UHL Imaging Response to health and wellbeing scrutiny committee regarding Radiologist shortages

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Executive Summary

Questions

1. As a Trust do we have effective oversight of Radiologist recruitment and reporting?
2. Have risks to patients been fully assessed and managed?
3. Are staffing and other resources used effectively to ensure examinations are reported in an appropriate timeframe?

Conclusion

1. The Imaging team have been reporting monthly on the volume of reports to be reported, broken down by modality and length of time waiting since November 2015.
2. A strong workforce plan has allowed the Leicester radiologist team to expand, although the growth in services and the overall rise in imaging demand means a capacity gap remains.
3. Risk is assessed through separate targets held for ED, Inpatients, GP, Routine Outpatients and suspected cancer Outpatients
4. Imaging report directly to commissioners monthly as part of the quality schedule on plain film reporting turnaround times.
5. Reporting capacity gaps for Head and Neck and neuroradiology reporting have been logged on the Trust risk register
6. Creative recruitment and robust job planning have supported the management of reporting the increasing demand for cross sectional imaging. Outsourcing and waiting list initiatives are used to manage peaks and troughs of demand.

Overview

The Royal College of radiologists (RCR) has been highlighting a national shortage of radiologists against a backdrop of consistently increasing demand**.**

'Friday 9 September 2016
The Royal College of Radiologists' (RCR) latest census of the UK clinical radiology workforce published today provides further stark evidence that vital NHS services are under immense strain. For the third year in a row, the census shows that radiologist numbers are failing to keep pace with the increases in demand for scans and X-rays.
Key findings of the 2015 census:
•99% of UK radiology departments could not meet scan and X-ray reporting demands and are relying on costly and inefficient short term fixes
•Last year the NHS spent £88.2 million on outsourcing radiology reporting, an increase of 51% from the year before. The amount spent in 2015 could have paid for over 1000 full-time consultant radiologists
•Between 2012 and 2015, the consultant radiology workforce grew by 5% but the number of CT and MRI scans rose by 29% and 26%'

With the appointment of an Imaging information analyst in 2015 improved data has led to a greater transparency of reporting volumes and reporting turnaround times.

There has been a variation in the numbers of unreported plain film radiographs. Snapshot surveys for the Royal College of Radiologists have identified similar and widespread issues between Trusts. UHL's response to this survey deteriorated over 18 months leading up to 2016 and issues in out-patient backlogs widened to include in-patient and emergency plain films.
The following actions have addressed some of the capacity gaps for plain film reporting, however, outsourcing of predominantly chest plain film reporting to manage peaks and troughs of demand and capacity is still in place.

- Addressed auto-reporting and historical data quality issues.
- Plain film reporting radiographic training continues (MSK , chest& abdo) 4 reporting radiographers in training.
- Robust timetable and targets for reporting radiographers.
- Agreed service level standards for additional hours.
- Robust auto-reporting (clinically agreed) communicated to radiographers.
- New methods of auto-reporting.
- Data showing report turnaround time is being monitored.
- Meaningful data has been developed (2016) and has been shared with the Imaging and CSI leadership teams, with relevant data for inpatient, cancer and outpatient imaging being shared at a Trust level.

The volume of cross sectional reporting continues to rise at approx. 10% per year. CT referrals from ED rose by 30% in 17/18. The reporting volumes have led to pressure on the radiologists. UHL have however had success in delivering a workforce plan to increase Radiologist workforce and to look at alternative recruitment methods.

Health Education East Midlands (HEEM) have recognised a need to train more radiologists adding an additional 2 trainees per year for a 5 year cycle starting two years ago. The required support from imaging in UHL to deliver this is in place. We have 4 additional trainees in post, increasing the support for emergency flow imaging.

The UHL Imaging department has bucked the trend in terms of medical recruitment; in the last three years the team has secured 20 consultant radiologists to fill vacancies created by retirement and growth of demand.

There are currently seven vacancies (from a staff group of 69 consultants), including a retirement, a specialist post vacant for three years (head and neck) and two new expansion posts. These will be advertised by the end of January 2017.

