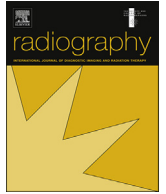




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Advanced and extended scope practice of diagnostic radiographers in Scotland: Exploring strategic imaging service imperatives

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

^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

Introduction: The development of diagnostic imaging services manifests features specific to the Scottish environment, in particular development of the radiographic workforce through implementing skills mix and role developments to enhance outcomes for patients. A component of a College of Radiographers Industry Partnership Scheme (CoRIPS) supported study, this research investigates perspectives of strategic service managers with Health Board responsibility for service delivery.

Method: A questionnaire survey was administered to strategic service managers across Scotland ($N = 14$), followed up with telephone interviews. There was a return rate of 57% ($n = 8$) for the questionnaires and $n = 4$ agreed to be interviewed. Data collected related to radiographer roles across their Board area; awareness and understanding of service development issues and features as well as perspective on opportunities and barriers in the context of Scottish Government policy, workforce logistics, attitudes and inter-professional relationships.

Results: The results indicate evidence of financial, logistical and political barriers to service evolution, offset by a sense of optimism that scope for beneficial change may be approaching. There are a range of significant initiatives in place and an appetite exists to pursue the development of radiographer roles and skill mix for the benefit of service users more generally.

Conclusion: The difficulties in achieving change are well understood and there are basic issues related to finance and industrial relations. There are also however, cultural elements to contend with in the form of attitudes demonstrated by some radiographers and significantly, the radiological community whose influence on the practice of independently regulated radiographers seems incongruent.

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Introduction

Across the United Kingdom (UK), demographic change, evolving technology and fiscal challenges have created substantial pressures on the delivery of diagnostic imaging services. Government health policy measures have sought to address those pressures.^{1,2} Although Scotland has a fully devolved health and social care system, those pressures exist in essentially the same way as the rest of the UK and the policy elements manifest similar features.^{3–5} These include ‘modernisation’ or redesign of services, integration of health and social care, implementation of skill mix and developed roles for non-medical practitioners, and the notion of patient-centredness in respect of strategic service delivery and visioning.

In 2012 the Scottish Government published its Allied Health Professions Delivery Plan (AHPDP)⁶ outlining the role of AHPs in transforming the Health service into a more patient centred and effective service. The plan made a clear statement of the need to have a ‘significant’ (though unspecified) proportion of plain film images reported by radiographers.

The implementation of policy is an influential means by which change occurs and there is evidence that in a UK context the Scottish experience of service evolution and change is subject to a notable lag factor.^{7,8} In the context of diagnostic radiography, this is manifested by poorer implementation of skill mix, role developments and advanced practice, confirmed in earlier research.^{7,9} The reasons for this are multi-factorial however notably, the devolved arrangements in Scotland are characterised by a structurally and culturally different system of management and leadership.¹⁰ Arguably this remains less ‘commercialised’ and

* Corresponding author.

E-mail address: ian.henderson6dt@gmail.com (I. Henderson).

more traditional in operation compared to the recent English experience. It may also be the case that a smaller professional community and substantial remote and rural constituency have some impact.

The operational 'reality' of developing extended scope and advanced practice roles for radiographers in Scotland has been explored in earlier research and some reasons for the existing service landscape identified.^{9,11,12} It is important in this context to examine the strategic and visionary aspects of service evolution in order to seek clarity in negotiating the path forward. Awareness of the perspectives of those involved in strategic management of imaging services is crucial in order to identify the facilitators and barriers to developing the service model for patient benefit.

Aims

- Examine the strategic factors that influence the implementation of service change.
- Identify drivers and inhibitors of change.
- Establish a perspective on how change can be achieved, looking ahead.

Method

The participants in this research were those with Health Board (Regional) level responsibility for imaging services and involvement in operational planning and development at a strategic level. They are referred to here under the generic term 'strategic manager'. Job specific questionnaires were sent to strategic managers in each of the fourteen Health Board areas across Scotland. There were two phases: a quantitative questionnaire survey and qualitative semi-structured telephone interviews.

