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Clinical Radiology

The Royal College of Radiologists

Job planning for interventional radiology

an addendum to *Guidance for job planning in clinical radiology*

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1. Background

The working patterns of interventional radiologists (IRs) are very different to those of their diagnostic radiologist colleagues. This stems from the need to have clinical responsibility for their patients, perform image-guided interventions and provide pre- and post-procedure care. Frequently IRs perform complex major procedures, many undertaken on an urgent or emergency basis. These procedures have the potential to deliver significant therapeutic benefits using minimally-invasive techniques, but carry a small but significant complication rate.

An IR's workload can be highly unpredictable, particularly in a smaller unit. It will typically include the following components.

- Diagnostic imaging:
  - Reporting imaging relevant to IR procedures
  - Contribution to the general workload
  - Involvement in multidisciplinary team meetings (MDTMs) including, where appropriate, presenting the relevant radiology.
- Clinical administrative activity:
  - Clinical correspondence, vetting of requests, verification of radiological reports, audit, data entry into registries, supervision of trainees' clinical work and so on.
- Patient care:
  - Pre-assessment clinics for IR patients
  - Review of patients before and after IR procedures on the ward and follow-up in clinics.
- Performance of IR procedures:
  - As part of planned IR lists
  - In hours/when on call for emergency cases
  - Emergency cases when not formally working (smaller or under-staffed units).
- Supporting professional activity including:
  - Activity related to appraisal and revalidation
  - Research
  - Teaching
  - Involvement in professional society activity.
- On-call activity, increasingly as part of a separate IR on-call rota.

The Royal College of Radiologists (RCR) and the Academy of Medical Royal Colleges (AoMRC) have published guidelines on job plans for consultant radiologists, and the British Medical Association (BMA) has published model job planning guidance for consultant diagnostic radiologists.[1–3] Much of the RCR job planning guide outlines principals that are relevant to IR job plans. These are endorsed by this addendum and are not repeated here.

The aim of this addendum is to highlight the aspects of job planning unique to IR consultants. It is hoped that awareness of these and their incorporation into agreed job plans will help to deliver safe and effective IR services.

2. Direct clinical care (DCC)

The RCR and BMA documents provide clear definitions of what constitutes DCC activity, and the same principles should apply to an ideal consultant IR job plan.[1,3] The specific needs of an IR to carry out DCC safely and effectively include:

- A suitable environment for seeing patients in clinic
- Admitting privileges to ward beds to allow admission of patients under their care. (This may be desirable for some consultant IRs and will require appropriate ward-based support including trainee doctors.)
- Access to a workstation with appropriate radiology information system (RIS) and picture archiving and communications systems (PACS) software and a suitable environment for reporting
- Access to appropriate fluoroscopy, ultrasound, computed tomography (CT) and magnetic resonance imaging (MRI) equipment located within suitable facilities for the performance of diagnostic imaging and IR procedures
- Appropriately trained radiographers, nurses and administrative staff
- Adequate time provision to carry out complex procedures, interpret diagnostic scans, supervise trainees, obtain informed consent from patients, carry out ward rounds, prepare for and participate in MDTMs and so on
- Support for ensuring quality and patient safety by facilitating data entry into local and/or national databases/registries. This will include time, clerical support and information technology (IT) infrastructure for data collection and entry
- Radiation protection equipment of a high standard given that IRs are routinely exposed to ionising radiation to a greater extent than their DR colleagues. The equipment must ensure that received doses are kept to a minimum (and at least below legally stated levels), and take into account the physical stresses of interventional procedures and lists.

3. Supporting professional activities (SPA)

The RCR and BMA documents provide clear definitions of what constitutes SPA activity, and the same principles should be adhered to in an ideal consultant IR job plan.[1–3]

The AoMRC recommends a minimum of 1.5 SPAs to allow a consultant to meet the requirements of appraisal and revalidation, with additional allowance depending on other activity undertaken.[2]

The RCR guidance on job planning agrees with this and recommends that a typical ten programmed activities (PA) job plan should have a 7.5 DCC/2.5 SPA split.[1] It also states that for the professional development of consultants in the NHS, 2.5 SPAs are important. However, the SPA requirement will be significantly greater than 2.5 where additional non-DCC activities are required for management roles, such as the trust's quality improvement and service delivery, that is, clinical leads, clinical directors, audit leads, Imaging Service Accreditation Scheme (ISAS) leads, leading the morbidity/mortality and/or learning from discrepancies meetings and so on.

The BMA guidance on job planning for a consultant diagnostic radiologist recommends 2–2.5 SPAs in a typical job plan.[3]

4. On-call activity

There is a move in most NHS trusts towards having a separate IR on call, either as sole providers or as part of a network. This is currently made difficult by a lack of adequate workforce.

There is considerable variation in on-call activity depending on the elective and emergency work particular centres carry out. Therefore, it is not possible to be prescriptive in terms of how on-call activity is included in a model IR job plan – this will depend on the frequency and intensity of on-call in a particular centre. On-call work should be accommodated in the job plan either through attracting additional remuneration or proportionate reduction in elective activity. The allocation of on-call activity within the job plan can be informed by undertaking a diary exercise of on-call activity over an appropriate time frame.

It should be recognised that many centres rely on the goodwill of their consultants to perform emergency procedures when not on call. While such arrangements have evolved through necessity, informal emergency cover is inevitably subject to unreliability and is not generally in the best interests of either patients or doctors. A formal, robust on-site or networked emergency rota should be in place, with well understood patient transfer policies where necessary. Any informal arrangements should be reflected in job-planning. Options could include a lieu half-day for an 'off-call' procedure, payment or an annualised DCC allocation for this activity.

IR emergency work is unpredictable and often occurs in night-time hours. Job plans should take into account that it is unsafe for an IR to be performing interventional procedures if they are sleep deprived. As a result, it would be appropriate to ensure that an IR is not scheduled to perform interventional procedures at times when there is a significant likelihood of disturbed rest the night preceding scheduled lists.

5. Ideal job plans

It is not considered possible to provide a model job plan, given the wide variation in the needs and expectations of trusts, services and individuals, but it is hoped that there will be recognition of the broad principles such as scope of work, balance between DCC and SPA activity and the need to provide adequate time, facilities and support staff.

The ideal diagnostic radiologist job plan assumes ten PAs of elective activity in a 7.5 DCC/2.5 SPA split, although there is likely to be significant individual variation in this due to factors including:[2]

- On-call activity
- Less-than-full-time work
- Subspecialist interests of individual IRs
- Additional activity when not on call.

6. Summary

IR is an important clinical subspecialty which underpins and supports a wide range of other specialties in a modern hospital. The requirements of modern IR jobs are very different from the those of purely diagnostic radiologists, and typically IR job plans should look more like those seen within surgical specialties. Job plans should reflect the clinical needs of this service to ensure that IRs and those radiologists who have a significant IR component within their jobs are able to deliver the best possible care to patients. In particular the job planning process should recognise the significant clinical time required for clinics, ward work and patient administration and commitments to on call, in addition to the traditional procedural and imaging lists.

This document was approved by the Clinical Radiology Professional Support and Standards Board on 26 January 2018.

References

1. The Royal College of Radiologists. *A guide to job planning in clinical radiology.* London: The Royal College of Radiologists, 2013.
2. Academy of Medical Royal Colleges. *Advice on supporting professional activities in consultant job planning.* London: Academy of Medical Royal Colleges, 2010.
3. British Medical Association. *Model job planning and workload document for consultants in diagnostic radiology.* London: British Medical Association, 2003.

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