Team working within clinical imaging

A contemporary view of skills mix

THE SOCIETY AND COLLEGE OF RADIOGRAPHERS

Joint guidance from
The Royal College of Radiologists
and
The Society and College
of Radiographers

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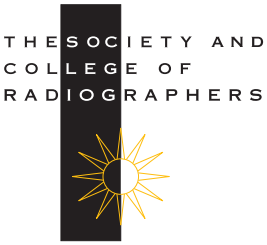

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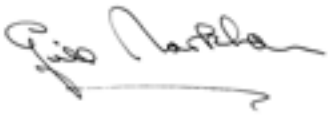
Foreword

This document aims to identify and disseminate examples of good skills mix practice within a sound and robust clinical governance framework. There is also clarification of delegation, transference of care and supervised roles. Whilst the Colleges acknowledge diverse views on skills mix amongst their Fellows and Members, we feel it is essential to give guidance on good, safe practice across a range of skills and expertise.

With the realignment of clinical practice in many fields of medicine, a significant number of which involve imaging, it is vital that clinical imaging departments work together in well defined teams, normally led by a consultant clinical radiologist who is able to bring a broad clinical overview using the benefit of a full clinical and radiological medical perspective.

This document takes into account previously published guidance from both The Royal College of Radiologists (RCR) and the Society and College of Radiographers (SCoR) relating to standards of practice, as appropriate. It is recognised that radiological service delivery will continue to evolve and both organisations will reflect this in their future work, jointly and separately.

We thank the working group for their focused and constructive contribution.



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1. Preamble

1.1 Skills mix in healthcare delivery is the efficient use of the knowledge and skills of all staff groups to provide quality, cost effective care in a timely manner. For clinical radiology services, this means the effective utilisation of all staff members employed to provide these services. This is limited only by the need to ensure staff are educated and trained to provide an excellent clinical service with patient safety as a fundamental given.

1.2 The Royal College of Radiologists (RCR) and the Society and College of Radiographers (SCoR) believe that appropriately constructed skills mix initiatives will benefit patients and their care by ensuring scarce workforce resource is appropriately focused. It will provide some staff with enhanced job satisfaction and improve service provision and delivery overall.

1.3 Clinical radiology is central to the delivery of healthcare, fundamental to almost all patient care pathways at all levels of care. The UK governments have identified diagnostic services as a priority area for further development in order to deliver waiting time targets by improving access to diagnostic procedures and subsequent treatment. A workforce crisis was identified within clinical radiology[1] both in the NHS in England and in NHSScotland. Similarly, there has been a chronic shortage of radiographers with poor recruitment into the profession over a number of years. Retention of qualified radiographers has also been lacking, with limited career structure and lack of opportunity for development cited as a reason[2].

1.4 These factors and the many recent developments, both clinical and political, inform this review and dictate the need for fresh guidance on skills mix and role development jointly agreed by the Colleges.

2. Introduction

2.1 Consultant clinical radiologists and radiographers have been in the vanguard of skills mix implementation internationally and the graduate status of radiography education in the UK has given the opportunity for structured career progression. Over the past three decades, consultant clinical radiologists have progressed development of increasingly complex investigations. Radiographers have developed skills in a number of different areas including ultrasound and accident and emergency services[3,4]. More recently, assistant practitioner roles in radiography have been developed taking on some of the more routine tasks of radiographers. An example of this is in breast screening where expertise has been developed in standard mammography projections in many localities.

2.2 A number of factors have contributed to increasing demand, and skills mix initiatives have helped meet that demand on clinical radiology services. These include:

2.2.1 An ever increasing volume of examinations, together with a more extensive range of procedures. Requests for magnetic resonance imaging (MRI) examinations and computed tomography (CT) examinations have risen at a rate of 15 per cent or more per annum in recent years, putting pressure on service provision.

2.2.2 Demand for more rapid access to diagnostic services to reduce waiting times. In 2002 the Audit Commission reported that, at any one time, 500,000 individuals were waiting for imaging services, and waits for some investigations were in excess of six months[5]. Although recent initiatives have improved waiting lists, pressure on clinical imaging services continues.

2.2.3 The need for more rapid turn-around times of examination reports to expedite the contribution of the imaging examination to subsequent patient management remains.

