

# Synergy

EMPOWERING RADIOGRAPHY PROFESSIONALS

## Worth a thousand words

Student Ben Potts launches his visual reference guide to patient positioning

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## World Radiography Day

Poster competition winners revealed!

## Inclusive pregnancy practice

How one radiographer won an award for implementing the Society's guidance

## Solidarity forever!

The SoR at the TUC Annual Congress

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# Synergy

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# Thank you and a ballot update



Ross McGhee  
President  
SoR | CoR

## “I’d like to thank you for your support during these turbulent times”



November cover star:  
final-year radiography  
student Ben Potts

As a member-led organisation, we thrive because of your involvement at every level. I would like to thank those of you who volunteer your time to sit on regional or national committees; our delegate leads who lead and represent their regions at our Annual Delegates’ Conference; the members of our advisory groups and special interest groups, who are helping to advance the profession; our accredited representatives who are supporting you in the workplace across learning, health-and-safety and industrial relations matters; and our board members of both UK Council and the College Board of Trustees – thank you for helping to lead the organisation. And to all our members – thank you for your continued support, particularly during these turbulent times.

As you know, we often request your input via consultation surveys, which we send out by email. Most recently, we asked members in Scotland, and then members in England and Wales, if they wanted to accept their relative pay awards or if they wanted to move forward to industrial action.

While the members who responded to both consultations resoundingly rejected the pay offer, only Scotland has moved forward to the formal

ballot stage.

In listening to your conversations on social media, I know a lot of you are confused as to why there will not be a formal ballot in England and Wales. Essentially, we did not have a high enough response to the England and Wales consultation to safely move forward to a formal ballot. With the government imposing legal thresholds for taking strike action, we could not forecast that we would meet the necessary thresholds. For more information on our decision, I encourage you to read this article: “SoR members in England and Wales overwhelmingly reject award” (available on our website at <https://tinyurl.com/3jbvm45a>).

For members in Northern Ireland, your consultation is coming soon. For members in Scotland, if you haven’t already, please return your ballot form by noon on Monday 7 November. For more details about the Scotland ballot, visit our website at <https://tinyurl.com/lfuk46t56>

*R. McGhee*

Ross McGhee  
President of the Society and College of Radiographers

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# CoR publishes updated *Education and Career Framework*

The latest edition provides a full overview of the core levels of practice and includes some important new additions

The College of Radiographers has unveiled the fourth edition of the *Education and Career Framework for the Radiography Workforce* (ECF).

Since the framework was last revised in 2013, numerous changes and challenges – within and outside the profession – have affected the role of the radiographer.

The overall goal of the ECF is to improve outcomes for patients through the education and training of the workforce. The fourth edition has been designed to help education providers design effective programmes while supporting the College’s own programme approval process. It will assist practitioners to plan their career development, something that is also encouraged through the College’s individual accreditation schemes.

The framework also supports managers responsible for workforce planning to introduce new roles in their departments and will also help to promote the profession to our wider stakeholders and the public.

**Workforce evolution**

The ECF provides a full overview of the four core levels of practice, with some new additions.

The support worker section has been expanded to include coverage of the clinical support worker, senior support worker, mammography associate and assistant practitioner roles. The mammography associate is a new addition, recognising the role this position plays in supporting the delivery of breast screening services across the country. The narrative around the various support workforce roles has been developed from the previous iteration of the ECF and should be considered with an eye to the skills escalator routes to enable staff to develop to practitioner level and beyond, should they wish to.

These changes have also been reflected in the College’s various accreditation schemes, including the addition of application pathways for mammography associates and assistant practitioners holding Level 5 qualifications and a refresh of the CoR’s practice educator accreditation scheme,

advanced and consultant practitioner schemes.

The practice educator has also been included for the first time, recognising the key role practice educators play in the education, training and development of the future and current workforce, as well as the influence practice educators can have on retaining staff.

The emerging enhanced practitioner level of practice is another new addition and the CoR is the first professional body to address this role in such detail. A key driver for its inclusion concerns the issue of workforce retention. This role seeks to bridge the perceived distance between the practitioner and advanced practice, encouraging and acknowledging career development up to this level and beyond.

Another change from the previous iteration is how the framework presents the role of the researcher. The ECF devotes a section to research and innovation, which encompasses the full range of research roles across all levels of practice. It highlights how engagement and participation in research is fundamental to the profession’s development and, indeed, to the continuation of its professional status.

“The publication of the revised ECF comes at an exciting time when we are seeing the scope of practice evolve into new areas”

**Knowledge skills and attributes**

In building the workforce of today and tomorrow, it is vital that individuals at each level of practice have the necessary knowledge, skills and attributes (KSAs) to undertake their role safely and effectively. The revised ECF, therefore, details the KSAs for all levels and roles, helping to support conversations around job profiling and evaluation and staff development. The KSAs were informed by the outcomes of a Delphi study before writing groups, comprising experts, members of the radiography profession and patient representatives, were tasked with drafting the various sections of the framework. The writing groups were given the freedom to add any additional KSAs that were not identified by the Delphi study but aligned with the national requirements of the various levels of practice.

**Written by the workforce, for the workforce**

In addition to members of the workforce contributing to the writing of the framework, Society of Radiographers members from across various levels of practice played a central role in creating the new ECF by providing case studies detailing each individual’s personal career journey. Bringing the framework to life, these contributions demonstrate the wealth of opportunity and potential career development pathways available to people wanting to join the profession as well as those already in post.

**Four pillars of practice**

The four core pillars of practice – clinical practice, education, leadership and management, and research and development – are embedded across all levels and roles included in the ECF, clearly demonstrating the College’s expectation that all members of the workforce have a role- and level-specific contribution to make.

It is the entwined combination of these four pillars at all levels that will deliver excellence for patients, with the goal of



Figure 1: The four pillars of clinical practice

supporting delivery of evidence-based and radiographer-led service transformation.

**Educational expectations**

Over the past decade, changes in government policy, health reform and population needs have made radiography workforce development a necessity. Clear incremental expectations have been laid bare in this iteration of the ECF, providing clear directional guidance to ensure that individuals at each level of practice have the appropriate education and qualifications to empower them in practice and ensure the sustainability and growth of radiography as a profession.

The educational expectations have been guided by supporting government policy from across the four nations, taking into consideration wider development of the allied health professions. The ECF serves to translate this national direction of travel for the radiography workforce, clearly defining the educational expectations of all levels of radiography practice from the support workforce to consultant practitioners and all other extended roles.

These educational expectations will be reflected in the College’s own programme-approvals process. Mapping documents and direct links to supporting documentation and schemes have been provided to assist education providers and practitioners to demonstrate and gauge their alignment with the ECF.

**Patient focus**

The golden thread running through all levels and roles in the ECF is the consideration of the patient. The patient is at the centre of everything the imaging and radiotherapy workforce does, so key themes such as values-based practice, patient-centred care and patient public and practitioner partnerships have been considered throughout.

Kathryn Williamson, professional officer for education and accreditation, said: “The publication of the College’s revised ECF comes at an exciting time, when we are seeing the scope of practice of radiographers evolve into new and emerging areas of practice. It is vital that, as the professional body, we support this evolution through our policies, programme-approval process and accreditation schemes. The revised ECF is intended to do that, ensuring the workforce has the appropriate underpinning level of education and training to build the evidence base, transform the services it provides and deliver excellence for our patients.”

A direct link to the framework will be sent to all members when the document goes live later this month.

*The College of Radiographers dedicates the publication of the fourth edition of the ECF to the memory of Jacquie Vallis, the professional officer for education and accreditation from 2018 to 2022.*

# PCI launches campaign to promote shared decision making

The Personalised Care Institute (PCI) is highlighting the importance of shared decision making after data from the more than 700,000 people who completed the GP Patient Survey revealed that patients want to be more involved in their healthcare decisions.

The PCI has created a communications toolkit (available at <https://tinyurl.com/2p8tk6yf>) with suggested copy for every channel and a selection of patient quote images for using on social media and websites, which are available to copy and paste.

Dr Emma Hyde, clinical director at the institute, said: “We would really appreciate your support in sharing this information across your personal and organisation networks.”

She continued: “The results of the survey suggest that patients’ expectations are changing. To support clinicians to manage this, we’d love for you to point your community towards the PCI’s free 30-minute e-learning refresher module on shared decision making, which has been created and peer reviewed by national subject leaders. A link to a new page promoting that module is included in the toolkit.

“Together, we can help to meet the expectations of patients. After completing the shared decision making e-learning refresher, nine out of 10 healthcare professionals said it would improve their daily practice.”

Read more from Dr Emma Hyde on p19 ►





The company was fined and ordered to pay costs at Leeds Magistrates' Court



kelvinjay | iStock | Getty Images Plus

# HSE fines Warwick-based healthcare company after workers exposed to excessive radiation

The Health and Safety Executive (HSE) has fined a company that provides diagnostic imaging services a six-figure sum following incidents at two sites in which employees were exposed to radiation levels in excess of the legal annual dose limit.

On 25 March 2019, a vial of a radioactive substance (FDG) leaked after it was installed into a shielded dispensing pot in the dispensing laboratory of Alliance Medical Limited's (AML) positron emission tomography-computed tomography (PET-CT) facility at St James's University Hospital in Leeds.

This resulted in two members of staff becoming contaminated with skin doses in excess of the annual dose limit as defined by the Ionising Radiations Regulations 2017.

In a second incident, on 15 November 2019, the same radioactive substance was unknowingly handled during the production process at the Alliance Medical Radiopharmacy Limited (AMRL) facility at Keele University Science Park in Staffordshire.

Consequently, a member of staff was contaminated with a skin dose in excess of the annual dose limit as defined by the Ionising Radiations Regulations 2017.

An investigation by HSE into the incident at the AML Leeds PET-CT centre found that training and instruction was inadequate and supervision was below an acceptable standard. Staff were not made fully aware

of the localised instructions and were using personal protective equipment unsuitable for work with radioactive material.

A separate investigation by HSE found that at AMRL's facility at Keele University Science Park, the radiation warning system associated with the particular production equipment was not operational at the time of the incident and had not undergone routine maintenance and testing at suitable intervals.

AML, based at the Icen Centre in Warwick Technology Park, pleaded guilty to breaches of the Ionising Radiations Regulations 2017, Regulations 12, 18(3), 18(4) and 18(5)a. The company was fined £300,000 and ordered to pay costs of £11,382 at Leeds Magistrates' Court on 29 September 2022.

## Guilty plea

AMRL, also based at the Icen Centre, pleaded guilty to breaches of the Ionising Radiations Regulations 2017, Regulations 9(2)a, 11(1) and 12. It was fined £120,000 and ordered to pay costs of £11,382 in the same court on the same date.

After the hearing, HSE specialist inspector Elizabeth Reeves said: "The workers in both these incidents were exposed to levels of radiation that could potentially impact on their health in the future.

"Employers in nuclear medicine must properly assess the risks to their employees

and others and ensure all radiation doses are as low as reasonably practicable.

"Both incidents could have been avoided by carrying out the correct control measures and ensuring safe working practices were followed. Companies should be aware that HSE will not hesitate to take appropriate enforcement actions against those that fall below the required standards."

The SoR said: "This HSE report highlights the need for the radiographic workforce using radioactive material to be adequately trained and for staff requiring supervision to be appropriately managed. All staff must know their responsibilities under the Ionising Radiations Regulations 2017 and practice the requirements of their local rules. The SoR expects employers to protect staff by undertaking appropriate risk assessments, using adequate control measures, and ensuring suitable personal protective equipment is always available. Staff are encouraged to work together with employers to design safe working practices.

