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Advanced and extended scope practice of radiographers: The Scottish perspective



I. Henderson ^{a, *}, S.A. Mathers ^{a, b}, J. McConnell ^{a, c}, D. Minnoch ^a

^a School of Health Sciences, Robert Gordon University, Garthdee Road, Aberdeen, AB10 7QG, UK

^b NHS Grampian Health Board, Aberdeen, AB24 2ZN, UK

^c Department of Radiology, Queen Elizabeth University Hospital, Glasgow, G51 4TF, UK

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ABSTRACT

Purpose: The impact of changing roles, skill mix and a shortage of consultant radiologists on the profession of diagnostic radiography is not clearly understood in Scotland although the anecdotal perspective suggests the situation in many areas does not equate to that of England. *Method:* A questionnaire survey was administered to 'lead diagnostic radiographers' across all Health

Boards in Scotland and this was supplemented with telephone interviews.

Results: The implementation of skill mix initiatives and particularly advanced/extended scope practice was found to be geographically variable with limited evidence of change in some areas. Lack of effective funding and backfill for training was found to be a major barrier to change, although it was also acknowledged that opposition from some professional groups could be a major factor.

Conclusion: Although there is some optimism and evidence of accelerating change, development of the radiographic workforce in Scotland does not in general compare favourably to the findings of Price et al., in 2007. The reasons are multi-factorial including fiscal, professional and geographical elements.

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Introduction

Healthcare imperatives in Scotland align with the rest of the UK in terms of demographic change and the challenges of achieving cost effectiveness. Health policy in Scotland is fully devolved from the rest of the UK, therefore the evolution of practice generally and diagnostic radiographic practice specifically, cannot be assumed to mirror that of England.

Evolution of radiographic practice has been a consistent feature of the profession historically, with examples and documented commentary appearing at least 50 years ago, influenced by a range of factors.^{1–5} Skill mix and role changes are prominent features of health policy development^{6–8} and despite evidence of service enhancement,^{9–12} such change has led to a patchy and often incoherent implementation, based as often on professional preference or opposition, than service need or evidence.^{13–17} Workforce development and allocation of resources in Scotland, has resulted in a notably different environment.^{18–20}

* Corresponding author. Tel.: +44 01224263362. E-mail address: p.i.henderson@rgu.ac.uk (I. Henderson). Relevant literature is predominantly UK wide with limited Scotland specific data. Notably however, McKenzie et al., exploring radiographer performed barium enemas, reported low rates of participation in Scotland.²¹ In 2002, Price et al.²² again identified comparatively low participation rates in a study of 'the extent and scope of changes to radiography practice'. More recently, lower participation rates were identified in Scotland^{13,23} where seven (out of twelve) Health Boards in Scotland had radiographers undertaking diagnostic image reporting, compared with ten (out of ten) English regions.

A scoping exercise was undertaken to initiate a Scottish evidence base, inform service development and provide a comparator with other health systems.

Aims

- Profile extended or advanced scope practice in diagnostic radiography across Scotland.
- Identify strategic and demographic features influencing the development of radiographer roles.
- Identify features or barriers that impact on development of radiographer roles.

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Method

Job specific questionnaires were distributed to: 1). Lead radiographers identified as having an operational management role within each imaging department throughout Scotland. For the purposes of this study, a lead radiographer is defined as a 'superintendent' or manager with operational responsibility for a service. They were contacted by title and the covering letter carried contextual information to confirm the correct recipient and enable identification of situations where they carried responsibility for more than one department thus avoiding duplicated returns. 2). Strategic managers with overarching Health Board responsibility for an imaging service. Strategic managers were identified by name through direct contact with Health Boards. There were two phases; a quantitative questionnaire survey and qualitative semi-structured telephone interviews.