2.3 Additional contributing factors include:

2.3.1 The current UK shortage of consultant clinical radiologists;

2.3.2 Technological developments; for example, digital imaging and image transmission;

2.3.3 Multidisciplinary team working placing demands on both consultant clinical radiologist and radiographer time;

2.3.4 The advent of progressively better informed patients, with enhanced expectations;

2.3.5 The need to retain and expand the radiography and allied health professional workforce through structured and enhanced career progression opportunities.

2.4 In response, these drivers have resulted in a need to make best use of available skills whilst maintaining standards. Skills mix and role development within departments of clinical radiology have tended to be pragmatic, opportunistic and driven by local champions. This has generally resulted in enhanced local provision of service but without necessarily assuring accreditation and transferability of the extended roles and skills.

2.5 Additionally, waiting times targets have been defined in each of the UK healthcare systems. These will drive demand for a coherent national approach to skills mix and role development in clinical radiology services. It is therefore timely for the SCoR and the RCR to produce joint skills mix guidance.

2.6 Throughout the healthcare sector there is ongoing review of service provision and the workforce profile required to deliver the service in the context of new and extended roles. While consultant clinical radiologists and radiographers continue to work together, they also work closely with other medical colleagues including those in primary care; and with nursing and other professional colleagues; for example, physiotherapists and midwives.

2.7 A number of government policies and publications have given structure to these developments by recognising the potential richness of the workforce and also by seeking to provide greater professional recognition.

2.8 The governments of the four UK countries and both Colleges recognise skills mix and role developments are essential components of future clinical radiology services provision. Hence, joint authoritative guidance from the Colleges and a national framework for implementing skills mix in clinical radiology services is timely. Whilst the focus of this document is predominantly aimed at consultant clinical radiologists, radiographers and the radiography workforce, much of the guidance is applicable to other staff groups; for example, nurses working within clinical radiology services. Using this guidance, it is anticipated that departments of clinical radiology can continue to make best use of their staff. Most importantly, however, this guidance will ensure that the skills developed by staff locally are recognised, accredited and are transferable nationally.

3. A framework for implementing skills mix in clinical radiology departments

3.1 *Effective and efficient service delivery*

The RCR and the SCoR recognise the important contribution to effective and efficient service delivery of skills mix and role development initiatives. Both Colleges believe that a national framework for skills mix in clinical radiology services requires robust mechanisms in place to enable development of appropriate, effective and safe practice that bears rigorous scrutiny and evaluation. Accordingly, both Colleges have agreed the following principles to underpin all skills mix developments.

3.2 *Patient benefit*

Skills mix initiatives should be undertaken with the clear understanding that service development or enhancement, for the benefit of patients, is the objective[6]. This should be the primary goal underlying the design and implementation of all skills mix initiatives with the fundamental aim of patient safety. Recognising the ability to deliver timely diagnostic services to a larger population will also provide benefit to the patient.

3.3 *Strategic context*

3.3.1 Skills mix developments need to be set within a coherent strategic vision for the clinical radiology service within the locality. A clear understanding of the deployment, education and training of practitioners at all levels, together with the associated resource implications is needed. This requires a 'whole system' review of evolving service needs and planning for succession as individuals move to new or other roles. This must be built around a team approach to service delivery and communication.

3.3.2 Resilience of service development is best achieved through formal development plans informed by needs assessment. This should review the workforce needs for the service taking into account the extended role possibilities and the requirement for education and training to construct and maintain these in the context of teamworking and patient safety. This allows planning and enables continuity of service when staff, medical or non-medical, move on.

3.4 *Education and training*

3.4.1 An appropriate education and training framework is required to establish extended roles, and the importance of Higher Education Institutions, to work in partnership with the professional bodies and the service to develop appropriate formal training and qualifications is recognised.

3.4.2 Both the RCR and the SCoR have their own national frameworks of accreditation for education which, separately, set the standards for the education and training of the two professions. It is expected that radiographers undertaking extended roles will have successfully completed the necessary underpinning education and training as determined and accredited by the SCoR.

3.4.3 Education and training necessary to support particular skills mix initiatives should be established at the development stage, using education and training needs analysis and adhering to the principles enshrined in the NHS Knowledge and Skills Framework. Training needs analysis must ensure that appropriate standards of practice are developed, referring to national guidance by the two Colleges wherever available. The education and training provided must ensure that the necessary standards will be achieved, and must be accessible to those requiring to be trained. Education and training provision together with accreditation will enable transferability of the developed skills, ensuring that the individuals undergoing development can use their skills elsewhere in the NHS. This aligns with the Colleges' shared vision that staff who develop their skills within a local context should acquire skills that are valued nationally and are transferable. It also accords with the wider NHS policy on development of its workforce.