"If you have concerns in your workplace that are not being addressed via the usual channels, please seek advice from your radiation protection supervisor or your SoR health and safety representative."

*The Working with Ionising Radiation: Ionising Radiations Regulations 2017 Approved Code of Practice and Guidance is available at [www.hse.gov.uk/pubns/books/l121.htm](http://www.hse.gov.uk/pubns/books/l121.htm)*

# Advanced practice event prompts lively discussion on the education pillar

An online event in September for advanced practitioner radiographers focused specifically on the education pillar. Fifty delegates joined the lively and positive discussion.

Chaired by Andy Creeden, advanced practitioner radiographer at University Hospitals Coventry and Warwickshire, and facilitated by Marie Gibson, lead reporting radiographer at University Hospitals of Leicester, the session started with six speakers shining a spotlight on their educational projects.

Charli Rowbotham, clinical specialist radiographer at Sheffield Teaching Hospitals, began by describing various educational initiatives at Sheffield. These included one-to-one teaching, Red Dot days and emergency nurse practitioner teaching.

Amy Richards, lead reporting radiographer at Leeds Teaching Hospitals, explained how Pacsbin and Radacad software were being used for teaching at Leeds Radiology Academy.

The use of YouTube for education was discussed by Adam Robinson, reporting radiographer at University Hospitals of Leicester, while Freya Johnson, consultant radiographer at NHS Greater Glasgow and Clyde, explained the collaborative approach to practitioner education being undertaken between health boards in Scotland.

Sarah Zycinski, advanced practitioner radiographer at Greater Glasgow and Clyde, explained how the radiology CPD group was meeting the learning needs of more than 450 radiographers and registrars, and had recently received CoR accreditation.

Roxanne Sicklen, clinical specialist sonographer at the Royal Free Hospital in London, covered how advanced practitioners' learning needs at the Royal Free are being met via sonography events and learning meetings, such as a journal club.

The speakers were followed by an open forum, which discussed the following topics:

- Opportunities for advanced practitioners to learn teaching skills.
- Sharing teaching across sites and hospitals via online and recorded sessions.
- Encouraging Band 5 and 6 radiographers to deliver teaching to their peers.
- Building bridges between advanced practitioners and higher education institutions.
- Increasing your own understanding of a subject through teaching.

*The next session will be scheduled for early in the new year. For more information, sign up to the radiography advanced practice mailing list at <https://tinyurl.com/bddb64d>*

# SoR responds to Daily Mail MRI safety claims

The Society of Radiographers would like to reassure patients attending for MRI scans following the "MRI blunders" story published in the Daily Mail on 15 October. The SoR says:

"Millions of MRI scans are performed safely in the UK each year by highly trained and educated registered radiographers.

"MRI does have unique safety considerations related to the use of very strong magnetic fields. Systems for reporting near misses are important across all healthcare and having these systems demonstrates good practice so that learning can be shared and processes refined across the entire pathway from referral so the risk to patients is reduced.

## Thorough screening and safety processes

"Radiographic staff and MRI departments have thorough screening and safety processes in place. It is important that these protocols are reviewed regularly in light of learning from near misses.

"MRI safety is a multi-professional responsibility and ensuring safety for patients starts when the referral is made for a scan by a referring clinician. Ensuring sufficient information about the scan and making checks are important at every step of the pathway.

"The Society has produced a number of information leaflets for referrers, ward staff and patients regarding the safety considerations for MRI. Please do have a look at these and, if you have any comments, please do get in touch with the SoR."

# Share your research at ECR 2023



The European Federation of Radiographer Societies (EFRS) Research Hub is seeking projects to present at the European Congress of Radiology (ECR) in Vienna next March.

All members from the UK can contribute as the Society of Radiographers is a member organisation of the EFRS. The EFRS is looking for image-related projects and those of professional importance that require human participants.

**The closing date for applications is 1 December.**

*For more information, visit [www.efrs.eu/cpd](http://www.efrs.eu/cpd) or email [researchhub@efrs.eu](mailto:researchhub@efrs.eu)*

# Online peer network for consultant radiographers

The Society of Radiographers is hosting an online workspace/ discussion board for people working in trainee consultant and consultant radiographer roles.

It provides a network of consultant radiographers and sonographers, who are able to communicate online directly with the Consultant Radiographer Advisory Group.

*Society members in trainee consultant and consultant radiographer roles who would like to access the workspace should contact Tracy O'Regan at [tracyo@sor.org](mailto:tracyo@sor.org) for further details.*

# My doctoral journey

**Martine Harris** describes her radiography journey to gaining her recent PhD and explains why research is at the core of the radiography profession



Martine Harris graduated from the University of Bradford in 2003 with a BSc Hons in diagnostic radiography and, after a couple of years working in plain film, she moved into CT.

“CT always interested me because it was fast paced and exciting and you still had the elements of trauma and acute care,” she says.

After gaining a postgraduate certificate in CT in 2006, Martine eventually wanted to progress her career on a more academic footing so found herself moving down the road to Wakefield.

“I wanted to do a master’s degree but Bradford didn’t offer one. I moved to Mid-Yorkshire Hospitals in Wakefield in a Band 6 role because I knew it was a forward-thinking trust and I might be able to develop myself in the long run.”

### Clinical research methods

In 2013, she began an MSc in clinical research methods as part of a programme run by the National Institute of Health Research, which backfilled 50% of her clinical role.

“I’ve always been interested in audit and service evaluation – what we are currently doing, how can we make it better and generating the evidence of how that looks in practice,” she says.

“Research had always been on my radar but I never thought it was an option as a career. This was about developing real understanding and knowledge of how I might go about developing evidence, and that excited me.”

The MSc, which was awarded in 2015, was “very much the catalyst to getting into research as a career”.

She adds: “I was lucky to be at Mid-Yorkshire because it had been working to develop a research radiographer post, which was a substantive post.”

Martine has been in that post ever since but she also works CT hours in her own time to keep up her clinical skills.

“I think it’s really important that you’re still able to have your ear to the ground,” she explains. “There are developments all the time in technology or the processes we use.”

She continues: “As a CT radiographer you’ve got to be on your toes all the time. You’re the first person to view the images so there’s an element of technical appraisal and clinical decision making. It’s really important that radiographers are developing those skills. You need to know what to do next, whether that’s to escalate to a radiologist or to go on and complete further scans for the patient.

“You don’t want the patient to have to come back and have more injections of X-ray dye. And you also don’t want to delay their diagnosis.”

Such interests led Martine to the subject of her doctoral research. “That was what prompted me to do my PhD, which was about developing a competency framework specifically for CT radiographers,” she says.

“We have several professional and regulatory-body frameworks that set out the standards for practising as a radiographer. However, there was nothing I could find that pointed to the technical

and clinical competencies required for CT radiographers and assistant practitioners at career level frameworks four to eight.”

She conducted a staged study using multiple methods to develop a competency framework that articulated the roles of assistant practitioners and qualified radiographers of different expertise levels.

“Not only does it identify what we need to know when we first start working in CT but it also sets out the development opportunities, leadership and specialised practice at higher levels such as six, seven or eight.”

### A champion for research

Martine is keen that the profession continues to embed research as one of its core activities. “You need to ask yourself: how do I collaborate with other people and start to generate some data and start to implement the evidence?”

“There are ways you can start to do that quite easily. There is a clear pathway from audit to research so just starting to gather a little bit of data as part of an audit identifies where there is a problem. Using a range of survey methods, you can then go outside your trust to see if other people have solved this problem or if it is a problem everywhere. Based on that, you can ask ‘what is the answer?’ and then test the answer. All of a sudden, you are in the realms of developing research.”

Having successfully negotiated the not inconsiderable hurdles of completing her thesis, Martine’s enthusiasm and passion for the radiography profession remain at the heart of what she does.

“It’s so exciting to be a part of research as a radiographer,” she says. “There as so many ways to be involved. By investing in radiographer research skills and experience we are developing the ideas, writing the papers and leading research. Now we’re writing the papers, we’re disseminating and leading that research. It’s just mind blowing.”

# Connect with other radiographers through East Midlands Imaging Network

The East Midlands Imaging Network (EMRAD) is a partnership of eight NHS trusts that covers 14 hospitals and more than five million patients.

It aims to deliver timely and expert radiology and imaging services to patients across the East Midlands, regardless of where they are treated.

Dammy Bello, communications and engagement lead for EMRAD, said: “Since its formation in 2013, EMRAD has achieved vanguard status, won several awards and been cited in national reports on innovation and progress in imaging services.

“We have long pioneered a successful, collaborative approach to imaging challenges in our hospitals, so we can use our people, equipment and resources to produce the best outcomes for our patients.”

As EMRAD continues to develop and move forwards as an imaging network, it wants to connect with radiographers at all levels. “This is because radiographers are an incredibly important part of our stakeholders,” said Dammy.

“Our quarterly newsletter and emails will keep radiographers updated with what is happening at EMRAD, such as upcoming projects.” Radiographers can opt out of receiving communications at any time.

EMRAD will take an increasing role in radiography training and there may be several regional opportunities. Be the first to know by signing up to the contactdatabase at <https://tinyurl.com/4v27vcbf> or emailing [info.emrad.nuh.nhs.uk](mailto:info.emrad.nuh.nhs.uk) with details of your name, organisation and job title.

EMRAD comprises the following trusts: Nottingham University Hospitals (host organisation); United Lincolnshire Hospitals; Northampton General Hospital; Sherwood Forest Hospitals; University Hospitals of Derby and Burton; Kettering General Hospital; Chesterfield Royal Hospital and University Hospitals of Leicester.

# Join EuSoMII for just €1



The European Society of Medical Imaging Informatics (EuSoMII) is offering members aged under 36 a discounted membership fee of €1 for their first year.

The European Federation of Radiographer Societies’ executive board is encouraging radiographers with a special interest in medical imaging informatics to engage with EuSoMII to contribute and enhance the radiographer’s role in his subject.

*If you are under 36 and would like to apply for discounted membership, visit <https://tinyurl.com/3pj26n7v>*

### In remembrance

## Elaine Hackett

*Helen Sutherland, quality and governance superintendent radiographer at Portsmouth Oncology Centre, Queen Alexandra Hospital, pays tribute to a valued colleague.*



It is with great sadness that we have to announce the passing of Elaine Hackett (née Ogle). Elaine was a very well liked and respected radiotherapy radiographer, who took early retirement from Portsmouth Hospitals Trust in October 2020.

She qualified as a therapeutic radiographer in 1985 at the Christie. Elaine then took her first job at Westminster Hospital, where she trained to become a senior 1. In 1993, she moved to Oldchurch Hospital and soon became a superintendent III in charge of the simulator section, including the mould room and brachy unit.

In 1998, Elaine took on the additional duties of managing the superficial and orthovoltage unit and the QA of the department. In May 1999, she completed an MSc module in breast planning and took on additional responsibilities for planning breast treatments.

In 2001, Elaine worked briefly at Charing Cross Hospital before returning to Oldchurch Hospital in 2002 as the radiotherapy service manager. In April 2008, she moved to Portsmouth with her husband, Chris. Elaine started as a senior radiographer before being promoted to brachytherapy superintendent and clinical governance lead for radiotherapy. She remained in this position until her retirement two years ago.

