

# Effect of Agenda for Change on Career Progression of the Radiographic Workforce 2009

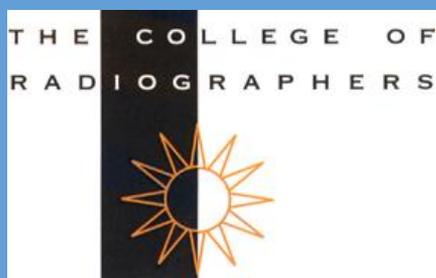
A report compiled by the

University of Hertfordshire

in collaboration with the

Institute for Employment Studies and Oxford Radcliffe Hospitals NHS Trust

for the Society and College of Radiographers



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**Research undertaken by the  
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# 1. Background and Nature of the Research

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## 1.1 Introduction

This report was commissioned by the Society and College of Radiographers (SCoR) to identify the effects of Agenda for Change (AfC) on career progression on the radiographic workforce in England and Wales. The situation in these two countries appeared relatively similar in that AfC was implemented at a similar time and under similar conditions. Scotland and Northern Ireland were excluded from the study since the implementation of AfC in those countries was quite different to England and Wales, and therefore results may not be comparable. Due to the larger number of employees per employer in Scotland, AfC was introduced there over a longer timescale. Northern Ireland is at an earlier stage of AfC implementation, and it is likely that the experiences and attitudes of participants there would differ from those elsewhere in the United Kingdom. Therefore, this survey concentrated on the views of radiographers, assistant practitioners and healthcare assistants (HCAs) across the spectrum of clinical imaging and radiotherapy in England and Wales. It is recognised that in the future it may be appropriate to carry out similar research among staff in Scotland and Northern Ireland.

The work was completed by a team of researchers from the School of Health and Emergency at the University of Hertfordshire, the Institute for Employment Studies and the Oxford Radcliffe Hospitals NHS Trust.

## 1.2 Background

Until 2004 radiographers, along with some other groups of National Health Service (NHS) staff had their pay and conditions determined through negotiations between management and trade union representatives through a Whitley Council framework. The framework was cumbersome (White and Hutchinson, 1996) and did not reward staff who wished to develop

a clinical career rather than follow a management pathway. Although the road to modernising pay and conditions in NHS trusts began in the 1990s when trusts were allowed to establish their own pay arrangements, fewer than twenty five NHS trusts did so (Corby, 2003). AfC set out a modernised pay system designed to ensure fair pay and a clearer system for career progression, with a common pay spine with bandings from 1 to 9 (DH undated). Implementation of AfC would initially include the undertaking of job evaluations, and later the introduction of the NHS Knowledge and Skills Framework (KSF) (Department of Health (DH), 2004a) in order to determine the banding to which individuals should be allocated. With the three core elements of AfC identified as job evaluation, harmonised terms and conditions, and the KSF, the over-riding principle was that staff would be paid on the basis of the work they undertook and the skills and knowledge they applied in their post (DH, 2004a).

Whitley Council terms and conditions were therefore to be replaced by a pay banding system linked to the newly-developed KSF. The Department of Health (2004b), through AfC, aimed to standardise roles and working conditions, improve recruitment, retention and morale, and help achieve a high quality workforce capable of delivering higher standards of patient care. Since AfC was implemented, the Department of Health has claimed that it has 'dramatically simplified the process of designing new ways of working and the establishment of extended roles' (DH undated).

Prior to AfC the College of Radiographers had introduced the Career Progression Framework (CPF) in 2002 in an attempt to provide a clear progression pathway for radiographers and ensure continuous improvement in patient services (CoR 2002). While there is evidence that the CPF has been adopted by a number of centres this is far from being universal (Price et al, 2009). In principle, the CPF should be compatible with both AfC and the KSF as they have similar intentions and, together, AfC and the KSF should provide the means by which the CPF is expedited. However, AfC did not have an easy introduction in radiography in spite of a promise for many of pay rises of up to 15% (Hutton 2005). There were concerns over increased working hours (AfC required radiographers to accede to a gradual increase in working hours from 35 to 37.5 hours a week), inconsistencies with job evaluations, confusion over on-call arrangements and, of particular interest given the focus of the this research, scepticism over whether AfC would facilitate professional development or improve retention (Anon, 2004).

Five years on from the introduction of AfC among NHS early implementers, and four years on for the majority, it is now timely to assess the impact that AfC has had on career progression in the radiographic workforce and to evaluate whether it has lived up to its original intended benefits or whether initial suspicions were justified.