3.4.4 The SCoR maintains procedures to approve education and training, and accredits practitioners in accordance with the level identified in its career progression framework[7]. These procedures ensure that there is national consistency to national standards so facilitating transferability across the UK. It is, therefore, important that adherence to the SCoR's approval and accreditation procedures is maintained.

3.5 *Continuing Medical Education/Continuing Professional Development*

3.5.1 Implementation of skills mix initiatives requires continuing medical education (CME) and continuing professional development (CPD) arrangements to be agreed, implemented and documented. This allows maintenance of competencies, further development, and acquisition of knowledge and skills relevant to enhancing patient care and service delivery to be documented. This must be consistent with the requirements of the General Medical Council (GMC) and the Health Professions Council (HPC), and in accordance with the policies and guidance of both Colleges.

3.5.2 All staff within departments of clinical radiology must undergo an annual development review to ensure a personal development programme is in place with identification of further role development and educational needs. At the same time, performance review should identify any area of concern and deficiency in performance, and additional training needs and performance objective requirements required to rectify these.

3.5.3 At the time of writing, the GMC and the Department of Health, together with the Medical Royal Colleges, are developing guidance for registered medical practitioners to ensure continued fitness to practise. The nature of the process of revalidation for the medical register is, as yet, undecided but is likely to require demonstration of continued competence.

3.5.4 Similarly, the HPC has developed standards for CPD and, with effect from July 2006, requires registered healthcare professionals to evidence their development and show that it is relevant to their current and future practice, as well as contributing to the quality of practice and service delivery.

3.6 *Clinical governance*

Comprehensive systems must be in place to assure clinical governance standards in the multidisciplinary context. All participants in skills mix and role development initiatives must understand their own particular roles and lines of accountability. This would usefully be explicit in documented, locally agreed arrangements. An appropriate system of clinical supervision[8–11] should be in place. This should be encompassed within an appropriate local governance framework. It is expected that this will include effective systems for on-going audit, arrangements for regular reviews of practice, and formal critical incident and error reviews. The locally agreed governance arrangements need to be in the context of employer-wide, general clinical governance arrangements and take account of relevant policy and guidance from the RCR and the SCoR.

3.7 *Legal framework*

Agreements and local policies promoting skills mix developments must identify the legal and ethical framework within which practice will operate. Professional relationships, lines of accountability, and transparent systems for delegation, transference and referral should be identified[12]. Explicit, documented detail of extended roles and responsibilities is required in each locality.

4. Referrals, transference and delegation of care

4.1 In order that medico-legal issues are not a barrier to implementation, the following guidance is given in relation to responsibilities. This represents the joint understanding of the RCR and the SCoR and is based on the guidance provided by the GMC[13].

4.2 Referrals for clinical radiology services can be made by medical practitioners or by a wide variety of other registered healthcare practitioners. The range of healthcare practitioners referring patients for such services is likely to grow in the future, so clarity in respect of arrangements is essential.

4.3 The GMC defines two situations in which a medical practitioner may request that another practitioner contributes to the care of a patient[13]. There is no equivalent definition or statement from the HPC or the Nursing and Midwifery Council.

4.4 Referral of a patient to a department of clinical radiology is a referral for an expert opinion that will assist the referring practitioner to manage and direct the subsequent care pathway for the referred patient. A referral to a department of clinical radiology will result in the transference of care of the referred patient for the duration of that patient's examination or procedure[13].

4.5 In terms of the GMC guidance[13], transference of care from one registered medical practitioner to another transfers responsibility for care for the duration of the transference. Where there is transference of care to other healthcare workers, the referring registered medical practitioner retains responsibility for the medical management of the patient. However, they cannot, in law, maintain responsibility for the competent execution of the investigations or procedures for which the patient was referred[8,12].

4.6 A request for an imaging examination is normally asking for a medical opinion. Consultant clinical radiologists receiving requests may delegate these to individual radiographers and do so in accordance with the guidance from the GMC[13] in that they retain responsibility for the medical management of the patient. They should be satisfied that the radiographer to whom the examination is delegated is competent. Rather than an individual decision, this should be confirmed through reference to arrangements that should be specified in the department in order to ensure clarity and facilitate working arrangements (as outlined in paragraph 3.6) on Clinical Governance. In these circumstances, the radiographer to whom the examination is delegated is **legally and professionally accountable** for the competent execution of the procedure, interpretation of the outcome, and communication of these to the delegating consultant clinical radiologist and/or the referrer. Working practice should be subject to local negotiation and agreement, with clarity of definition and common understanding. This should be documented.