Her wealth of expertise and knowledge was widely sought after and Elaine was a pivotal member of the superintendent team. She was also a keen gardener and had been looking forward to spending lots of time in her garden upon her retirement.

Sadly, she became ill this year and spent much of the past six months in hospital. Elaine was transferred to a hospice and spent her last few days there with Chris by her side.

*If you would like to make a donation to Rowans Hospice in Elaine’s memory, please visit [www.rowanshospice.co.uk](http://www.rowanshospice.co.uk)*

### In remembrance

## Michele Mayes

*The radiology department of Fairfield Hospital in Bury, Greater Manchester and the wider Northern Care Alliance team remember their colleague.*



It is with great sadness that we announce the death of Michele Mayes, imaging quality and safety manager, who passed away on Saturday 10 September.

Michele spent her career in Bury, starting at Bury General and then at Fairfield Hospital. She began as a radiographer, progressing to senior and specialist radiographer. She became the department manager in 2009 and spent the next 10 years managing the department before taking on her most recent role in 2019.

Michele made many friends over the course of her career and was a highly respected and valued member of her team. She was the most wonderful colleague and friend and will be very much missed by her colleagues across the Northern Care Alliance.



David Haggerty

# Inclusiveness in practice

**David Haggerty**, advanced practitioner radiographer at East Suffolk and North Essex NHS Foundation Trust, recently won recognition for his work introducing an inclusive pregnancy status form at his trust. Here he talks about the process and reveals the challenges he faced

The Mid and South Essex, and Suffolk and North East Essex allied health professionals (AHP) faculty wanted to celebrate the successful work of AHPs in each system and to showcase our role in improving the integrated care systems according to its four principles:

- Improving outcomes in population health and healthcare.
- Tackling inequalities in outcomes, experience and access.
- Enhancing productivity and value for money.
- Helping the NHS support broader social and economic development.

It asked staff members to nominate colleagues who went “above and beyond” plus any projects, innovations and service improvements that demonstrated the brilliance of AHPs.

## Inclusive pregnancy

I won the Research, Innovation and Public Health category for my efforts in instigating an inclusive pregnancy status (IPS) form in our department and trust.

My colleague Tacha Clarke and I had been trying for some time to devise ways to support our trans, non-binary and intersex (TNBI) service users and be more inclusive in terms of pregnancy checking.

The release of the Society of Radiographers’ recommendations gave us a solid foundation on which to build this project at a local level. The process to get to where we are now has, at times, been rather combative but the overriding message is one I feel strongly about.

In 2020, I worked with a local LGBTQIA youth group and challenged the members

to design posters to explain to our trans and non-binary service users that pregnancy checking was required. The posters worked well but, ultimately, they did not feel robust enough because they relied on the patients seeing and understanding the message.

## Sensitive topic

This is understandably a sensitive topic and one with clear legal protection for our TNBI patients. We needed to find a method that adhered to our radiological legislation while complying with equality and diversity legislation. This topic required specific attention and increased urgency because our department had experienced a number of radiation incidents/near misses when trans males were imaged without

the necessary pregnancy queries being undertaken.

This experience is reflected nationally by the Care Quality Commission, whose 2019/20 annual report documented errors caused by inadequate checks and how IR(ME)R employers must use inclusive language in all procedures.

Fortunately, none of these patients were pregnant. However, there is still a risk of pregnancy even if cross-sex hormones are being taken and we were remiss for not checking. Despite our pregnancy protocol being thorough, it is still ultimately based on the hospital system’s strict binary options, which, understandably, are not always a true reflection of biological sex. If an IPS form had been in place, these instances would not have occurred.

## Proud legacy

Sadly, Tacha left our department recently but I am proud of the legacy that we began to create together. She will always be credited for this because we worked hard and well as a team. We did not claim to be experts but we read the literature, attended webinars and spoke to the SoR team responsible to educate ourselves. I have continued to forge ahead after we managed to get divisional and trust approval for our adapted version of the SoR recommendations. The only way this vital update is going to work is through education and support.

Before the official SoR recommendations for the IPS were published, we had been working with the blood services team because it shared similar concerns for patient safety regarding TNBI service users, notably trans males and the non-

binary community. Now our IPS form has been given the green light, I am passionate about highlighting this issue to help raise awareness and help the blood services team to strike the right legal/health and safety balance and find a practical solution to protect this identified risk group.

## Waiting and watching

I believe many trusts and health boards are waiting to see how things develop with the introduction of a diagnostic IPS form. I fully appreciate that change can be unsettling and staff are anxious about offending patients unintentionally or having their clinical time extended by more paperwork. However, the risks are still the same regardless of the size of the population involved and we should always try to aim for best practice recommendations when it comes to radiation protection and reducing inequalities in healthcare.

Ultimately, I see the IPS as another vital update to our pregnancy protocol, which I have seen evolve during my 22 years of registration. I remember the unease when we started to ask patients about their last menstrual period and now it is common practice.

I feel we have generated more support for the introduction of the IPS than for any other initiative previously implemented in our department. I hope it will be given the best opportunity to become embedded in our everyday practices. Fortunately our trust has a proactive stance when it comes to equality, diversity and inclusivity.

## A solid foundation

I must thank the SoR for working so hard on this issue and publishing the recommendations in the first place – this gave us a solid foundation to build on.

Rachael Webster, one of the lead authors, and SoR professional officer Lynda Johnson have been superb points of contact throughout the process and, as a Society member, I have truly felt supported and reassured by hearing their first-hand experiences of implementing their work. ■



## Professional officer Lynda Johnson, who was instrumental in developing and promoting the Society’s inclusive pregnancy status guidance, offers a personal view of David’s work

We shouldn’t underestimate how much of a personal achievement this is for David and Tacha. It takes strong character and leadership to pick up this work, believe in its value and make the case for change. They and other radiographers leading this work are an inspiration.

It’s been a joy to hear of David and Tacha’s progress with this work, which is such an excellent example of what we can achieve as advocates of inclusive practice.

I share their enthusiasm to spread the word across the radiographic workforce as we approach the first anniversary of the publication of the IPS guidance. David and Tacha’s efforts are a shining example of how reading the evidence and making best use of professional-body guidance can make a real impact for patients.

The SoR and Live Through This, the LGBTQIA+ cancer charity, congratulate David on his well-earned award.



# Empathy, understanding and respect

The SoR hosted the third of its annual Patient Voice sessions at UKIO 2022 in Liverpool. We report on the popular interactive event, called Building Inclusive Cultures

The session at UKIO 2022 in Liverpool was the third in the College’s Patient Voice series. Chair Lynda Johnson, Society and College of Radiographers professional officer, introduced the event by thanking Sandie Mathers, chair of the College of Radiographers Board of Trustees, for introducing the Patient Voice series to the conference two years ago.

Sandie said the Patient Advisory Group (PAG) had worked hard to ensure the Patient Voice sessions were included in the UKIO programme, noting that this was the first live Patient Voice session because the previous two had been virtual.

Sandie thanked all the PAG members and its chair, Philip Plant, for their support and Lynda for developing the Building Inclusive Culture session. Sandie added that she hoped these important patient-focused sessions would continue to be an increasing part of the UKIO programme.

### Commitment

Lynda also explained that the Society was fully committed to furthering the cause of patient involvement.

She said: “The SoR has set a clear agenda for patient-centred care through the publication of some key documents, particularly the *Patient, Public and Practitioner Partnership within Imaging and Radiotherapy Guiding Principles*.”

Lynda said the Society published its *Inclusive Pregnancy Status Guidelines* a year ago and she added that just that week, another member of the panel, Gareth Hill, had published *Supporting Lesbian, Gay and Bisexual People in Healthcare*. These and all SoR documents are public access and available on the Society’s website.

First to present was Stewart O’Callaghan, chief executive and founder of Live Through

This. Stewart had used their experience of cancer to develop the charity, which works to improve the representation, information and support available to members of the queer community affected by cancer.

Stewart began by asking attendees what inclusivity looked like to them. Responses included: listening to all voices, transparency, being person centred, fairness, equality, openness and understanding.

Stewart went on to explain what an inclusive culture involved, emphasising the difference between equality and equity. While equality means “treating everyone the same”, equity is the absence of systemic barriers in health, social determinants of health or policies between groups with varying levels of social advantages.

Stewart said that conflating the two terms can lead to errors: “Everyone isn’t the same and we might have to support some people additionally so they can access equitable healthcare. We might have to do more so everyone can get the same.”

Stewart went on to cover the barriers to inclusive culture, including implicit bias, where people act on the basis of prejudice and stereotypes without intending to do so.

“We think we’re doing the right thing but sometimes we can still be causing a problem,” they said. “We have to reflect on this and make sure it isn’t affecting our treatment of others.”

Despite such barriers, healthcare workers are open to learning about ways to overcome them. Stewart referenced a study of oncologists’ attitudes to

LGBTIQ+ patients – only 8% said they felt confident in their knowledge and just 5% felt prepared by their training but 75% believed they would benefit from education on the subject.

Stewart concluded by saying that as part of their reflection on what building an inclusive culture means, practitioners may want to update their guidance and policies.

### Person-centred culture

The next to speak was Gareth Hill, who qualified as a radiographer in 2007 and has progressed to deputy director, evidence, at Healthcare Improvement Scotland. He recently completed a PhD examining lesbian, gay and bisexual people’s support needs relating to cancer.

Commenting on the last two points, Gareth said: “We want to foster a sense of cultural humility rather than competence and have a healthy approach to challenge in our teams.”

#### Questions to ask when implementing change

- What are the barriers?
- Is my proposed change being developed elsewhere?
- Where are the internal support and resources?
- Which other authors, colleagues or patients should be involved?
- Does the change need a pilot phase?
- How will you evaluate the impact?

#### The key qualities of a person-centred culture

- Allyship and advocacy.
- Acknowledging power dynamics.
- Change in research interest and priorities.
- Cultural humility.
- Healthy challenge to create a person-centred culture.

Gareth added that research methodologies in the area were gravitating away from traditional quantitative and qualitative approaches towards participatory and participatory action research: “It is interesting to see that this is starting to be supported more by the relevant professional bodies. Within radiography, there is more scope to be able to use these methods.”

He went on to describe his own research, working with lesbian and gay people affected by cancer.

“We followed a participatory enquiry [approach] but we worked with the participants to establish an image of themselves. Rather than, for example, asking them what their experiences of care were, we used the maps that the participants created to reflect on who they were. I was absolutely blown away by the work they did. It was a really useful tool to allow people to be able to discuss their experiences,” Gareth said.

“There were a lot of stories about what had happened to these people when they were in receipt of care and that’s where the development of the practitioner guide [*Supporting Lesbian, Gay and Bisexual People in Healthcare*] came from as one output of the research.”

Gareth gave an example of care received by one of the participants, who described her experience with a nurse: “She’s going through the paperwork before they administer the first dose and says, ‘I’m sorry I have to ask you this, but could you be pregnant?’ I said no because I’m a lesbian. She looked very surprised and walked away. I thought she hadn’t seemed like anyone who might be homophobic. Then she came back and said: ‘Your form says you were widowed but then you say you are lesbian?’

“I then had to explain: ‘Well, actually, it was my civil partner who died and I ticked the widowed box.’ That was horrible.”

Gareth said this experience highlights that there are still some health professionals who don’t understand that same-sex partners can be next of kin..

He then asked the audience for similar examples in their own practice. The responses included a transgender woman being the subject of radiographers’ inappropriate comments while being treated for prostate cancer, and the partner of a lesbian patient being referred to as her “friend”.

