

Case Study

A development framework for the consultant radiographer in oncology: the Leeds experience

Neill Roberts

Department of Radiotherapy, Leeds Teaching Hospitals NHS Trust, Leeds, West Yorkshire, UK

(Received 26 November 2015; revised 7 January 2016; accepted 9 January 2016; first published online 4 March 2016)

Abstract

The role of the consultant radiographer in radiotherapy is a relatively new concept and to date the number of post holders in these roles remains low. Despite challenges to role creation for the non-medical consultant, the benefits of role development and skill mix within the national health service are evident. Among these challenges is the need to ensure appropriate and credible training of the consultant radiographer. This case study focusses on the local experience of developing a suitable competency framework for the first Consultant Radiographer at the Leeds Cancer Centre. It highlights elements of the framework that equip the post holder to carry out the role and how the governance underpinning such a framework could be used by other radiotherapy centres across the United Kingdom.

Keywords: advanced practice; consultant radiographer; education and training; radiotherapy role development

BACKGROUND

It is now approaching 13 years since the establishment of the first UK Consultant Radiographer post in Oncology. From a policy context the main drivers for role development of radiographers, including the concept of expert practice, came at the turn of the century with the reform of cancer services across the NHS.¹ The subsequent strive to eliminate unacceptable waiting times for cancer treatment, along with a recognition that 80% of cancers treated by radiotherapy could be managed by radiographers, helped to reinforce the notion that

access to care and patient satisfaction were central tenets to the success of the Consultant Radiographer role in oncology.²

It has not been plain sailing from here, however. The numbers of consultant radiographers appointed nationally has failed to balloon and to date, despite a recent exponential increase, there remain only around 20 posts. So why is this the case and what barriers exist that challenge the growth of this role?

The four core dimensions of the non-medical consultant role have been clearly defined to give a multi-dimensional breadth that promotes independent working across professional boundaries. These centre around expert clinical practice; professional leadership; research and

Correspondence to: Neill Roberts, Department of Radiotherapy, Leeds Teaching Hospitals NHS Trust, Leeds, West Yorkshire, LS9 7JT, UK. Tel: 0113 206 7650. E-mail: Neil.roberts7@nhs.net

education.³ In turn work has also been undertaken, within the profession, to discern role expansion from role development in advanced practice.⁴ The idea that the latter requires a greater degree of clinical autonomy and hence has a greater impact on the radiographer's scope of practice is arguably where the challenge exists in role creation at a local level.⁵ With the perceived benefits of skill mix also come the perceived blurring of professional boundaries and identities and so importance is placed on the building of inter-professional relationships and particularly support from clinician colleagues when identifying the need for a consultant radiographer.⁶

There is limited evidence as to the direct impact such a role has had across the clinical spheres and the leadership and education domains, however, to the contrary this may be a more appropriate time than ever in developing such a role. The national health service (NHS) has recently undergone a period of intense scrutiny into how it operates and governs itself; the role of effective clinical leadership has emerged as fundamental to the running of services, as is working beyond traditional professional boundaries to include the multi-professional team.⁷ Such recommendations always come with checks and balances and it is perhaps equally as important to recognise the value of quality training and development of staff who will fulfil these roles. This same report espoused the importance of competency-based training for health professionals and more specifically the tailored approach to development which might include a combination of formal education with work-based learning and observation so readily seen in the pre-qualification and registration setting.

HOW TO TRAIN A CONSULTANT RADIOGRAPHER?

From this policy background, it falls on service leaders, education providers and professional bodies to shape the development of these roles and it is here where there is still much work to be done. It is acknowledged that there is currently a scarcity of formal or standardised education for

advanced practice, mainly due to the diverse training needs such practice brings.⁸

It was these considerations that weighed heavily in the development of the first Consultant Radiographer in Oncology at Leeds. The Leeds Cancer Centre (LCC) is a regional cancer centre for Yorkshire and serves a population of 2.7 million across the Yorkshire Cancer Network (YCN); the radiotherapy department is one of the largest in the country treating over 6,500 patients a year across a fleet of ten service delivery linear accelerators, a gamma knife and brachytherapy service.⁹ The centre treats specialised cases such as paediatrics and is now a national referrer for the evaluation of all current Stereotactic Ablative Radiotherapy indications.¹⁰ In addition to providing highly specialised services, the radiotherapy department has high referral rates for breast cancer and this constitutes just over 20% of total patient referrals for radiotherapy.¹¹ In maintaining this service, the limited numbers of Clinical Oncologists divide time between the LCC and peripheral sites across the YCN; the vast majority specialise in more than one cancer. It is against this backdrop, combined with the need to maintain a patient centred and timely care pathway as demanded by national cancer waiting time targets, that the benefits of skill mix can potentially be realised. It is true to say that the growth of the role is largely down to a local niche in the service where skill mix can offer efficiencies while at the same time aiming to add to the quality of the patient experience. However, developing an effective and credible training package was critical not only to equip the holder of this post, but also to provide a template and standard for future positions.

