overview of 4 domains, possible due to backfill with band 8a
57	No
61	No changes
62	No. Some. Yes
63	No
66	I have retired from my original post but maintain a bank contract at the hospital and university. I have maintained my training workload by working independently

Response ID	Response
67	We used to spend a considerable amount of our time each morning inserting wires for breast patients going to theatre. This has now been replaced with Magseeds/Savi Scouts. Requests for imaging are now closely vetted - follow-up appointments. Depending on the procedure/request will require a different number of slots. The through-put of patients is now more closely monitored and regulated
69	No
71	Covid has impacted practice
72	No obvious change in service design for years that I can see. I've learnt new skills and am always looking for opportunity to develop clinically. I have, however, learnt that a work-life balance is necessary to avoid burnout
74	Focus of work has stayed the same but have gained new skills, eg clinical assessment, independent prescribing as well as planning using dosimetry to develop the role further and improve techniques used
75	N/A
80	I am required to mentor trainee advanced practitioners plus fill the gaps of radiologist and advanced practitioner annual leave, sickness and maternity leave
81	Have learnt so many new skills, breast examination and NMP. A lot of my work is focused clinically and I have begun to educate the team and others in the trust. Feel like a guinea pig at times as others outside the dept may not know my job role. MDT have seen the difference my post has made so I guess that has changed things
82	Yes. Learning new skills and gaining further knowledge has enabled me to undertake more patient reviews post treatment
84	Local service design has not really changed. However, being involved in research and doing a PhD part time has developed not only my research skills, but also those of prioritisation of workload, resilience, networking etc
86	In the last two years there has been a huge expansion in the role of advanced practice. We now have eight advanced practitioners and the number of consultant rads has risen from one to four
87	Clinical aspect of role unchanged. New technologies have resulted in additional learning and implementing of new pathways
91	Retirement of consultant radiologist. Additional trainee consultant post put in place until consultant returned until qualified. No longer have a manager that has a heavy clinical load - this has now been separated into the consultant trainee post
92	New skills - to encompass consent, Px and planning and follow-up to change AP to CTR. Focus of work - streamlined to cover less palliative patients for period during training, purposeful focus on non-clinical domains to fulfil role
93	Introduction of new techniques - Magseed and Magtrace. Preparatory work for CESM. Remodelling of 2WW service
94	Yes it has. I have tried to be ahead of the curve and ensure the service is proactive in its changes rather than reactive. So continuous development and strategic leadership is a prime directive from my perception

Response ID	Response
96	Learnt new skills through additional training courses and completing my MSc
98	Our biggest change has been an expansion in the number of clinics to meet with demand
99	No

20. Finally, any other comments or information you'd like to add? Any areas not covered or impact of your role?

Response ID	Response
6	Ability for work from home and flexible working following Covid pandemic has been really beneficial. Continues to be a lack of understanding of job roles and banding
10	My clinical and leadership skills developed as a consultant sonographer have enabled me to have the basic skills to become the clinical director of radiology
11	Unfortunately funding is an issue locally. Ideally I would like to be full time (job warrants it). Lack of routes to becoming a consultant means that it is often a large jump from advanced to consultant practice
15	I do really enjoy my clinical work and patient-facing care, but I am keen to develop my role into more of the broader sense of a consultant. Time/staff have an impact on this though
20	Variability and differences in interpretation of CP roles in radiography remain a barrier where there is continued local bias on what these roles should be and the education pathways that should underpin their development. Nationally recognised roles with a clear expectation of core skills and defined area of practice still feel a long way off
21	I feel once one attains this level of working, one is seldom invested in with regards to their clinical skillset
22	I am concerned that as the years pass other professionals in the NHS do not see the consultant radiographer role in the same way as it was formed 20 years ago. With almost every new manager/doctor they have to be educated as per my role. It is becoming tedious having to explain myself and then to find that some resent the role. I know of one retired consultant radiographer who has been replaced with a radiologist and have concerns that we may have been employed to fill a gap in the radiologist workforce which may now lead to a decrease in the consultant radiographer role
28	I was an 8a in my previous role and have stayed at that level for this trainee period. Upon accreditation, this banding will change to 8b. I think the role is having a positive impact, but it's a very steep learning curve with a heavy education/training burden as I have said. If accreditation is achieved, I think productivity will increase greatly and repay the trust's investment admirably
33	Staff retention a huge issue and impacts my role
35	Frustrating being stuck in an 8a training role while waiting to finish MSc (Covid delays). Also disparity in pay between trusts: previous colleagues get 8c although only do clinical and not other pillars. Not being able to do overtime as 8s not eligible. Dept trying to get staff to work Saturdays as extra to meet demand, and I'm willing but unable to be paid anything other than basic rate. (Sorry - general moan, not really relevant!)
36	No local pathways, creating a chaotic period of training
37	Limited number of AHP roles vs nurses seems to create a lot of issues within trust. A lot of guidance set out for nurses which doesn't apply to other AHP roles. Either we have to 'fit in' to their practices or end up designing a whole new system. Eagerly awaiting the SoR guidance/accreditation for consultant practice