There then followed a general discussion about the difficulties of challenging a non-inclusive culture.

The final panellist was Kerrie-Anne Calder, who, following a career in clinical

radiotherapy, now works as a radiotherapy lecturer at the University of Liverpool.

Kerrie-Anne began by emphasising the importance of allyship: “When I was a student, we never had sessions like this. We were never told that we needed to support gay people differently.”

She said that although she had not received training in inclusive practice at first, she felt it was important to treat everyone the same: “I thought I was doing a great job because I was treating everyone the same and I was quite proud of that. As I’ve gone through my career and moved into teaching, I’ve realised how many mistakes I have made and I’ve learnt so

much from working with Stewart and Gareth.”

Kerrie-Anne explained why, although she is not gay, she believes LGBTQ issues are her issues. “They are a big factor in my professional life. Unfortunately, when I came out of clinical practice it still wasn’t at the forefront of my thinking. My main aim is to make sure I do a lot of sessions with Stewart to teach our students more.”

She said the object of those sessions was to stop her students from making the same mistakes she had: “We need empathy, understanding and respect.”

Kerrie-Anne discussed how the use of specialised equipment to treat particular



### The panel’s pledges

**“To challenge discriminatory comments and behaviours that are used to block change.”**

- Lynda

**“To always engage with the community so they can guide my work to improve the patient experience.”**

- Stewart

**“To be aware of and responsive to issues faced by LGBTQ+ people accessing care, to use inclusive language and respect identity.”**

- Gareth

**“To be an inclusive teacher, to support my students in their learning and encourage them to become inclusive practitioners.”**

- Kerrie-Anne

Stewart O’Callaghan discusses patient and practitioner experiences

areas of the body presented difficulties for LGBTQ patients undergoing radiotherapy.

“A transgender female with prostate cancer was put on [a site specific] machine. Every day we would go out and say: ‘Mr Jones, can you drink your water?’ and then it would come to this female patient and it would be: ‘Mrs Jones, can you drink your water?’ We’d outed her to everybody. I treated her the same and I didn’t single her out. I shouted out her name and gave her the instructions the same as everyone else. It was only after I’d started looking into equality issues that it dawned on me what I had done to that person.

“That’s one of the things that I really want to stop happening. We were wrong as a department to do that to the patient but I’m going to make sure that my students don’t make that same mistake.”

Stewart ended the session by asking everyone to make a pledge to build their own inclusive culture. ■

# Standing together

A round-up of the major issues your Society has been campaigning on at this year's gathering of the UK unions

The SoR delegation to this year's TUC Congress in Brighton was kept busy supporting important motions relating to healthcare, discussing collaboration with other unions and networking and building crucial connections across the NHS and private sector.

## Claire Donaldson addresses the gender pay and pension gap

The Society's immediate Past President, Claire Donaldson, addressed delegates on the need to address the gender pay gap and its impact on pensions in the public sector.

Claire spoke in support of a motion, submitted by the Educational Institute of Scotland, which said that closing the gender pay gap must become a higher priority for the government, employers and the trade union movement.

"It won't be a surprise to learn that, historically, the public sector pension schemes discriminated against women. The original models assumed women cashed in their pension upon marriage, part-time low earners were encouraged to opt out and all final salary schemes benefited those most likely to accrue a full pension and achieve a higher final salary. In other words, men!" Claire told Congress.

She went on to quote statistics showing that the NHS employs 1.5 million people, 77% of whom are women. In 2021, 78% of the men employed in NHS England were earning the upper-middle and upper quartiles of pay.

"The effects of the government's policy of underfunding pay in the public sector over the past 12 years are blatantly obvious across all sectors," said Claire. "Those of us working in health have been subject to the policy of holding down main-grade salaries covered by the government's Pay Review Body, which has eroded the take-home pay and the differentials between grades. This not only has a negative impact on recruitment and retention, but also on the economy as a whole."

She said pay and pension reform must top the agenda when addressing the recruitment and retention crisis engulfing the radiography profession and the wider NHS.

"We need to attract more people into the profession, we need them to want to work in the NHS and, once they're in, we need



Claire Donaldson discusses pay (top) and Tom Welton (right) votes on behalf of the entire 29,000-strong SoR membership



them to stay. A graduate radiographer in England after three years is still earning under £30,000 per year – around £10K less than a graduate accountant with Deloitte." The motion was carried.

## Richard Evans calls for bereavement training for sonographers

The SoR chief executive, Richard Evans, spoke in support of a motion submitted by the Royal College of Midwives (RCM) calling for greater support for bereavement counselling following miscarriage. "An estimated one in five pregnancies ends in miscarriage yet, despite this, women still face stigma and are not

able to talk about their loss. Staff shortages and a lack of funding have led to reduced training of healthcare staff in bereavement care and specialist services are unable to run seven days a week," said the RCM.

The motion called for investment in specialist bereavement services and for unions to negotiate agreements that embed the existing legal protections for those who have suffered a miscarriage and encourage employers to sign the Miscarriage Association's pregnancy loss pledge.

Speaking in support of the motion, Richard said that sonographers play a fundamental role in the diagnosis and initial communication of findings during miscarriage and other early pregnancy complications. He said that although all staff who come into contact with bereaved parents should have access to bereavement care training as part of the national bereavement care pathway for miscarriage, ectopic pregnancy and molar pregnancy, not all sonographers are able to access suitable, funded training during their working hours.

"Some dedicated sonographers undertake training in their own time and/or at their own expense, but this is not sustainable for all and is clearly not acceptable as a means to ensure these essential skills are developed," Richard said.

"For parents to be given personalised care and support, it is essential that sufficient numbers of trained staff are available, particularly in specialist bereavement services. Miscarriages are diagnosed in early pregnancy assessment units and other outpatient settings seven days a week. To provide equity of access to care, staff

## "If public services such as the NHS are required to run 24 hours a day, nutritious and affordable hot food should be available regardless of time of day"

trained in bereavement care should be available every day."

The motion also called for delegates to negotiate for employers to adopt humane practices in line with the Pregnancy Loss Pledge. Richard concluded by saying this was important and compassionate work and urged Congress to support the motion. It was carried.

## Tom Welton supports call for hot food for shift workers

The SoR vice-president, Tom Welton, proposed the Society's motion that hot food be provided to shift workers in healthcare.

The motion said that during the pandemic, NHS staff morale was boosted by gestures of appreciation from the public, such as hot food being brought to hospitals for staff working at night.

"Now, these examples serve as cold reminders of the return to reality for NHS staff, who are expected to work long hours for poor reward with the added choice of eating poorly in snatched breaks or going hungry as canteen facilities close when visitors leave or patients sleep," said the motion.

Tom told delegates that although staff are expected to work unsociable hours to provide a service to the public, they have been left with reduced working standards.

"During the working day, hot food is available as well as, in most cases, on- and off-site retail outlets. At night, this provision does not routinely run for economic reasons. This leaves staff with little option for fresh, nutritious food, fostering a culture of fast-food consumption. If public services, such as the NHS, are required to run 24 hours a day, 365 days a year, nutritious and affordable hot food should be available to all those expected to work, regardless of the time of day," he said.

Tom said the motion called on the TUC General Council to actively support health and other workers campaigning for access to nutritious and affordable hot food at regular intervals whenever they work across a 24-hour period. It also called for guidance to champion the economic, social and health benefits of investing in key workers' diets. The motion was carried.

## SoR demands charter to protect rights of health and social care recruits from overseas

Tom spoke powerfully to propose a motion calling on Congress to develop and publish a charter for overseas recruits into health and social care. It also called for the following actions:

- Name and challenge employers in the public and private sector who fail to meet these standards.
- Challenge the Home Office to remove the right to sponsor visas from any employer who is found to abuse overseas workers with modern slavery clauses or practices.
- Develop materials and training to mainstream challenging equality and racism into all rep work.
- Support unions developing equality reps to champion anti-racism in workplaces.

"With the increased reliance on overseas recruits, the treatment of these colleagues urgently needs to be called to question. Unions regularly find examples of employers, including the NHS, threatening to recover visa fees and travel costs or holding recruits to bogus training fees," said Tom as he proposed the motion, which was supported by a number of unions.

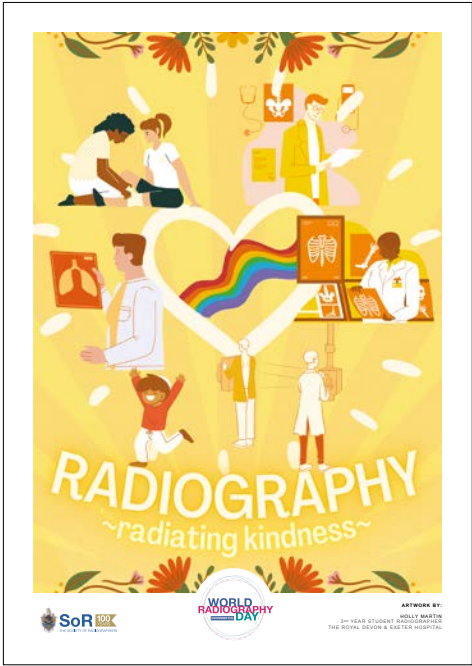
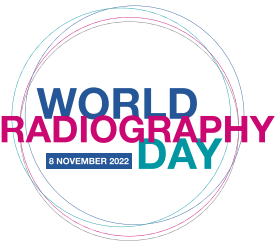
"Some private-sector companies impose exceptionally long notice periods and/or extended probation periods into overseas recruits' contracts. Clauses to recover professional indemnity risks are also known. This constitutes organised abuse that draws parallels with modern day slavery. A British tabloid has reported NHS staff being tied into their roles for up to five years and facing penalties as steep as £14,000 to move jobs or return to their original country. Not only does this taint the reputation of world-renowned institutions like the NHS, it is blatant exploitation of vulnerable workers." The motion was carried unanimously

The Society's two proposed motions, led by Tom, were brought forward from resolutions carried at the SoR's Annual Delegates' Conference in April, ensuring our members' voices were heard on the national stage. In total, the SoR spoke on six motions at the TUC Annual Congress. ■



# Talent show

The SoR’s annual poster competition once again demonstrated the wealth of our members’ talent and imagination. Here the winners talk about their inspiration and what World Radiography Day means to them



**Holly Martin**  
*Third-year student radiographer,  
Royal Devon and Exeter Hospital*

I wanted to show how even though a patient may be with a radiographer for a short time, they can still have a pleasant experience and leave feeling happy. It comes down to the kindness and respect that radiographers give their patients. Sometimes patients are nervous about a scan and it is our job to show them that there is no need to be. To symbolise this I chose flowers and yellow for the main colour of the poster.

Some of the radiographers I have worked with inspired this design because they have given amazing patient care and shown kindness to everyone around them.

World Radiography Day is meaningful to me because people can learn about how the radiography profession plays a critical role in healthcare. Increasing awareness of the profession is good because it may encourage others to pursue radiography as a career.

In the future I hope to see a workforce without staff shortages so radiographers can spend more quality time with patients. This extra time could promote more personal interactions with our patients, leading to enhanced job satisfaction and better imaging and care.



