THERAPEUTIC RADIOGRAPHY AT THE CROSSROADS – straight on up!

Hazel Colyer

National Radiotherapy Conference, Birmingham, Saturday 29th January 2011

This is the Year of Radiotherapy and, after 40 years of promoting the profession, I couldn't be more pleased, I guess it does say to all of us how far we have come in that time. However, there has really never been a more challenging time to be a healthcare professional than now, (and I don't necessarily mean that in a wholly positive way) because I think we are experiencing the the greatest shake up in the NHS that has happened since its inception in 1948 and arguably, it's not going to ever be the same again! For therapeutic radiographers, this comes on top of changes to cancer services that have been ongoing now for the past 10 years or so. Mindful of the fact that our cancer survival rates are among the worst in Europe, and still remain among the worst in Europe, recent governments have invested very heavily in the provision of cancer services, including very large numbers of new LINACs, with which we seem somehow to have become synonymous, in a way that I find quite worrying. But what this has meant for us is that there has been a resurgence in the popularity of radiotherapy as a curative treatment modality. I think radiotherapy went into the doldrums about 20 years ago and there were people who were predicting its demise at that time.

I want to spend these few minutes advocating for professional role development because there are great opportunities for radiographers in the current context. There are clearly major service pressures. However, I want to invite you to resist the temptation to use the service pressures to avoid the challenge of change. I am interested in professionalisation and have spent whatever bits of my academic career I can, often thinking and writing about that and so striving for what I would call full professionalisation through increasing the scope of our professional practice will serve the public better and give therapeutic radiographers the position that they really deserve in the healthcare multi-disciplinary team.

I am a radiographer who also happens to be a senior manager in education. Because of this, I inhabit two very different worlds. I try still to remain close to the professional world of radiotherapy because that's what I chose to do 40 years ago and it's a profession that I still love. However, I also live a lot of the time in a very different environment, in the Human Resource-led world of workforce planning and development, and in that world subsidiarity and locally-based commissioning are

the key issues that we are grappling with. It is from this perspective, from the perspective of someone who is insetting where we are trying to respond to the needs of the workforce, both in terms of pre-registration education and in continuing professional development. It is from that perspective that I offer you the following observations and share with you my significant concern that, while full professionalisation should be our aim, there is a real job to be done both in educating those who commission services to see what is really possible for cancer patients, but also in overcoming the perceived reluctance of many in the profession who seem to just want to hang on to what they know and are comfortable with and not reach out and see what might be possible for us.

The world of therapeutic radiography has been catapulted to prominence. Major strides in technology, such as IGRT and Adaptive Radiotherapy have revived our fortunes and there is significant pressure for IMRT to be made available to all of those for whom it is of proven benefit, although interestingly it remains unavailable in county in which I live. Radiotherapy is part of the management of 40% of patients who are cured of cancer (NRIG Technology Sub Group Report 2009) and it helps to cure more patients than chemotherapy. The NRAG (2007) report to ministers spelt out what is needed to make our service world class. Cancer remains a priority, even in these straitened times.

The SCoR has had a very proactive and open stance to professional role development that began in the mid 1990s and that I have been really proud to be associated with in the background. That proactivity has ensured that, when the Cancer Reform Strategy was published in 2007 and NRAG began its long work of bringing radiotherapy services back up to the highest level, therapeutic radiographers were ‘at the table’ and integral to the work streams. And this continues still through the NRIG, so at that top level structurally through the professional bodies, through the the organisations, our contribution and our role is acknowledged.

But what I want to ask is where is the evidence that this stance, which was formalised in 2002 with the publication of a 4-tier structure, from assistants to consultants, which was fleshed out in a position paper in 2006 that describes a whole range of potential extended roles for radiographers in different settings and culminating in recent guidance to support the development of local staffing models for radiotherapy services in 2009. What is the evidence that these published

documents have effected change in the way that radiographers work? What evidence is there that all of the strategy and all of the efforts to professionalise radiotherapy have been accepted and internalised by the majority of radiographers and also, and this is absolutely crucial, understood by those who commission cancer services?

I was at the Radiotherapy Advisory Group meeting last week, where a recent survey disclosed that we still have fewer than ten consultant therapy radiographers among a workforce of more than 20,000 and in the four countries, more than 60 cancer centres.

Disappointingly, it is my view and my contention that many in the profession are unable or unwilling to accept the leadership that has been offered and the opportunities that are out there to change the way that we work and to take on the challenge of greater responsibility for patients.

The reasons for this are unclear; there is no doubt that clinical oncology services are under great pressure, and that situation is not conducive to embracing and leading change. The focus on the need for more therapeutic radiographers to avert a crisis in the day to day service delivery reinforces this and it might be argued that the profession has become rather over-confident now because it is seen as absolutely essential to the delivery of cancer services – they can't do it without us – and so perhaps we do not see the need to change. Partly as a result of this, service commissioners are also failing to engage with the level of thinking required about workforce planning. That if we are going to really provide the world class services for cancer patients that have been promised, then we have to reprofile our services in ways that enable that to happen.