The training of a non-medical consultant brings with it a plethora of complex issues and the creation of a suitable competency-based syllabus is only one facet of the framework to be considered. It has been suggested that the transition to consultant level practice is a life-changing event as opposed to a straight forward promotion with various stages of emotional trauma ranging from elation to crisis.¹² If this notion is applied at a local level then the training framework needs to engage the post holder on a credible pathway of competence that is not only approved but

accepted and even respected by colleagues and peers across all professional levels. To achieve integration and change perception at a local level is arguably to interfere with the natural order of things and in some quarters is a significant barrier to the success of the role. Certainly, within the expert practice domain of this role we look to our clinician colleagues to affirm a gold standard of clinical knowledge and applied understanding that is accepted and established nationally as the benchmark for oncology practice. The educational standards set out by the Fellowship of the Royal College of Radiologists (FRCR) represent the gold standard for Consultant Clinical Oncologists in the United Kingdom.¹³ In applying these same standards for the non-medical consultant, we address competence to practice, while also applying a basic standard to the role that could be recognised and transferred beyond local boundaries. There must be an appreciation that consultant allied health professionals are not medics, yet rightly or wrongly, the definition of expert practice will be interpreted differently given the area of specialism and local context. Within this context, the role is designed to take on areas of practice and decision making traditionally covered by medics. As such the trainee follows an adapted version of the FRCR syllabus that covers a breadth of scientific knowledge required to carry out the duties within the given specialism (in this case the treatment and management of breast cancer patients). Both core and specific competencies have been translated by the General Medical Council into a Good Medical Practice (GMP) framework where the trainee is assessed against the four areas of knowledge, skills and performance; safety and quality; communication; partnership and teamwork.¹⁴ Such a prescriptive framework allows a focussed approach and governance arrangement for the trainee within their specific area of practice. Experience to date has proven that following such an established approach builds relationships between non-medical and medical colleagues where mutual respect and co-operation in training are recognised. Governance arrangements for this new role are especially important to ensure training develops in a timely manner and in the intended direction of travel for the local service. In this case, an experienced Clinical Oncologist within the

breast oncology team acts as clinical supervisor to support the trainee throughout the training year, in facilitating the necessary clinical exposure and completion of work-based assessments. The role of educational supervisor exists to offer moderation to the training content and provide support in direction and content of learning. In this case, such a role is taken by an Oncologist outside of the breast oncology team, but with significant experience in clinical and medical education.

The importance of the infrastructure around the appointment of the non-medical consultant cannot be underplayed. In following such an established training approach that has been tried and tested by many before, it opens communication and provides access to learning opportunities and clinical experience that serves the medical training community. In this case, elements of both the core and specific scientific competencies are being met via FRCR tailored lectures on subjects such as radiation physics; biology; statistics; pharmacology and tumour biology that are attended alongside FRCR Part I and II medical trainees. At the same time, clinical experience and work-based assessments are carried out across a host of environments within Leeds Teaching Hospitals clinics in new patients, on treatment and follow-up, with additional exposure at peripheral clinics across the YCN. Experience to date would suggest that this approach to training goes a significant way to positively impacting the perceptions of the role among peers in radiotherapy and more widely across the patient pathway in breast cancer where close working relationships need to exist with professions such as surgeons; breast care nurses; research nurses; radiologists; medical oncologists and pathologists. It is a difficult balancing act for the consultant radiographer to navigate, where leadership within the radiotherapy community must be tempered with a need to develop and establish a credible reputation across a wider sphere of practice where influencing skills are used effectively as the norm.