4.7 For many examinations, including plain radiographic studies and ultrasound investigations, reporting radiographers/sonographers can receive, implement and complete referral examinations directly. However, delivery of these tasks must have been delegated and agreed in writing by the Lead Consultant Clinical Radiologist. The GMC guidance on transfer of care will apply.

4.8 Skills mix initiatives may also include accredited assistant practitioners in radiography who are appointed to a supervised role to carry out specific radiographic tasks under the supervision of a registered radiographer. In these circumstances, the radiographer is accountable for appropriate supervision of the assistant. The assistant is responsible for executing the specific tasks competently. This applies similarly in situations where an assistant is working under the supervision of a registered medical practitioner or a registered nurse. **There is no delegation or transference of care to assistant practitioners. These are supervised roles.**

5. Teams and roles within teams

5.1 The concept of team working is well established within healthcare and other professions. Team working confers benefits for the individual and the organisation as a whole.

5.2 Respect for each other's competencies and understanding of the skill and knowledge sets of the whole team make best use of each team member. Conversely, it is important that individuals recognise their own professional limitations and that of the various team members. Successful teams exhibit the following characteristics:

5.2.1 Shared and explicit objectives;

5.2.2 A range of skills and the ability to facilitate skill transfer between individuals within the teams;

5.2.3 A common understanding of the strengths and weaknesses of the members of the team;

5.2.4 An ability to appreciate, and respond to external pressures and demands;

5.2.5 The capacity to evolve and adapt over time;

5.2.6 The involvement of members in problem solving and decision making;

5.2.7 An effective communication structure, safeguarding individual members by providing a reference framework within which to act.

5.3 Traditionally, decisions regarding the medical management of patients have been made by doctors. However, not all such decisions are taken by doctors only, with many now taken in consultation with the patient by teams or individuals (non-medical) within the team, in line with agreed protocols.

5.4 As individuals take on less traditional roles they need to understand the importance of working within teams. No individual should work in isolation. It is essential that there is appropriately accredited medical clinical supervision[9] in the context of the multidisciplinary team, and recognition of both a clinical and professional governance framework with continued professional development, appraisal and professional support. It is recognised that with image transmission this may involve rotation of personnel or remote support on occasions.

6. Individual responsibilities

6.1 *Responsibilities of the non-medical practitioner*

6.1.1 It is explicit in the *Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (2000)*[14] that operators and practitioners as defined in the regulations are appropriately trained. It follows that appropriate training must have been undertaken before an individual performs any delegated role, duty or task, and that the training is documented. Similarly, those carrying out specific tasks under supervision must have undertaken adequate and proper training.

6.1.2 With skills mix and role development initiatives, radiographers will, as with medical practitioners, need to develop enhanced knowledge and skills to enable them to carry out their extended roles effectively and safely. They must ensure that they undertake adequate initial education and training necessary to achieve this, as well as on-going professional development.

6.1.3 Participation in clinical audit and other good practice procedures is essential to ensure that standards are maintained.

6.1.4 Where individuals are undertaking delegated roles, duties or tasks, these should be performed in accordance with a scheme of work and protocols agreed jointly by the delegator and the individual to whom the work is delegated. It is particularly important that such schemes of work are reviewed at least annually and both delegators and those delegatees should be responsible for ensuring that schemes of work are current and adequately reflect the roles, duties and tasks being undertaken.

6.1.5 Practitioners must recognise that responsibility for the proper undertaking of delegated roles, duties and tasks is the responsibility of the delegatee. This responsibility is shared with the delegator only in so far as the delegator must be assured that the delegatee has been appropriately trained and has the necessary knowledge and skills.

6.1.6 **Individual practitioners need to understand that they are legally accountable for their own actions and may be deemed negligent if they fail to demonstrate due care and diligence in performing their duties, including any delegated duties. Acting within a clinical team does not absolve any individual of personal responsibility and accountability in law.**

6.1.7 All practitioners, medical and non-medical, must be aware of their own limitations and never act beyond the level of their professional competence.

6.1.8 Should reports by non-medical practitioners contain medical advice and interpretation, this must be subject to a protocol agreed by the relevant team of consultant clinical radiologists, radiographers and others as appropriate.