Subsidiarity was the term enshrined in Lord Darzi's Next Stage Review (2008) and, you might ask who is Lord Darzi and clearly he is yesterday's man and he has vanished from our lives and been replaced by Andrew Lansley. I'm not sure that that's an improvement but that's certainly where we are and Andrew Lansley making it up as he goes along is my impression. Nevertheless, the starting point for determining need and planning services is, and will remain, the LOCAL health economy. It is at that local level that the new ways of working that could and will be developed will impact and need to be developed. Quite a lot of work has gone on in preparation for that. Those care pathways identified by Darzi were used by the Primary Care Trusts to develop local workforce plans based on local information.

These plans embraced the concept of a competent, flexible, workforce able to deliver safe, effective, person-centred services in a timely way.

On the whole, this work of gathering this data and taking this intelligence about the workforce and trying to work out how the workforce could be stretched and extended to cover the needs of patients more clearly has been an HR function. Certainly, in the area where I work, in Kent and Medway, all of the staff are professional HR workers, and it is really quite unusual to find anyone with a health professional background.

Quite specifically, their role has been to advise about about non-medical education commissioning (both pre-registration and CPD) and in local education partnership groups, we have tried to work together on what the local workforce should look like.

From the many meetings that I have attended since the groups were set up in 2007, it seems to me that, whilst they 'talk the talk' about flexibility, skill mix and new ways of working, they still remain wedded to the commissioning by numbers, numbers of particular professions. (We need X of this and Y of that!) Not patient focussed, but more profession centred. So we are still asking the question 'how many nurses' rather than 'what kind of service and who is best placed to deliver it? In relation to cancer services, there is a frightening ignorance of the role of Therapeutic Radiographers and I have often been asked to explain what we do and how we differ from diagnostic colleagues.

My argument is that, at the present time, local ignorance about therapeutic radiography is another factor impacting on the wider profession and contributing to its narrow view of itself as the key and essential professional group in the delivery of radiotherapy treatment. The intention is to place the responsibility of commissioning of services into the hands of GPs. We are working with GPs in my local area and the general view is that they are not especially enamoured with this new responsibility, excepting, in particular, enthusiastic groups. That there is a frightening level of ignorance about how they will commission responsibly and effectively. The work that the local PCTs have already done will be crucial in informing and supporting GPs to understand the commissioning process. However I don't really have any sense that that this transfer of power to GPs will alter commissioners' perceptions, particularly about therapeutic radiography, its role and

the opportunities that Therapeutic Radiographers have and could have to contribute to the whole of the patient's journey through the cancer pathway.

In addition, short term concerns about numbers, recruitment and attrition are colluding with the profession's desire for the status quo and certain unwillingness to change. Convenient this may be, but local GP commissioners may one day wake up and insist on re0profiling the cancer workforce in ways that are possibly detrimental to Therapeutic Radiographers. There really is nothing like a funding crisis to concentrate the mind! And we are experiencing a funding crisis. Taking 20% out of the budget of the NHS in efficiency savings is not maintaining frontline services, it can not be so, it's too large an amount of money to take out of the system for it not to have an effect on front-line service delivery.

Safety, improved outcomes and patient satisfaction – the key messages from the latest white paper published in July last year. I think all of those things can be maintained and even enhanced without therapeutic radiographers being present at every treatment and I think that is a salutary observation and one that we need to think about.

So why do we remain so wedded to our technician role? The notion of being rather high class technicians. The technical skills of radiotherapy planning and delivery are indeed the very craft of our profession and they distinguish us from others and we need them so I am not advocating that we shouldn't have them. However, it is also true that much radiotherapy is boring and routine to the experienced radiographer, not challenging or complex. Radiotherapy graduates need these craft skills but many will not remain in cancer services unless there is more to it than that.

Graduates are being educated and prepared to manage complexity and take on new roles such as the practitioners models outlined in RT Moving Forward (2009), to assume responsibility, to make decisions, to refer people on through the journey. Arguably they are over educated for treating women with breast cancer day in and day out. The kind of service redesign that I would envisage would allow us to assume a fully professionalised role and to use our knowledge and skills, which are highly specialised, for greater patient benefit.

Unfortunately, in my view, this aspiration is also being hampered by the blurring of the traditional distinction between professions, as the term has been degraded and is replaced by the much looser term 'professionalism'. There is that sense that 'We

are all professionals now!' – the policeman, the plumber and the medic. Whilst this suggests the adoption of standards and behaviours that are commendable in themselves, the term does not privilege the higher levels of knowledge, skill, understanding, the ability to lead, manage change, take on complexity, to function autonomously and decision making. These are the attributes that are integral to genuine professional practice – and are sought by and promised to our graduates.

Therapeutic radiography, like the NHS, is at a crossroads and there is a choice to be made; either to use the opportunities that are afforded by change to forge ahead with professional career development in the ways identified and made possible by the work of the SCoR and others over the past 15 years, or to remain as very high class technicians.

There is still a long way to go to achieve world class cancer services or even to be as good as most European countries. And, so as therapeutic radiographers, in this Year of Radiotherapy, we really do need to reject degraded terms like professionalism, wake up and realise that playing a full part in achieving the best depends on letting go of some of the old in order to embrace the new. Let us also make this the Year of the Therapeutic Radiographer.