Radiology Department – Restorative Conference Part Two – 29 Feb 2024

Attendance: Jehan Loke, Adam Lee, Teresa Anderson, Joseph Jewitt, Matt Carmalt, Marianne Gale, David Ananin, Reuben Haupt, Rob Loneragan, Sally Woodburne, Lloyd Ridley,

ProActive Resolutions: John McDonald, Max Kimber, Madeleine Dignam

Reflections and summary of key feedback:

- Radiographers feel left to make decisions outside their scope. This is due to the deficit of experiences senior doctors, although we are as busy as we have always been.
- Staffing levels in Radiography means we have to cope with a wide scope in our roles, from deciding on building works, to moving a patient, to changing a bin, to completing our work as radiologists and more. It is also extremely difficult to stray on top of all the admin.
- In MRI – I have to make clinical decisions when this should be done by a specialist.
- Radiologists – it's an incredibly hard-working environment, covering a huge volume of work with not enough staff.
- The registrars seem happier, with the improvements in their working hours and a better work life balance.

Renumeration

- The work on the Award is still ongoing.
- There has been a major win and now awaiting signoff from the Ministry to reduce facility fees for 2 years. This will mean more money in Rights of Private Practice.
- We are not guaranteeing level 5, but there will be enough money to pay level 5.

Update- this was signed off at 11am

- There was feedback that this was a positive step and will likely assist with recruiting in the future. Concerns were raised that this doesn't (fully) address the retention of existing staff and everyone acknowledged it was a very positive development that will assist in recruitment and retention.

Outsourcing

- Reuben updated that we are now down to only 7 remaining scans in the backlog, with corresponding benefits for the registrars, with the removal of overnights.

- Teresa updated that the remaining additional backlog will go to Everlight Radiology this week.

Dental Arrangements

- Reuben reported that this is progressing well. This arrangement is now being documented, with agreement on which items can be billed, and the process for referrals.

The TBD list

- The TBD list is working very well, is being used positively and the work is being shared.

Clinical Support time

- A Business Rules document has been drafted with the relevant checks and balances and signoff is underway, with help from Marianne and David.

Work from home/IT

- Equipment has been ordered now. It has been slower than hoped, because we have maximised face to face consultation, and involvement. This is important in bringing everyone on the journey. This is particularly vital as a number of these processes are linked together, such as the 10hour day, work from home, and clinical support time. The hardware will be available by late March, again another very positive development.

Attracting and retaining radiologists

- There is a major question: Would those who have left, consider returning and on what terms? **TO BE EXPLORED AS AN ACTION ITEM.**
- What does our exit interview process tell us about why people have left? What are the remaining issues with those who have stayed but reduced their hours?
- Exit interviews are usually offered by Workforce and can also be done by the DMS. It was agreed that it would be helpful to share the information and use it to the benefit of the department. **TO BE EXPLORED AS AN ACTION ITEM.**
- We believe that uncertainty could be a major issue in retention, even though we have been able to guarantee the fees over the last 6 months, uncertain remains a challenge in recruiting radiologists.
- Many of the people who left had a long history at Concord and had planned to stay here until they retired. People said they couldn't handle the emotional load and they no longer felt that the culture was positive at Concord.
- Many people have left because they found their experience traumatic and have gone somewhere they feel valued.
- A lot of people who have left are registrars. In the past we were able to retain our registrars.
- A key issue is how to retain the current group of registrars. The registrars are happier due to the changes, but they also need to see the senior consultants becoming happier.

Action: Joseph to work with Workforce to identify themes and issues from Radiology exit interviews.

Action: ProActive to identify Radiologists who have left who would be willing to be interviewed.

Action: Joseph and Stewart to work with Matt and Rob to bring all the registrars together, particularly the senior registrars, to discuss what is working and not working to support their retention.

The Interventional Radiologists offering is working much better than previously and this has made a huge positive difference.

There is an issue with registrars doing things beyond their scope, which is high risk, with no backup.

The registrars are much happier as they now have IRs who are interested in educating and training the registrars. This may not extend to the diagnostics area.