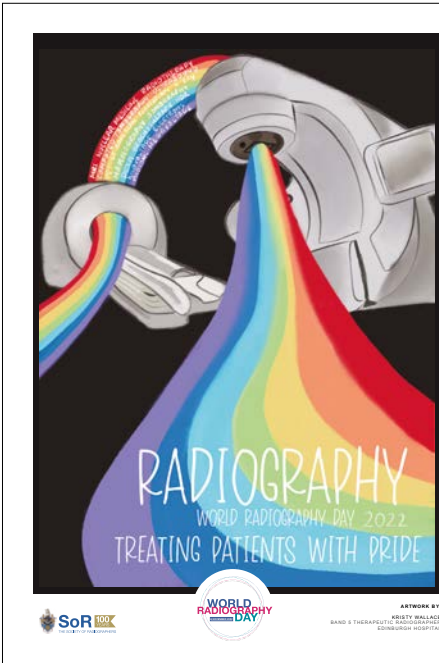
**Hollie Townsend**  
*Masters student, Derriford Hospital, Plymouth*

My idea for the poster came from the theme of pride. “Pride in all we do” is something that connects radiographers across the world, in every hospital, county and country. I wanted to show how the role of radiographer goes beyond X-rays so my poster includes radiographers of every kind performing various duties and showing compassion in their roles.

I have met many radiographers from different parts of the world and different walks of life. All have one thing in common – their compassion and care for others, which has inspired this poster.

I think radiographers are often overlooked in the healthcare setting and sometimes forgotten about. I believe they are the backbone of the NHS and important beyond measure, so World Radiography Day shines a light on them as people and professionals and gives them a day of recognition and praise.

In the future I hope to see more information about getting into radiography through funded degrees. Also there should be more recognition of the work radiographers do and more support for their wellbeing so they are able to continue doing an amazing job!



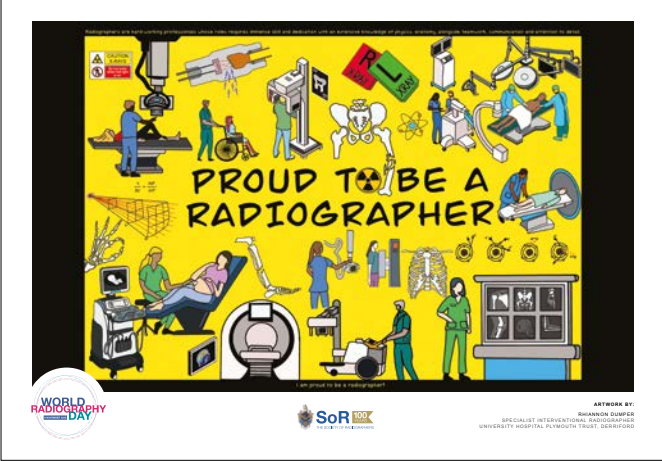
**Kristy Wallace**  
*Band 5 therapeutic radiographer,  
Edinburgh Hospital*

I wanted my poster to be based on therapeutic radiography so I started with the linac and went from there. As I started drawing, I got the idea of a rainbow beam coming from the machine. I then added the CT scanner to show another part of the radiotherapy journey and to represent one of the many ways our diagnostic colleagues are involved.

I think when times are tough, even through Covid, the one thing that we can all agree on is that we are proud of the work we do for our patients so I used the rainbow beam to represent that. A lot of my colleagues are very supportive of any artwork I do in my spare time so it was really nice to be able to share something that represents the work they are proud to do.

World Radiography Day is a day for us to showcase our profession. People often have little understanding of what we do as therapeutic radiographers. So many people come for radiotherapy fearing the complete unknown and not realising that it isn’t so scary, so being able to promote our profession a little more and appreciate how far we have come is great.

I hope there will come a time when we have no need for palliative treatment because we can cure everyone. We just have to continue pushing forward to advance our diagnostic and treatment capabilities to get to that point. I’d also love to have radiography therapy dogs – for the patients, of course!



**Rhiannon Dumper**  
*Specialist interventional radiographer,  
University Hospital Plymouth Trust, Derriford*

The ideas from my poster came from my experience of working in a busy major trauma centre with a range of modalities. I chose to incorporate things that stand out to me as a radiographer and things I think the public see when they come for imaging. I wanted to include a range of imaging modalities – CT, MRI, ultrasound and even theatre imaging – so people can see the spectrum of work. I also included lots of physics-related images, including a diagram for inverse square law, the construction of an X-ray tube and the interaction of atoms to produce X-rays. It is important to show this because radiographers are often thought of as “button pushers” whereas, in reality, they have a wide range of knowledge and skills that they use every day to produce optimum-quality images.

World Radiography Day is an opportunity to show others what I do. Radiography is not a well-known profession so it gives us the chance to show other professionals as well as the public what we do and the depth and breadth of our knowledge, from physics to anatomy and physiology. World Radiography Day makes me feel proud and it’s nice to celebrate our colleagues and our department as a whole. It also gives us an opportunity to talk to patients and other care groups and make them more aware of the impact we make on patient care and the diagnosis of injuries and illness.

In the future I hope to see increasing numbers of radiographers in all modalities and areas. It is a rewarding job with lots of different directions to take and lots of opportunities. I also hope to see the continued increase in advanced practice roles, such as reporting or performing procedures. I think these roles are amazing and really give radiographers the chance to show how dedicated, hardworking and intelligent they are. I also hope radiographers continue to feel proud about their work and their roles in healthcare. ■



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## Opinion

# Make it personal

Dr Emma Hyde, clinical director at the Personalised Care Institute, explains the importance of personalised care in imaging and oncology



I am a diagnostic radiographer by background and, after spending 10 years in clinical practice, have been teaching student radiographers in higher education since 2006. I developed an interest in person-centred approaches to care while carrying out research as part of my masters in education.

This led to me undertake a large-scale national research project to define informed measures of patient-centred care in diagnostic radiography as part of my PhD. In autumn last year, I was appointed clinical director of the Personalised Care Institute, based on my PhD research and subsequent postdoctoral work on person-centred and personalised care.

## Personal experience

I have experienced at first hand the importance of personalised care. When my mother-in-law was diagnosed with a large glioblastoma in 2018, our family was left reeling. We had to come to terms with the knowledge that even with all the treatment planned for her (surgery, radiotherapy and chemotherapy), we possibly only had a year left with her.

Throughout her illness, my mother-in-law had repeated interactions with both diagnostic and therapeutic radiographers, mould room technicians, oncologists and a variety of other healthcare professionals. Most of those experiences were truly person-centred – shared decision making, personalised care and support planning were all evident. As I had found when researching my PhD project, the little things made a big difference.

Being given a blanket during an MRI scan, being allowed to take a family member to the radiotherapy mask fitting or the MRI scanner to hold her hand, and having conversations about the weather or what had happened on the latest episode of *Escape to the Chateau* – not just about her illness – made an enormous difference to my mother-in-law.

Extra pillows and positioning aids helped to make her more comfortable, particularly when her legs became swollen and ulcerated due to the steroids she was taking. None of these acts of kindness was expensive or complicated but they made an enormous difference by making her feel cared for. And as a family, we appreciated our inclusion in shared decision-making conversations and care planning.

## Work to do

In my role as clinical director of the Personalised Care Institute, I have realised how far ahead many radiographers and sonographers are in terms of their knowledge and application of personalised care approaches. However, there is still work to do in some areas to raise awareness and increase the numbers of health and care professionals who are trained to meet the targets set out in the NHS Long Term Plan (2019).

## Excellent CPD

The institute supports the health and care workforce to deliver personalised care by providing free and quality-assured education, training and resources. We offer several e-learning courses in areas such as shared decision making, personalised care and support planning and remote consultations. We also run regular live webinars on topics including long-term mental health conditions and social prescribing, and have a podcast on topics such as long Covid and veterans' health. All of this is excellent CPD! ■

If you would like to find out more about what the institute offers, visit [www.personalisedcareinstitute.org.uk](http://www.personalisedcareinstitute.org.uk)

## “The institute supports the health and care workforce by providing free and quality-assured education, training and resources”



# Fear of the red flag

Ultrasound screening for Down’s syndrome can be stressful for any sonographer. **Ellen Dyer** describes the process of scrutinising clinical skills and the positive role of critical feedback

For the past 12 years, the Down’s syndrome screening quality assurance support service (DQASS) has audited our paired crown rump length (CRL) and nuchal translucency (NT) images and measurement bias/spread to safeguard the performance of the combined screening programme for trisomy 21, 18 and 13. Each department has a screening support sonographer (SSS) and deputy who, according to the NHS Fetal Anomaly Screening Programme (FASP), “oversee the implementation, delivery and monitoring of the ultrasound aspects of the [combined screening] service”.

Every six months, the SSS disseminates the DQASS graphs (feedback plots) for each individual sonographer, describing the bias and spread of their combined screening test measurements for CRL and NT (FASP 2022). Green, amber and red flags are given to sonographers based on this information. An ideal feedback plot (green flag) should have 50% of measurements within the grey band around the 50th centile, 25% of measurements would be above the grey and a further 25% would be below the grey band. Figure 1 demonstrates a green flag feedback plot with most measurements in the ideal range. Sonographers should ideally aim to achieve a green flag rating, which equates to less than 0.1mm bias in measurements.

We all know that we should welcome peer review as part of quality assurance and improvement at all levels of practice. Despite this, many of us struggle to see it in a positive light. We worry about receiving constructive feedback. However, I would argue that we need to develop professional resilience learn to embrace constructive critical peer review.

An example of this is receiving a red flag for negative/positive bias from DQASS – this can be difficult to deal with, especially when unforeseen. I would encourage sonographers who in this position to use it as an opportunity to pause and reflect. Although we need to recognise the importance of correcting bias to optimise detection rates and avoid false negative or false positive screening results, it is important that the sonographer affected does not panic about a red flag. With the help of the SSS, the sonographer has 12 weeks to complete an action plan and submit a further 25 paired measurements to DQASS.

**I would recommend:**

- Using your SSS to understand your bias.
- Revisiting the basics by repeating the e-learning module.
- Reviewing images with your SSS: even if your images are acceptable, are there ways that they can be improved? Could you magnify the image slightly? Could you be more aware of not including the zygoma in your images?
- Experimenting with your machine presets because these can

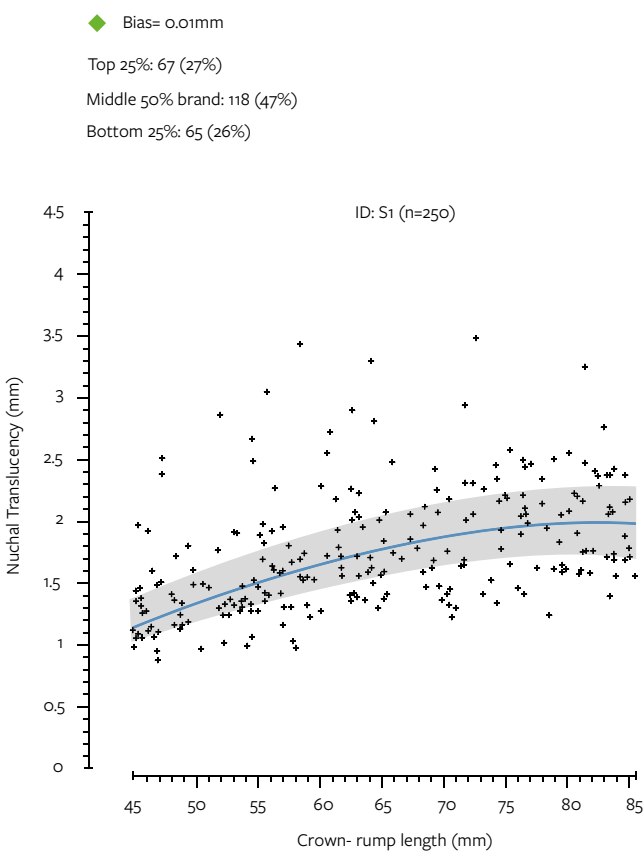


Figure 1. Feedback plot with a green flag for normal bias and spread (FASP 2022)

affect the results. Try reducing the dynamic range, using focal magnification for calliper placement and/or switching off compound imaging to see if it improves your images.