There have been a number of factors in the success of this recruitment:

- Re-written and updated job descriptions and adverts to promote the service's specialties and excellent equipment base.
- A strong social media campaign.
- Positive messages from the current team, radiologists were asked to promote UHL in external discussions, presence and papers at conferences from our specialist radiologists.
- Trainees within the service are choosing to stay with an excellent TPD team in place. The team now has a strong group of young consultants which will encourage others to join them.
- UHL have a clinically led Imaging service, intertwined with management
- Clear strategic direction for Imaging.
- The medical leadership team have proactively engaged with candidates.
- Positive perception of the department as a place to work.
- Fellow chose to apply for a consultant post within UHL.

The Imaging department have three MTIs (overseas trainees) currently with two more to start next month. This was a new venture for Imaging in 17/18, and is working very well so far with excellent candidates who are enjoying their time at the Trust and may choose to apply for a permanent post.

UHL Imaging are using outsourced reporting to manage the growth in demand for inpatient and outpatient Imaging, reporting demand and capacity will be examined this year and further actions will be planned to address any remaining gap.

Governance and monitoring of KPIs

A daily report is available showing all outstanding reporting in all modalities (CT,MRI,Xray). Outstanding reporting is monitored at a departmental level through the monthly Imaging Quality and Safety board, and at a CMG level monthly through the Imaging assurance and performance meeting.

The Imaging department are also required to report to the CCG monthly through an agreed quality schedule on turnaround of plain film reporting, and quarterly on all reporting turnaround times.

Managing Reporting Workloads

Outsourcing

Outsourcing to a tele-radiology company forms part of the management of timely reporting for most Trusts. UHL have a contract with Medica, outsourcing predominantly MSK and Neuro cross sectional reporting. There is a demand and capacity gap for MSK reporting due to rising demand.The reporting takes place remotely and there are governance arrangements in place.
This is an effective but expensive option for managing reporting turnaround times. However outsourcing has some potential challenges including delays whilst deciding to send images out, cost, de-engagement of local staff and perhaps no relationship with UHL clinical colleagues. An issue with the current system is that responsibility for the prompt reporting of images is not fully clear.

Additionally there are hidden costs with some outsourced images being reported again in house due to quality or reliability of the reporter. Additionally complex and time consuming scans are often left for the UHL staff and can wait excessive amounts of time to be reported.

WLIs

The workload of clinical radiology continues to increase year on year and challenges radiology services to increase their efficiency while maintaining and improving the quality. Demand and capacity work shows areas where there is a mis-match that results in the need for extra capacity above normal job plans, this is underpinned by vacancies in the aligned specialties of neuro and head and neck radiology.
Current strategy supports the use of flexible sessions which have traditionally been met largely by outsourcing. However, many drivers including cost, quality and speed of turn around dictate a broader tactical spread of in and out sourcing. This also aligns our outputs more closely to delivering trust and national targets such as 6 week wait, cancer and RTT.
Imaging insourcing guidelines apply to all clinical radiologists or reporting radiographers where a report, scan or interventional procedure is required as part of an additional session of work outside of current job plans. The guidelines provide an administration process for the authorisation and allocation of this work. Currently UHL uses a mix of methods to ensure images are reported in a timely manner and patient care is maximised.
Insourcing allows the cost effective, timely reporting of images where activity exceeds set targets above the actual capacity in place at the time. Work is allocated by following an agreed rota where patients are allocated to the person by the clerical administrator. The work is identified by the use of the appropriate escalation policy, in conjunction with operational management to identify service priority and work is paid at the correct trust rate or any variation is agreed in advance by the Imaging board.

Summary

The imaging department within UHL have developed a transparent, open approach to monitoring imaging activity (referrals, scans and reporting) and are sighted to changing demand within the various subspecialties.

In addition, although a service noted as having workforce shortages nationally, the team have bucked the national trend with recruitment to both Radiologist and Radiographer vacancies over recent years, retaining local talent and attracting both regional and national talent within key specialties.

This is barely enough to keep pace with the seemingly unstoppable growth in requests for imaging from both primary and secondary care clinicians. Work has commenced to ensure that only the right patient is scanned, first time, along pathways that help the referrer to avoid requesting every patient, every time.