Culture change is still needed.

- Planning for the second MRI still has some way to go, but it was agreed to push ahead with current arrangements.
- The current situation requires compromises, we only have one floor. We need the second MRI and agreement was not to wait for stage 2.
- Adam agrees that radiographer's concerns were listened to, and that a compromise needed to be reached.
- The HoD was involved with others in representing the department. They advocated and refused signoff on the first set off plans.
- There was agreement that while the arrangements are not ideal, as a compromise we should still move ahead with the second MRI.

Action: Agreed the MRI should continue to progress

Action: It was identified that in future there may need to be better communication, which is shared more broadly, on how decisions are reached.

Nursing

- We have an old profile that doesn't represent our current workload. Nursing staff are too thinly spread. We run short with people coming up to leave, LSL, or if anyone is sick.
- We have a thriving interventionalists service, which is a huge positive change, but not enough nursing to staff this.
- We had 14 nurses ten years ago, we now have 11-12 nurses, with a massive increase in workload, with a significant increase in complex cases.
- We have asked Helen to relook at the profile as we believe it needs to be updated.
- The problem is not necessarily on paper but on the floor. Sometimes the NUM can't provide nurses for MRI, or must split nurses between sections.
- A lot of nursing staff are not full FTE, many are part-time. Currently there are two temporary staff which has been helpful, but without them there would be only 6 on the floor.
- You can't sub in a nurse from the pool as they need to be radiologist specialist.
- An inefficiency in one area has a huge inefficiency flow everywhere.

Action: Sally and Helen will work with Joseph to have another look at profile for respiratory nursing, and not just to the data but to look at staffing, rostering and which modalities are covered. Joseph to allocate someone to observe the wards over a few days to look at needs.

Action: Joseph to continue working with antiseptic nursing team, so this need is met as a satellite service to reduce pressure on the radiology nurses.

IT Issues

This has been more complex and harder than we thought and we don't yet have enough staff on IT.

PAC's administrator, this process will start next week.

DHI have been keen to provide us with support.

Medical Staffing

- 3 SRMO have started a few weeks ago and it's been really positive. They seem to be enjoying their time and the registrars are very appreciative**.**

- The demand to get Radiology training is very high which helps, and Concord has a very high reputation in terms of the training.
- The issue remains that we are bottom heavy, with lots of SRMOs but thin at the top with senior specialists. We need to stem the flow of senior staff.
- Registrars use to learn from the senior supervisors, so now senior registrars are training junior registrars. A lot of people are doing well beyond the job description, we all have to have multiple roles to make this work.
- VMO – Attracting Diagnostic Radiologists has been much harder. We had only one applicant who wasn't appropriate. It is hard to recruit.

Fee for Service model

- Questions were asked on whether fees can be changed and can we do fee for service?
- The CE confirmed that they are looking at this for Canterbury as a smaller hospital where this may be an option. This is not possible at CRGH or RPA.

Attracting Fellows

- Can we get Fellows (who have done 5 years of training) as a way of strengthening our workforce and help bridge the gap between registrars and senior doctors?
- Can we do this via speciality (MRI) or body type/imaging?
- The HoD is working with the Ops Director to try and instigate this by next year, although the issue remains that in order for this to work to be done we need the right levels of supervision.

Canterbury

- We now have a mobile phone, but it was proposed that they will now switch to a pager number. This will allow everyone at Canterbury to know there is one number to contact.
- This is now being well covered.

Clinical Streams

- We meet weekly as a Stream. These are vital for us to have the ability to receive feedback and make decisions rapidly.
- Meetings are now on Teams, and this works better as we are so fractionated as a team in terms of our hours.

Work from Home

- A business rule has been drafted and is now waiting for approval, which ensures face to face supervision, and minimum hospital hours.
- IT support is in the system. Workstations have been ordered and awaiting their arrival. We can start roll out as soon as the workstations arrive and they are expected by the end of March.
- Some people have shared that they would increase their fractions once the work from home arrangements are finalised.

Small group conversations

- These have been provided by ProActive.