LIFE BEYOND CLINICAL PRACTICE

As has been cited previously, the role of the consultant has been defined as one moving

between four pillars or domains.¹⁵ This case study has primarily addressed the 'expert practice' domain of the role but the competency framework being undertaken is aimed at developing the individual to be appropriately competent to move between these domains. One example of meeting GMP 1 (knowledge, skills and performance) is in the need to complete Good Clinical Practice training in order to take part in clinical research, in addition to demonstrating recent research experience. In addition, other aspects of the framework require evidence of ongoing development and feedback as a way of validation, to ensure the skills necessary to practice in the domains of research; education provision and leadership. In this case, the post holder has a partner role established with Sheffield Hallam University within the job description. This imbeds research and education provision within the routine role of the job where the clinical expertise of the post holder can be effectively utilised in breast cancer-specific education courses at undergraduate and post-graduate level. The partnership with higher education must not be underestimated for the trainee or fully competent consultant. The resources and experience that can be brought to bear from such a partnership will benefit both the Higher Education Institution (HEI) and local Trust. In this case, the collaboration between the two institutions can help to facilitate national trial development or even something as simple as a study day. Experience to date would suggest that such a formal partnership does promote closer working which has thus far facilitated collaborative working on research projects and also provided support for students completing academic projects within the sphere of breast cancer and radiotherapy. At its most simple, this arrangement adds to the available resource of both the University and the Teaching hospital in carrying out functions of education and training.

In demonstrating fulfilment of this role, not only in initial competency, but also as a part of lifelong learning, there is a requirement for the post holder to actively seek out appropriate development opportunities that do not necessarily sit within a formal training framework. As has been discussed, the consultant radiographer role moves between core dimensions where

experience in communication, organisation and even professional networking are a pre-requisite. These skills are utilised in seeking out development opportunities and in engaging radiographers; physicists and clinicians nationally. These connections will aid learning through different experiences, practices or technical developments, helping to underpin the knowledge and experience for the post holder in work across the domains of this role and in ensuring its success in the future.

SUMMARY

This discussion has focussed broadly on the relatively new role of the consultant radiographer in radiotherapy and the barriers and challenges that exist in the creation of these posts. However, the background of an evolving NHS and the benefits of skill mix and advanced practice offer a counter weight to these challenges when considering role development at both a local and national level. From this local perspective the emphasis has been placed on adopting a robust and transferrable competency framework for the current trainee, but also to be applied as a template for future trainees to the consultant radiographer role. This framework will act to underpin the level of knowledge and skill required by the post holder to move between the domains of the role successfully, while following approved governance that is recognised through the various spheres of practice in which the post holder is likely to operate.

Acknowledgements

The author would like to thank Professor Heidi Probst for her assistance with the publication of this article.

Conflicts of Interest

None.

References

1. Department of Health (DoH). The NHS cancer plan: a plan for investment a plan for reform. 2000. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4098139. Accessed on 9th September 2015.

2. Department of Health (DoH). Cancer reform strategy. 2007. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006. Accessed on 14th August 2015.
3. McSherry R, Johnson S. (eds) *Demystifying the Nurse/Therapist Consultant*. Cheltenham: Nelson Thomes, 2005.
4. Society and College of Radiographers. *Implementing the Career Framework in Radiotherapy—Policy Into Practice*. London: The Society and College of Radiographers, 2009.
5. Eddy A. Advanced practice for therapy radiographers—a discussion paper. *Radiography* 2008; 14: 24–31.
6. Paterson A. Consultant radiographers—the point of no return. *Radiography* 2009; 15: 2–5.
7. Department of Health (DoH). *Hard Truths: The Journey to Putting Patients First, Volume 1, Government Response to the Mid Staffordshire NHS Foundation Trust Public Enquiry*, 2014. London: Crown Copyright.
8. Topham C. Advanced medical radiation technologist practice and the Canadian Association of Medical Radiation Technologists: history and perspective. *J Med Imaging Radiat Sci* 2014; 45: 348–351.
9. Leeds Teaching Hospitals NHS Trust, monthly radiotherapy performance: September 2015 (produced October 2015).
10. NHS England. NHS Commissioning. 2015. <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/comm-eval/> Accessed on 5th October 2015.
11. Fileccia L. Voluntary deep inspiration breath hold technique, version 1.4. 2015. Leeds Cancer Centre.
12. Hardy M, Nightingale J. Paper 1: conceptualizing the transition from advanced to consultant practitioner: career promotion or significant life event?. *J Med Imaging Radiat Sci* 2014; 45: 356–364.
13. The Royal College of Radiologists, The Faculty of Clinical Oncology. *Specialty training curriculum for clinical oncology*, 2014. https://www.rcr.ac.uk/sites/default/files/curriculum_2015_clinical_oncology_3_aug_2015.pdf. Accessed on 2nd August 2015.
14. Owens J, Dodwell D. *Specialty training curriculum in clinical oncology for consultant therapy radiographers (CTR)*, March 2015, Adapted with permission from the Faculty of Clinical Oncology, Royal College of Radiologists.
15. Department of Health. *Advance letter PAM (PTA) 2/2001*. London: Stationary Office, 2001.