Response ID	Response
42	I was the fifth consultant sonographer ever to be appointed. I did not have a training post but had spent many years developing my skills myself and completing an MSc in preparation. I was appointed at 8b and this has not changed since appointment. It would be interesting to see what the average consultant post banding is nowadays
46	My role has potential to improve care countywide. The barrier to this is NHS bureaucracy and in particular, senior nursing trying to block change/progress
48	Feel that teaching, education and support seem very neglected in this role but I feel they are highly important. Previous consultant radiographer in this post literally did no teaching for staff (radiography or medical/ENPS etc) in the last 10 years!
51	For my path I would say a more tailor-made training for consultancy post to incorporate the four domains would be my recommendation. I have completed a full Master's and 1 module extra to fulfil my training! A lot of academia and feel a module or contribution towards consultancy leadership would prepare for the job role better, with this being included as part of a dedicated Master's designed specifically for trainee consultant radiographer pathway
53	Unfortunately I did feel that my role at my previous employer had little to no impact. I was reporting 100% of the time towards the end and any changes we did try to implement were pushed back due to clinical staff needs. In the end I felt that it was in my own best interest to step away as I wasn't able to do the job that I wanted to do, nor did I feel appreciated in the role
57	Role of the consultant radiographer is not valued and recognised within most trusts. Recent job review scored less points than a review undertaken in 2012, despite a major overhaul to the job description with increased responsibility in all factors. The same job could be considered an 8c at a nearby trust. Lack of support and understanding from AP and AHP leads. The constant feeling of needing to justify the job and role despite the expectation to work at the radiologist level
62	Am duo-registered therapeutic and diagnostic - that was not an option. My research works across both domains
63	No
67	Staffing and lack of it is a HUGE barrier for me being able to make the most of my consultant role
69	Introduction of national standards and guidelines would be helpful, as would affiliation and recognition from a governing body, eg RCR
72	I'd really like to see a consultant/trainee consultant study day/meeting to bounce ideas off others, and appreciate how others work
81	When I got my post I had to wait a number of months for my current post to be back-filled. Felt the pressure to start my consultant training and still do my old post until it was filled. Realised that my health is important too and so easy to burn out

Response ID	Response
84	Being an established consultant who came into post when there was no framework can sometimes be intimidating and give feelings of inadequacy when we observe other trainees coming through with the protection of a teaching and assessment framework. Going back and fulfilling these requirements (eg doing the ACP) is impossible and not required, but I think we value reassurance from the SCoR that as 'trail blazers' we made the best of the non-formal learning opportunities that were available, and are suitably recognised as competent practising consultant radiographers despite the lack of formal prospective training. The validation process is important for this but has been paused for quite a while, and will be great when it is fully relaunched
86	I have recently become a consultant trainee and the recent SCoR consultant guidance with 'model' job descriptions was very useful in planning my work. Thank you!
92	Selection of training courses limited. Lack of definitive clear guidance about governance and legal aspects of role. Improved information about expectations of education for those starting CTR but for those in 'link-grade', ie have provided AP services for many years, unclear about exact path
93	None
94	Even though one may be a consultant in a specific site, it should not be underestimated how much of other areas one must also be au fait with - cutting-edge techniques and research relevant to your role. Sometimes in the trainee area this is often neglected
99	This is a rewarding but stressful role. I like being a part of the patient's journey but constantly worry that the clinical workload impacts on other domains of practice

Conclusion

The descriptive survey results and consultant radiographer experiences should be used when developing trainee consultant and consultant radiographer roles, for example writing business cases and developing job plans. The data can inform succession planning and planning for substantive posts, and to plan training and development for trainee consultant and consultant radiographers and clinical imaging and therapeutic radiography workforces. The ongoing survey work of CRAG is intended to guide approaches to meet service demand in the future. In addition to the use of survey evidence for those purposes, there is also advice available for professionals from the SoR CRAG: Consultant Radiographer Advisory Group | Society of Radiographers

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THE SOCIETY OF RADIOGRAPHERS