- These modifications might be small but a 0.1mm change in measurement may be enough to improve bias.

Above all, we should be open with our colleagues and talk about our experiences of critical feedback. We will all receive critical feedback at some point during our careers. There is no such thing as the perfect sonographer, the key is using that feedback to better ourselves, keep learning and improving. ■

# A week in the life of a radiographer/sonographer

**Donna Holdcroft** explains how she divides her time between two different yet complementary roles



**I am a radiographer/sonographer who works 50% in radiography education and 50% in product development for a major imaging systems manufacturer.**

## Monday

Monday is my university day and I travel the 120-mile round trip to our department.

In the morning, I meet the director of studies to talk about assessments, see the IT technician about some videos I want to use in my modules and then walk to a local hospital to discuss guest lecturing with a specialist clinician.

In the afternoon, I have to locate the ultrasound equipment in the basement and prepare it for teaching. Between meetings, I catch up on emails and continue to prepare material for the academic year, such as handbooks and interactive quizzes.

## Tuesday

On Tuesday I split my day – in the morning I work in product development and my afternoon is spent at the university.

In the morning, we always have a meeting with our developers abroad to discuss progress on current projects and future ideas. This meeting is engineer led and I am the clinical member of the team. I advise on implications for patient workflow. Afterwards I update my clinical colleagues on the meeting and discuss tasks for the week.

Only one more meeting this morning – a very pleasant one with an intern I am supervising. His project is coming to an end and I help him consolidate his presentation.

After a few emails it’s lunchtime and time to change roles. My university time today consists of lecture preparation.

## Wednesday

This is a university day and I work from home. I have an early meeting with another clinical colleague to discuss teaching on my modules, followed by more preparation interspersed with planning meetings with my colleagues.

On my working-from-home days, I always try to get some exercise so I go for a lunchtime walk to clear away the cobwebs.

In the afternoon, I have an online meeting with a third-year student whose dissertation I am supervising and then I prepare the paperwork for my personal development review next week.

## Thursday

Today is a busy product development day because we have a deadline to meet and our interns are presenting their projects so I need to put my head down. I also have my fortnightly one-to-one with my clinical line manager.

My day is spent researching and trying to be inventive as I prepare a presentation that also needs to present clinical matters in a way the engineers can understand.

At the interns’ meeting, it is fantastic to see the young people’s enthusiasm and their high-quality work.

## Friday

My clinical colleague is off on Fridays so this is a busy day for me. I continue my development research but I also need to support the engineers on clinical matters. The day is interspersed with clinical reviews and triage sessions, where I test software and assist with decisions on user and patient interactions.

At 3pm we have our ultrasound team “stand-up” meeting, when we talk about the progress we have made on our projects. I really enjoy the open and honest nature of working in this environment.

At the last meeting of the week, the company gets together at 3.30pm to talk about things we have been enthusiastic about this week.

After sending my weekly report to our managers and directors, I log off and end another busy week feeling very lucky to be working in two roles I love. ■

# Specialist advice and expertise

This month we look at the work of the Society’s Nuclear Medicine and Molecular Imaging Advisory Group

Members of the Nuclear Medicine and Molecular Imaging Advisory Group (NMMAG) continue to advise and inform the work of the SoR by responding to consultations and using their meetings to discuss hot topics and issues in the nuclear medicine workforce and practice.

Jo Weekes, consultant radiographer (nuclear medicine) and chair of NMMAG, has led discussions and debate on many topics, with all members willingly sharing their clinical knowledge and expertise to further the work of the SoR in nuclear medicine.

Sue Johnson, professional officer lead for the SoR, and NMMAG representatives attended the British Nuclear Medicine Society (BNMS) spring meeting and presented updates to its members. This has led to a formal request from BNMS to collaborate on developing professional standards in nuclear medicine for the multi-professional non-medical workforce.

### Classified workers

Lynda Johnson, professional officer for radiation protection, recently updated NMMAG on plans for classified workers in nuclear medicine.

The Health and Safety Executive (HSE) maintains its position requiring the classification of all nuclear medicine workers who work with unsealed sources. This is due to become a requirement when the process for applying for consent changes, currently planned for April next year. HSE has seen incidents of large occupational overdoses, disparities between theoretical dose prediction and actual measured skin doses, and medical assessments that have been too rudimentary to accurately assess skin dose or skin damage. It considers this a necessary change to adequately safeguard workers.

The SoR is aware that some radiation protection advisers (RPAs) have raised concerns about this approach, as opposed to employing the occupational risk assessment. An RPA will consider staff training, equipment fail-safe measures and local procedures when designating controlled and supervised areas. Regulation 21 of The Ionising Radiations Regulations 2017 requires the employer to designate as classified persons those employees who are likely to receive an effective dose greater than 6 mSv per year or an equivalent dose greater than 15 mSv per year for the lens of the eye or greater than 150 mSv per year for the skin or the extremities. Those employees must be informed immediately that they have been so designated.

HSE’s guidance *Work With Ionising Radiation, Ionising Radiations Regulations 2017, Approved Code of Practice* advises that an employer should designate as a classified person any employee who works with any source of ionising radiation capable of giving a dose rate greater than 20 mSv or an equivalent dose in excess of a dose limit in several minutes. Some representatives in the medical sector feel there is a balance to be met around what is considered to be a “reasonable” case for classification.

Where the advice received by an RPA is different to the recommendations made by HSE or the actions of the employer, it is suggested that early collaboration is sought and all risk factors are considered. Your SoR accredited health and safety representative can add value and support these discussions.

### Prostate cancer therapy

Jo Weekes has written the following update for members on Lutetium Vipivotide tetraxetan (<sup>177</sup>Lu-prostate-specific membrane antigen MA-617) and the impact of MHRA approval in the UK nuclear medicine community.

<sup>177</sup>Lutetium PSMA (prostate-specific membrane antigen) is an innovative molecular radiotherapy (MRT) used to treat metastatic castration-resistant prostate cancer.

PSMA is a type of protein expressed on the membrane of prostate cells that is believed to have numerous cellular functions. Although the epithelium of the prostate naturally creates very low levels of PSMA, cancerous prostate tumours produce extremely high levels (often 1,000 times higher than a normal prostate cell). If prostate cancer has metastasised to other areas of the body, the PSMA will be detectable in those areas also. <sup>177</sup>Lu-PSMA is a radiation-based treatment that attaches itself to the PSMA receptors located on the cancer cells (Figure 1). <sup>177</sup>Lutetium emits beta radiation that effectively damages cancer cells and, over time, destroys them.

This therapy is used in combination with the PET diagnostic imaging radiopharmaceutical <sup>68</sup>Gallium-PSMA to identify areas of cancer that produce this PSMA protein.

Both <sup>177</sup>Lu-PSMA and <sup>68</sup>Gallium-PSMA are proven (VISION Phase III Trial<sup>1</sup>) to significantly improve prostate cancer survival rates and quality of life as well as to extend the time it takes for the disease to progress (Figure 2<sup>3</sup>).

The demand for <sup>177</sup>Lu-PSMA for the treatment of bone and soft tissue metastases from prostate cancer is expected to increase dramatically following MHRA approval (August 2022) after the favourable results/reports from the recent VISION Trial. This will naturally increase the requirement of pre-imaging for diagnosis and post-treatment imaging to evaluate response of the treatment along with the necessity to perform patient dosimetry. However, the NHS infrastructure for MRT services has not kept pace with the rapidly developing new era of the development of new radiopharmaceuticals to treat cancer.

There are a number of issues that need to be tackled urgently to enable the UK to take advantage of the opportunities from this emerging new form of cancer treatment<sup>3</sup>.

1. Infrastructure. The UK MRT service infrastructure will require an expansion in both diagnostic and therapeutic nuclear medicine provision to enable the demand for MRT to be undertaken.
2. Workforce. There is a lack of specialist trained multidisciplinary

nuclear medicine teams (radiographers, technologists, radiopharmacists, nursing and medical physics experts).

3. Radiopharmaceutical supply. There are issues with the supply of <sup>68</sup>Gallium-PSMA and the availability of PET services. This may be alleviated by using <sup>99m</sup>Tc-PSMA. However, at present it is an unlicensed product and we are unsure if this radiopharmaceutical will be included in the National Institute for Health and Care Excellence criteria.
4. Dosimetry requirements. There is a legislative requirement for patient-based dosimetry to be performed at centres that provide MRT.
5. Reimbursement. Funding is needed not only for the radiopharmaceuticals but for the increased planar, SPECT/CT image acquisitions that will be required to perform dosimetry. Dosimetry software plus additional gamma camera time to support pre- and post-treatment imaging will need to be acquired. The costs incurred in providing an MRT service infrastructure may be offset by cost savings in overall patient care and informed treatments.
6. Training, education and research. Funding is also needed to support basic research into radiochemistry, physics and radiobiology.

### Summary

If all the above issues are not taken seriously and moved forward by NHS England and the Radiotherapy Operational Delivery Networks, the availability of this innovative MRT to treat metastatic castration-resistant prostate cancer will become a geographical lottery regarding the overall survival and quality of care for this cohort of patients.

Various working parties have highlighted that there are gaps in ensuring that MRT can be readily integrated into cancer care following several recent publications from BNMS, The Royal College of Radiologists, Royal College of Physicians, Institute of Physics and Engineering in Medicine, National Cancer Research Institute and The Health Policy Partnership. The UK MRT Consortium has recently been created to produce a cohesive, coordinated voice in the clinical and patient community to ensure we can offer consensus-driven proposals to the NHS to scale up effectively and optimise the use of MRT. ■

### References

1. Morris MJ, De Bono JS, Chi KN et al. Phase 3 study of lutetium-177-PSMA-617 in patients with metastatic castration-resistant prostate cancer (VISION). *Journal of Clinical Oncology* 2021; 39 (suppl 15): LBA4.
2. Sartor M, Johann de Bono M, et al. Lutetium-177-PSMA-617 for metastatic castration-resistant prostate cancer. *New England Journal of Medicine* 2021; 385: 1091-1103.
3. Flux G, Buscombe J. BNMS position statement on molecular radiotherapy. *Nuclear Medicine Communications* 2021, 42: 1161-1163.