Phase 1: A questionnaire was administered to participants throughout Scotland between July and November 2013. Elements of the questionnaire were designed with regard to the work of Price et al.¹³ in order to facilitate possible future comparability and commonality of terms. The questions comprised a selection of closed and semi-structured questions providing quantitative data supported by contextual comment. Piloting was carried out by a group of lead radiographers in England. Questionnaires were distributed by post in recognition of variable IT arrangements on clinical sites. The questionnaire included a link to a web based electronic version for those who preferred to respond in this way.

The sample included NHS acute and community hospitals (n = 103) and private hospitals (n = 8). Questionnaire included a coded reference with unique identifier.

Phase 2: All stage 1 participants were invited to take part in a semi-structured telephone interview to explore questionnaire responses in more detail. In total, eight participants (3 Urban and 5 Remote and Rural) agreed to take part and they were all subsequently interviewed. An interview schedule was developed based on key issues arising from the questionnaire responses.^{24,25} These were implementation of advanced practice; conceptualising skill mix; national health strategy; staff training; terms and conditions and looking to the future. Participants were provided with a transcript of their interview to confirm accuracy of the content.

Ethical implications

For a study of this type, NHS REC approval was not required for research involving NHS staff, however as this was a multi-centred study, R&D approval was required from each site taking part. This was obtained through the Scottish Network of Clinical Effectiveness Managers. Additionally, the study was approved by the Robert Gordon University Research and Enterprise Services, Ethics Subcommittee.

Data analysis

Structural and procedural data only from the study is considered in the following analysis.

Phase 1: Quantitative analysis was primarily descriptive and presented in tabular form. Fisher's Exact Test was however used to compare the presence of advanced practice in urban with remote and rural hospitals (P < 0.05). The data were managed and analysed using SPSS[®] v21.

Phase 2: The recorded interviews were transcribed and anonymised. The data analysis was based on the fivefold process recommended by Pope et al.²⁶; 1) familiarisation; 2) identifying a thematic framework; 3) indexing; 4) charting and mapping; and 5) interpretation

Results

Questionnaires were distributed to lead radiographers in hospitals throughout Scotland (N = 111). There were returns from a total of 42 hospitals. Forty of the questionnaires (21 urban and 19 rural) were completed, providing a disappointing, though usable response rate of 36% (n = 40/111). To encourage response, reminders were sent out on two occasions and the deadline was extended for two weeks. Twelve of the fourteen Health Board areas were represented in the responses.

Practice areas

Breakdown of radiographers with staff gradings and working profiles are given in Table 1. Notable points are: 6.5% of practitioner posts are graded in band 7; 17% of advanced practitioner posts are in band 6.

Radiographer roles

A total of 226 radiographers carried out an abnormality highlighting system with 24 participating in an abnormality commenting system. Nine radiographers were described as carrying out hot reporting of Accident and Emergency images (A&E), and 21 carried out cold reporting. Other roles carried out are shown in Table 2.

Diagnostic ultrasound

Sonographers are defined here as radiographers holding a postgraduate qualification in ultrasound. Areas in which sonographers provide a service and their reporting procedures in Table 3. Sonographers predominantly report independently of radiologists, although there are instances of double checking and check box type procedures.

Ultrasound was widely described as an established area of advanced practice for radiographers. 'Ultrasound only, that's been recognised', (21,RR), with funding available 'for ultrasound University based courses and work place training (20,U).

Onward referral

Fourteen sites stated that sonographers referred patients for further imaging, mainly following abdominal ultrasound. In six sites radiographers could refer patients for DEXA scanning following skeletal trauma.

Reporting by radiographers

Data collected related to radiographers with a formal postgraduate qualification, indicating areas of reporting carried out, whether they produced reports independent of radiologists (Table 4), and the reported percentage of total reporting workload

Table 1

Radiographer numbers and pay gradings as described by respondents (n = 40).

Role title/level		AfC banding							
		3	4	5	6	7	8a	8b	8c
Practitioner/radiographer	P/T			25	133	12	1		
	F/T			39	103	9	1	1	
Advanced practitioner	P/T				5	18	1		
	F/T				6	28	6		
Consultant practitioner	P/T								
	F/T							1	

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