6.1.9 Practitioners are advised to be members of an organisation which can provide professional and legal advice as well as indemnity insurance. They are further advised to ensure that their job descriptions are kept up to date and include all aspects of their extended roles.

6.2 *Responsibilities of the medical practitioner*

6.2.1 **Consultant clinical radiologists are the key personnel for the provision of radiological opinions (in both the secondary and primary care sectors). Consultant clinical radiologists have the breadth of training and depth of knowledge to provide flexible, high quality clinical services.**

6.2.2 Consequently, compliance with GMC guidelines on referrals, transference of care and delegation[13] is essential.

6.2.3 Clinical roles, duties and tasks can be transferred to another appropriately qualified and registered healthcare professional provided that he or she is deemed to be competent. It is the responsibility of the delegator to be satisfied in this regard. Competence includes an understanding of the risks and benefits of procedures as laid down in *IR(ME)R (2000)*[14].

6.2.4 It is also important to recognise that the medical management and care of the patient is retained by the delegator and is in accordance with GMC guidance[13].

6.2.5 Consultant clinical radiologists may refer patients for particular purposes such as an additional investigation, or care and treatment that falls outside of his/her competence. Such referral may be to another registered medical practitioner or to another registered healthcare professional. Again GMC guidance applies[13]. Care is transferred completely for the duration of the referral when this is to another registered medical practitioner. However, the medical responsibility for the patient is retained when referral is made to a non-medical practitioner.

6.2.6 Delegated roles, duties and tasks should be clearly defined and schemes of work agreed. Supervision arrangements need to be stated clearly in the schemes of work, and adhered to.

6.2.7 Schemes of work, including supervision arrangements, must be reviewed and updated at least annually. Schemes of work need explicit agreement and understanding of all the medical and non-medical practitioners to whom they relate.

6.3 *Responsibilities of the employing organisation*

6.3.1 It is recognised that local healthcare arrangements will result in the responsibilities being discharged in a variety of different ways depending on local arrangements.

6.3.2 Employers must provide mutually agreed and approved initial and continuing education, training and competence assessment, including the necessary competence assessment to support skills mix and role development initiatives. Such education and training must be appropriately accredited and, wherever possible, transferable.

6.3.3 They should ensure that there are appropriate supervision and clinical governance frameworks in place to support skills mix and role development initiatives[8–11].

6.3.4 Employers must agree and document skills mix and role developments at the local level and accept vicarious liability for staff undertaking new roles, duties and tasks. Employers must maintain clear, accurate records of employees who are trained and deemed competent to carry out extended roles, including the nature of the roles, duties and tasks involved. Such records should be readily available to all relevant staff affected by the skills mix and role development initiative, for example, lead consultant clinical radiologists, radiology services managers and the staff to whom the records relate and refer.

6.3.5 Employers must ensure that job descriptions are updated regularly and reflect the extended roles of employees.

6.3.6 Similarly, employers must ensure that schemes of work and protocols informing and governing skills mix and role development initiatives are reviewed at least annually, with changes agreed by all those affected.

6.3.7 Processes should be in place to ensure that those undertaking new roles, duties and tasks are doing so appropriately with patient safety being fundamental.

6.3.8 Patients should be informed of the procedures they are undergoing and the staff undertaking them. Where new roles, duties and tasks are introduced, it is important to reassure patients that the staff involved have the relevant training and experience, and have been accredited as competent to carry out the work.

7. Conclusion

7.1 The RCR and the SCoR issue this joint guidance in order to support appropriate skills mix and role development in the context of robust professional regulation, patient safety and clinical governance. Both Colleges acknowledge the importance of robust teamworking with clear documented lines of responsibility and accountability for an optimum skills mix and role development framework.

7.2 This guidance recognises the need to implement skills mix and role development initiatives to support major changes in the professions. Such major changes are required for the service to evolve to deliver appropriate examinations and timely reports in the context of modern patient management.

7.3 The aim of this joint guidance is to provide a framework for implementation of skills mix and role development to support the major changes which healthcare services in general and diagnostic services in particular are currently facing. The guidance is fully congruent with the current developments in relation to non-medical terms and conditions and arrangements for career and skills progression. Change in the model of service provision will be necessary to meet the challenge of appropriate and timely diagnostic examinations, together with prompt availability of a report delivered to the highest standard. This will secure sustainability of service provision through effective evolution, and continue to develop the role of clinical radiology in patient management.

January 2007

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