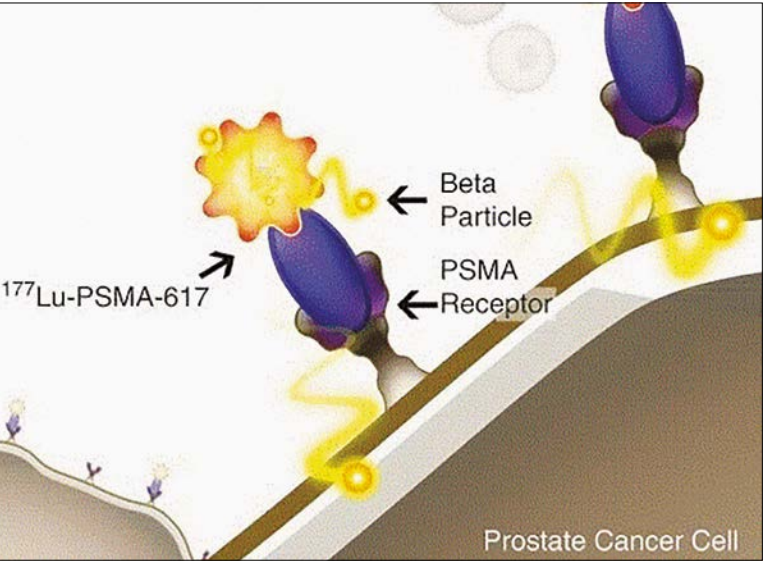


Figure 1. Action of <sup>177</sup>Lu-PSMA in a prostate cancer cell

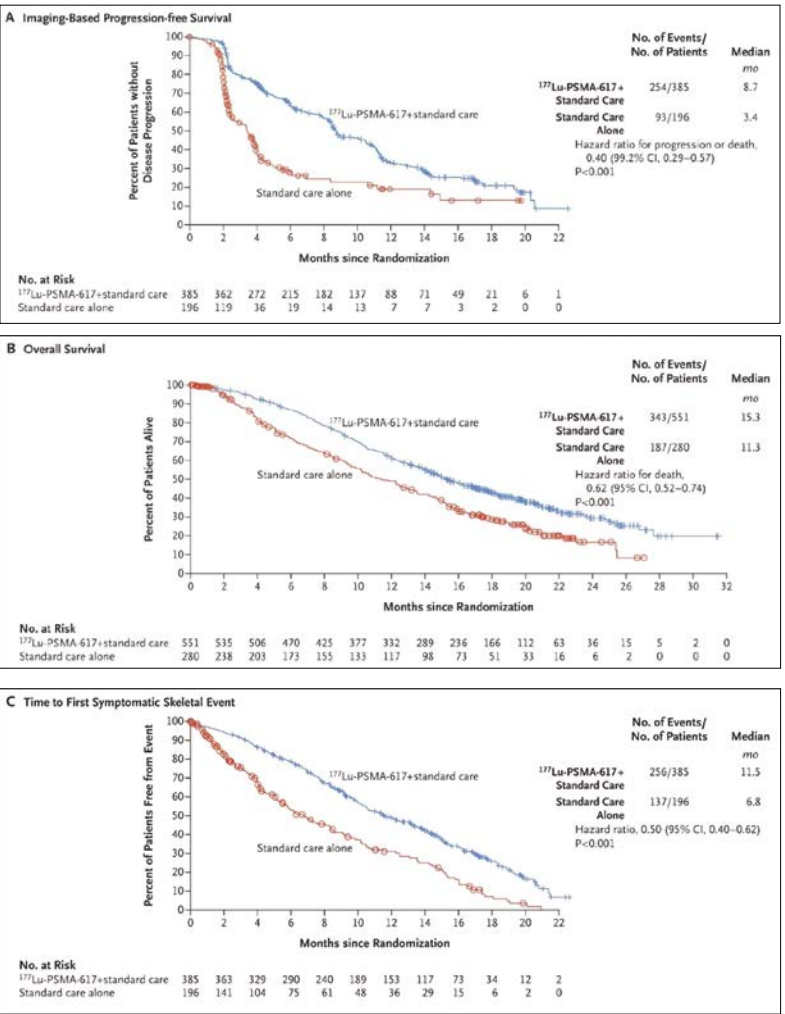


Figure 2. Prostate cancer survival rates



# Great timing

The Timeline Project by Cancer Research UK RadNet Cambridge and Cambridge University Hospitals NHS Foundation Trust came out of a passion for patient involvement. **Rachael Webster**, senior therapeutic radiographer, describes an exciting journey

In 2019, Cambridge was named one of seven centres of excellence in radiation research by Cancer Research UK. At Cancer Research UK RadNet Cambridge, we are committed to patient and public involvement and engagement (PPIE). We wanted to expand this across the workstreams and into our local radiotherapy department at Addenbrooke’s Hospital in Cambridge. After a good chat with one of our patient representatives, we thought the best way to get more people involved in radiotherapy research and PPIE was to celebrate the amazing work that patients and the public have done over many years to help shape the radiotherapy services we see today. Involving patients was the goal from the very beginning – we needed to hear the patients’ voices to celebrate them.

People joined the group for different reasons. Neil, one of the participants, said: “I wanted to be involved in the project so that I could help to promote the modern science of radiotherapy and how it can benefit patients.”

Beverly said she wanted to help others facing treatment, adding: “I feel more knowledgeable, more comfortable and I feel quite an advocate for helping people to feel the same. It was a way of giving something back that felt really important to me.”

And Caroline said she valued the opportunity to get involved, explaining: “Knowing that there was a way to make your voice heard and a way you can make a difference for other people was very empowering for me.”

### What is the Timeline Project?

We know radiotherapy can be scary for people and hope that we can relieve some of the anxieties patients have about it. Radiotherapy is not often spoken about in general conversation or discussed in the media so not a lot of people know what it involves.

There are a lot of outdated misconceptions and fears about radiotherapy. We know radiotherapy is a safe, accurate and effective treatment for many cancers and around 50% of patients will receive radiotherapy as a part of their treatment. Developments in technology and what we now know about radiotherapy have changed immensely over the decades – radiotherapy is improving all the time and it is important that it is better understood by the public so we can take research and practice even further.

We wanted to display this in the local radiotherapy department so a timeline was proposed as a way of highlighting the key moments when patient involvement and radiotherapy have developed together. Our aims were to provide more information on radiotherapy, promote patient and public involvement and create a bright and friendly display that would enhance the local radiotherapy department’s environment. The display is now mounted in the Cambridge University Hospitals NHS Foundation Trust radiotherapy department, with all the online resources linked via QR code to the CRUK RadNet Cambridge website. It was important to us and the PPIE group to include our younger patients, which is why we worked with our paediatric play specialists to create a hide-and-seek game for children.

We successfully secured funding for the display through Addenbrooke’s charitable trust, CRUK RadNet Cambridge’s development fund and the local radiotherapy department. The support from all these stakeholders helped to create a truly collaborative project with patients at its heart.

If we can help just one person to feel a little better about having radiotherapy by providing information that will help calm their fears, we have created something worthwhile.

“If we can help just one person to feel a little better about having radiotherapy by providing information to calm their fears, we have made something worthwhile”



Rachael Webster: “Our aim was to create a bright and friendly display”

### Why involve patients and the public?

The goal for this project was to involve patients and the public from the very beginning. The display and associated online content was all made in partnership with PPIE. We are so grateful to everyone who gave their time, shared their knowledge with the project and who continue to want to be a part of the CRUK RadNet PPIE group. By listening to them, the project has evolved so much. We have had the privilege of listening to their experiences of radiotherapy and it is wonderful that some of them have shared this on our videos and podcasts.

### Next steps

We would love to do more community engagement to break down some of the barriers to radiotherapy research and PPIE for groups that are so often underrepresented. We did our recruitment during Covid lockdowns, which made going out into the community almost impossible. In the future, we need to consider underrepresented groups, such as BAME and LGBTIQ+ people, and build relationships with the community to better understand how we can bring more voices into the narrative. Diversity of voices is key to ensuring we are developing radiotherapy research that matters to patients and the public, and we are passionate about making this happen.

Working in partnership with the PPIE group has been an absolute joy. All the members have had time to share ideas and everyone was given the opportunity to share their voice. The video interviews and the podcast series really highlight the patients’ voices in a powerful way. ■



**LISTEN**  
To listen to the All About Radiotherapy podcast series, visit <https://tinyurl.com/mtc8r8vp>



**WATCH**  
To watch the videos and see the digital version of the display, visit <https://tinyurl.com/3sn8mrb3>



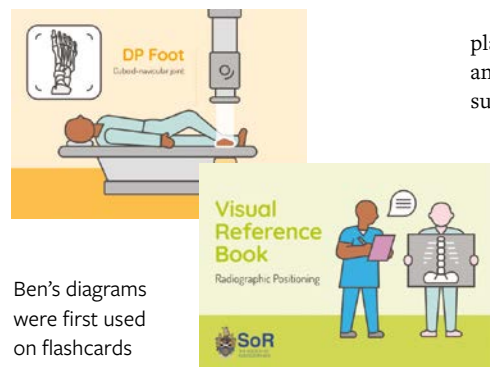
# The correct position

Final-year radiography student **Ben Potts** explains how his experience of ADHD and dyslexia helped him create a visual reference guide to patient positioning



The visual reference guide is a booklet of simple diagrams of the patient positions commonly performed in an emergency X-ray department. It eliminates the need to read paragraphs of information and condenses each position to a visual trigger, which includes a diagram, centring point and tips or considerations. It is not intended to be comprehensive or to give students all the information they need to know but only to function as a reminder of the material they have already learnt or started learning.

It has been created for neurodivergent students and those who prefer or react better to visual rather than textual information. However, I believe it, like most things done in the name of inclusion, could be of benefit to all, so any student, regardless of their neurotype or learning style, may find it helpful.



Ben's diagrams were first used on flashcards

## Background

I am dyslexic and have ADHD. One of the main challenges I experience is poor working memory. This means I can learn something and have that knowledge but I am unable to access it in a timely manner. I have heard it described as being a performance problem, not a knowledge problem. I like to think of it as having the information stored in a filing cabinet but briefly misplacing the key.

Interestingly, this has been shown to occur with information learnt by verbal (and therefore textual) means, but not with visual information. This is exacerbated by time pressure and so can be particularly troublesome in a busy emergency department. Personally, I experience this the most when I am learning but, once I have practised something a significant number of times, I am able to find the key quickly.

When discussing my placement support plan with my link lecturer, Danny Simone, and educational lead, Maria Reynolds, one suggestion was to create flashcards. They both agreed that they had benefited from this practice and Maria showed me her notes from her training. I decided I would create some for the patient positions I often struggle to recall.

Despite my lack of artistic prowess, I decided to share them on Twitter in case they would be

helpful to others. They were well received and, from that point, I have worked with the Society to upgrade them into a professional resource. To confirm the accuracy of the diagrams, consultant radiographer Laurence Skermer was generous enough to check them for me.

As well as being useful in practice, I found that I have learnt a lot about positioning from creating the guide. As I am starting my final year, I am at the point where I no longer need it but I hope the guide aids others in their learning. ■

To order a free copy, visit <https://surveys.sor.org/s3/Visual-Reference-Guide-Order>

“As well as being useful in practice, I have learnt a lot about positioning by creating this guide and I hope it aids others in their learning”

# Simulation Champions update

Nicky Hutton and Sarah-Jane Ketterer reveal the findings of their investigation into the use of simulation in therapeutic radiography education



Nicky Hutton (far left)  
Clinical team leader at  
Clatterbridge Cancer Centre  
Sarah-Jane Ketterer  
Lecturer at the  
University of Liverpool

Since the start of the year, Nicky Hutton and Sarah-Jane Ketterer have been working with the Society on secondment, funded by Health Education England, to produce guidance for the use of simulation in the education and training of pre-registration therapeutic radiography students.

Nicky and Sarah-Jane have undertaken a modified Delphi project to establish consensus opinion on the key areas for simulation use in pre-registration education to inform the new national guidance document. Here they explain their findings.