Phase 1: Following a pilot with a group of regional imaging service managers in England, postal questionnaires were administered to the subjects. Closed and semi-structured questions were utilised providing quantitative data supported by contextual comment. Questionnaires included a coded unique identifier.

Phase 2: Phase 1 participants were invited to undertake a semi-structured telephone interview to explore questionnaire responses. Five agreed to take part although one subsequently withdrew. An interview schedule was developed based on key issues arising from the questionnaire responses^{13,14}: implementation of advanced practice; conceptualising skill mix; national health strategy; staff training; terms and conditions; looking to the future.

Ethical implications

NHS REC approval was not required for research involving NHS staff, however as a multi-centred study, R&D approval was required from each site, 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

Phase 1: Quantitative analysis was primarily descriptive and presented in tabular form. Inferential analysis was inappropriate for such a low sample size.

Phase 2: The recorded interviews were transcribed and anonymised. Data analysis utilised the fivefold process recommended by Pope et al.¹⁵: 1) familiarisation; 2) identifying a thematic framework; 3) indexing; 4) charting and mapping; and 5) interpretation

Results

Questionnaires

From fourteen administered, eight questionnaires were returned giving a 57% response rate, following three email reminders and extension of the return deadline by two weeks which provided an additional two responses. Throughout the results section, participants' comments are shown in parenthesis.

4 tier working

Three participants employed the 4-tier career structure as defined by the Society and College of Radiographers. The majority ($n = 5$) stated they employed some elements of it (Table 1). One respondent indicated the change had arisen from a costed strategic plan while others described evolution of service, or a bit of both.

Four participants indicated no post-implementation audit had been carried out. Of the four who did carry out audit, two described audit after introduction of assistant practitioners, one as part of a larger benchmarking exercise and one relating to ultrasound service waiting times in outlying areas. None described any formal research.

With regard to the introduction of advanced practice, only two participants described negative aspects '*limited access to workload make it problematic to maintain competencies*' and, '*due to reporting pressures it has been agreed that radiologists are a more flexible workforce and have therefore been funded in preference to an advanced practitioner*'.

Staff were willing to engage with the implementation of the 4 tier system, although initial concerns were raised by radiographers around introduction of assistant practitioners and '*reluctance by consultant radiologists to support implementation of consultant radiographers as they feel 'consultant' is a misleading term*'. Participants described two industrial relations issues arising from the introduction; both centred around re-banding of radiographers for advanced practice roles.

Five participants described barriers to implementing 4 tier working. The majority outlined financial issues relating to re-banding and funding of new posts. There was also some staff reluctance to take on new roles and implement change. The current pay protection arrangement was seen as significant since some staff with pay protection were unwilling to undertake a change that might be financially punitive. In Scotland, pay protection consequent to the implementation of the Agenda for Change terms and conditions system is not time limited. It is the case therefore that for some practitioners who may have had a high pre Agenda for Change grade, e.g. 'Senior 1' and were job evaluated at a lower banding, there may be a disincentive to seek a higher level post, losing the protection and incurring a drop in salary. These barriers were identified in both rural and urban sites. Participants suggested strategies to overcome these barriers including: i) Ongoing review of demand and capacity with Board level support to increase capacity when required; ii) Change to pay protection arrangements; iii) Fixed sessions for radiologist mentoring of reporting radiographers; iv) Possible collaborative approach to consultant radiologist access and clinical leadership.

Timescale from initial funding to fully implemented service varied from two to five years. The period was shorter if there were radiologist vacancies and impossible to implement if there was a full complement of radiologists. One participant described employing a qualified reporting radiographer, but having no opportunity to use their skills, since no consultant radiologist was in post to provide mentorship.

Team working

$n = 6$ participants were familiar with the College of Radiographers and Royal College of Radiologists joint document 'Team

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