## How does this fit with other SoR workforce projects?

The 2021 SoR Radiotherapy RePAIR project reported clear evidence to support further investigation into simulation, both the amount and types of that might be feasible and the timing of this in programmes. It includes understanding how simulation could be optimised and embedded in education and training pre-registration programmes, supporting the need for national guidance.

## What is simulation?

Understanding of the term “simulation” varies, with differing opinions on the activities it covers. The following definition was agreed with the steering group and used throughout the project to help focus responses on a common understanding of simulation and associated activities: “Simulation is a technique – not a technology – to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner.” (Gaba DM. The future vision of simulation in health care. *Simul Healthc*. 2007; 2 (2): 126-135.)

## Project summary

A multi-stage, mixed-method approach was used. This included an initial scoping survey of simulation provision, a consensus study using a modified Delphi research methodology and focus groups with key stakeholders.

The modified Delphi study provided consensus opinion on the priority areas for simulation within pre-registration education

and training of therapeutic radiographers and the timing of these activities related to the individual level of the learner.

Responses to the Delphi study were received from a wide range of experts and key stakeholders, including 13 higher education institutions (HEIs), 38 NHS radiotherapy placement providers and five private radiotherapy centres.

The guidance document provides key recommendations for the effective use of simulation, including continuing and developing partnership working between HEIs and clinical placement providers, mapping simulation activities to learning outcomes and HCPC Standards of Proficiency, and the importance of using simulation models.

The guidance then outlines four overarching themes upon which educators should focus their simulation efforts to ensure maximum gain for student learning and experience: communication; treatment and imaging scenarios; radiotherapy treatment planning; and mandatory training. In each of these themes are the subject areas that reached consensus in the Delphi study, supported by evidence from the focus groups.

Supporting the guidance document are multi-professional case studies demonstrating how areas of the curriculum can be delivered via simulation, with the expectation that they are used as a guide and tailored to course programmes. There is a blank template to guide educators when developing new simulation activities, plus an appendix detailing the use of validated simulation models and the key elements required for successful simulations.

## Next steps

The project has indicated the need for continued evaluation of simulation interventions to supplement the current evidence base, particularly in achieving learning outcomes.

There is scope for significant future development and collaboration in terms of sharing practice and collaborative research initiatives. Dissemination of simulation practice will be key to wider adoption and the use of forums, such as the SoR Simulation Special Interest Group, can be instrumental in providing a platform for sharing ideas and experience.

Simulation practice will continue to evolve as techniques and technology advance. It is hoped the guidance document and the supporting multi-professional case studies will act as a live resource, alongside the HEE simulation frameworks and networks, to support the development and enhanced use of simulation in the future. We look forward to sharing the guidance, which is expected to be published at the end of this year. ■



# Education and events

## What’s coming up in November



Your chance to catch up

### The Sleep Series – watch on demand

Part of our RADIATE: Wellbeing programme

A good night’s sleep is not just about recharging our bodies. Without enough rest, our brains cannot function properly and this can impair our ability to concentrate, think clearly and even process memories. During The Sleep Series, Dr Sophie Bostock (AKA The Sleep Scientist) has been teaching us strategies to help us sleep better and live better.

If you missed the first two live sessions, they’re available to watch on demand for a limited time on the RADIATE: Wellbeing hub at [www.sor.org/radiate](http://www.sor.org/radiate)

Here’s what some of our members have said about the series so far:

“It was an excellent webinar. I was shocked by how many people have bad sleep patterns but, at the same time, I was also reassured to know I’m not alone, we are all sleep deprived zombies, but, hopefully, not for long.”

“It was a very interesting and thought-provoking session. The expert speaker was charis- and engaging – the session flew by.”

“Excellent session! I am very interested in sleep hygiene and love finding tips on how to improve the quality of sleep. At present, I am not doing so much on-call work, however, I was very interested in this subject as it really does affect my mental health and my job.”

“The workshop was amazing, I really enjoyed the experience as a third-year student radiographer. This will really help me during my final year – filled with examinations, lectures and placements – and in the future when I’m a qualified radiographer.”

The Sleep Series – final session

### Dealing with Insomnia and Stubborn Sleep Problems

Virtual | Tuesday 22 November, 19:00-20:00

Are you having trouble sleeping? In this session we will share powerful techniques to tackle insomnia and the most common sleep problems. We’ll look at why some people get stuck in a cycle of stress and poor sleep, and how you can reset your natural sleep patterns.

Register for your free place at [www.sor.org/radiate](http://www.sor.org/radiate)

Also this month

### Achieving Excellence in Radiography Education and Research

In person | Friday 25 November |

University of Suffolk, Ipswich

Do you want to improve the student experience and the training of the future radiographic workforce? This one-day conference will leave you feeling empowered and full of ideas to implement in your own practice. Let’s reconnect and move forward!

See the full programme and book your place at [www.sor.org/events](http://www.sor.org/events)



## QIP Tips

# Getting from A to B

## How to use process maps to understand the patient pathway

Do you ever wonder how a patient gets from A to B and what is involved? All the patients that come through the doors of an imaging department will be following a patient pathway, some of these are very short while others are a “long and winding road” with many twists and turns. I am sure you come across many different patient pathways in your daily work, some are confined to imaging while others involve complex integration with other departments.

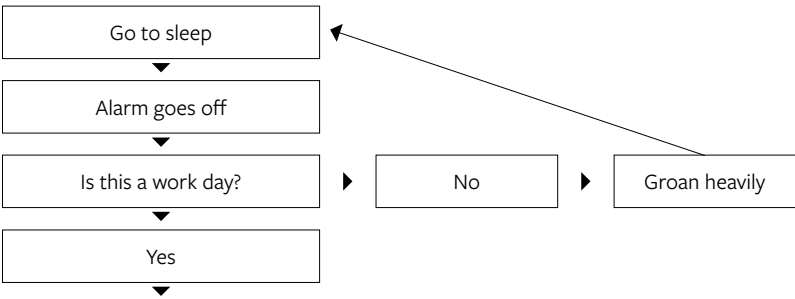
As a radiographer you may only be aware of the small part of the pathway that is relevant to you and your interaction with the patient and are not sure what happens next. But do you think it would improve patient care if you knew what was happening next and you could discuss this with the patient? Maybe if we understood the “longer road” we could improve and maybe even shorten it.

In the QSI we talk a lot about patient pathways and they are often highlighted as an area of improvement for services as they start their QSI journey. It’s not that services don’t have pathways in place, it’s more that they aren’t formally documented so we don’t know what they involve. Services need to provide evidence of these, show they are managed and that plans are in place to ensure staffing and equipment requirements are met to avoid affecting the patient pathway. As part of the accreditation process, services will need to demonstrate for each standard statement that they have a system in place and also:

- How does everyone know about your system?
- How do you know everyone is working to the system?
- How do you know that you couldn’t have a better system?

### How can you do this?

You can start very easily by choosing a patient pathway, maybe it’s a new one or a well-established one that isn’t working as well as you think it can. Start by creating a process map that will give you a visualisation of how the pathway currently works so you can see who and what is involved in each part of the



Source: NHS England and NHS Improvement, Conventional Process Mapping

pathway. This should help you identify any areas of waste or duplication and will also highlight where you have got it right. You can then use these parts of the pathway to support others. The map should be updated as you improve your process.

Your process maps don’t need to be complicated. For example, the simple process map above shows the steps for getting up in the morning, with boxes representing the activities and a diamond for a decision.

One of the biggest challenges when looking at your processes is getting the right people together to identify each step of the process you want to review and getting the time to do it. Making a small change in a pathway that works for you may have very different consequences in a different part of the pathway to either another service or to patient care. So review any changes to make sure they are better for all concerned.

### Helpful tips

- Where possible, create process maps with Post-it notes. People will feel more comfortable making changes to this, increasing the chance that your map will be accurate.
- Have everyone involved in the process present when you create the process map. This will allow for discussions about all parts of the process, including the parts done by people who are not part of the imaging service.
- If you can’t have everyone present, consider starting the map and then

leaving it in a shared space (such as the staff room) where people can see and make changes to it.

- When making the map, keep it visible to everyone so that all team members can see what is being suggested.
- Once you have a map that people agree on, look for any duplication, any “dead ends” or any steps that don’t add value. Consider focusing your improvements in these areas.
- Discuss the parts that people do differently. It may be important to start by reducing variation before embarking on other ideas for change.
- Agree on the beginning and end point before starting your process map.
- Consider having a patient look over your map to check that your understanding of their experience is correct.

Challenging the way that things are done can often be difficult and met with resistance but unless we make that decision and challenge ourselves, we don’t know if a process can be improved. ■



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# Do you earn less than £25,655 a year?

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For more information on how to apply, email us at [membership@sor.org](mailto:membership@sor.org)



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"Hi, I'm Blu and I work in the digital team. I look after the website and social media. In my spare time I enjoy taking my two-year-old son on outings, listening to endless amounts of music and spending time with my family."



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## Approaching the black hole

A review of abnormal areas of lucency on chest radiographs

Page 6



## Primary pulmonary sarcoma

A rare differential diagnosis of pulmonary embolism

### Case presentation

The patient is a 29-year-old woman with a history of obstructive pulmonary disease, gradual weight loss over three months and a history of chest X-ray to rule out aspergillosis, which demonstrated a density in the left hilum not previously seen. This was concerning for malignancy and was a CT chest and abdomen scan booked (Figure 1).

An aortic CT chest/abdomen scan was performed, which demonstrated a pulmonary artery measuring 40 x 40 mm transversally. The main bronchus of the left main pulmonary artery and a lower thoracic intercostal bronchus were in the right main pulmonary artery (Figure 2).

The outcome of the imaging was that the

main pulmonary artery of the patient's left

hilum after the CT was (Figure 3).

The patient was transferred to a specialist

centre for a CT-guided biopsy but,

concurrently, this was unsuccessful and

the PPS was found to be impossible. The

patient received palliative care and died 5.5 months from the date of the imaging discussed in this case study.

Poor survival outcomes in PPS (Table 1)

can be confirmed by recognition of first

presentation – delaying the diagnosis

even by days may affect survival.

### Steps to diagnosis

#### 1. Clinical history

Clinical history obtained from the patient is crucial for a correct diagnosis. For example, whereas APL usually presents with sudden onset SOB, PPS has a gradual onset. The such as weight loss, are indicative of with these symptoms, PPS should be considered as a differential diagnosis.

Unfortunately, many patients with PPS

have been misdiagnosed and treated

treatment, as reported in studies by

Gardner and 35 cases<sup>10</sup>.

In cases of misdiagnosis, the continuation

of clinical investigations attributed to

APL or CTPL, despite anti-coagulation

treatment, in respect of PPS.



Table 1. Median survival of patients with primary PPS

| Study                                   | Type                                     | Median survival |
|---|--|-----------------|
| Bandopadhyay et al (2016) <sup>11</sup> | Literature review (185 patients)         | 17 months       |
| Bandopadhyay et al (2016) <sup>11</sup> | Retrospective single site (150 patients) | 21.6 months     |
| Wong et al (2015) <sup>12</sup>         | Retrospective single site (100 patients) | 17 months       |
| Reisner et al (2013) <sup>13</sup>      | Retrospective single site (31 patients)  | 17 months       |

<sup>11</sup>Bandopadhyay et al (2016) compared final site data to a literature review using MEDLINE and EMBASE databases, then the two values.

<sup>12</sup>Bandopadhyay et al (2016) cases should include cases in Wong et al and Reisner et al, although the literature review included studies from 2001 to 2010.

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