### **1.3 Aims of the Research**

The aims of the project were to investigate the effects of Agenda for Change on the radiographic workforce within the following three career impact categories:

1. Career development expectations
2. Career progression opportunities
3. Barriers to and incentives for career progression

The radiographic workforce consists of radiographers, assistant practitioners and healthcare assistants in diagnostic imaging and radiotherapy.

### **1.4 Report Structure**

A multi-method approach was adopted to meet the requirements of the project: a literature review was undertaken followed by interviews with key stakeholders, a survey of the radiographic workforce, and finally, follow-up interviews with volunteers who had responded to the survey.

The literature review explored issues and consequences of AfC as a whole and its impact on career progression. It is reported in Chapter 2. The findings from telephone interviews conducted with individuals identified as key stakeholders are presented in Chapter 3, with key stakeholders being identified because of their role and experiences of AfC, either immediately prior to its introduction and/or during its implementation and/or its current operation.

Chapter 4 reports the outcomes from the survey of radiographers, assistant practitioners and healthcare assistants. This was a cross-sectional survey by means of an online questionnaire. The survey was open to the radiographic workforce in the NHS in England and Wales.

Chapter 5 discusses issues arising from the report and Chapter 6 presents conclusions and recommendations to the SCoR on the effects of AfC on career progression.

The work was undertaken from November 2008 to May 2009 as agreed with the SCoR. The research provides for the first time a comprehensive report on the impact of AfC and the NHSKSF on career progression informed by the views and experiences of the radiographic workforce in England and Wales.

## **1.5 Method of investigation**

### **1.5.1 Literature review**

Although our recent research scoping of radiographic practice (Price et al 2009) has made us aware of many of the main issues currently viewed as affecting career progression within radiography, the programme of work started with a review of the recent literature relating to career progression under AfC within health professions to ensure that all current research was available to the research team to inform the design of the questionnaire instrument.

### **1.5.2 Interviews with key stakeholders**

Ethical approval for the interviews and online survey was obtained from the School of Health and Emergency Professions Ethics Committee, University of Hertfordshire. A series of telephone interviews were conducted with a number of key stakeholders who were identified as having expert or specialist knowledge of AfC and its influence on the radiographic profession due to the role they held at the time of its implementation or due to their current role. These included past presidents, industrial relations officers from the SoR, society representatives from early implementer sites, and consultant radiographers. Their views helped inform the questionnaire design and allowed some comparison of staff opinion towards AfC in relation to career progression opportunities at the time of implementation with current opinion.

### **1.5.3 Survey**

The cross-sectional survey was devised using the Bristol Online Survey (BOS) service which allows development, deployment and analysis of surveys via the Web. A full copy of the survey can be found in Appendix 1: Online survey.

The survey was open to the whole of the NHS-based radiographic workforce in England and Wales in order to maximise the likelihood of obtaining a representative sample. Staff working in the independent sector were excluded from the survey since they are not bound by AfC terms and conditions. NHS staff practising in Scotland and Northern Ireland were also excluded, due to differences in AfC implementation. Articles publicising the study and how to access it were featured in issues of 'Synergy News', 'RAD' magazine, and 'Toptalk', an e-mail newsletter for radiography leaders. In addition, fliers were distributed at two national conferences held in December and January.

The online survey was available at <http://sdu-surveys.herts.ac.uk/effect-of-afc> and was “live” between 4pm on 20<sup>th</sup> January 2009 and midnight on 28<sup>th</sup> February 2009. Online responses totalled 2339. Paper copies were supplied with a pre-paid return envelope on request. Completed paper questionnaires returned no later than Monday 2<sup>nd</sup> March 2009 were included in the survey. There were 75 requests for paper copies and 34 were returned. For ease and consistency of analysis, these 34 responses were entered by hand into the online survey dataset by a member of the research team. Total responses for analysis were 2373.

### **1.5.3.1 Materials and questionnaire design**

The survey comprised five sections and 44 questions in total requiring a mixture of ‘tick-box’ and free text responses. It was straightforward to complete and allowed individuals to give free text responses where they wished. All questions were optional in order to maximise the number of submitted responses. Participants had the option of completing the survey in one visit or they could save their responses, log-out, and return to complete it at a later date. Section 1 requested demographic information. Section 2 explored participants’ current role and AfC banding, and previous grade if practising prior to the implementation of AfC. Information on whether participants perceived their current grade as fair and details on any appeals they may have undergone was also requested. Section 3 investigated career progression and development and asked participants about recent appraisals and the KSF. Section 4 focused on the experience of new graduate practitioners in terms of career expectations and likely progression in relation to Annex T. Section 5 asked participants about how their attitude towards AfC may have changed over time by providing an opportunity to cast a theoretical vote. It also sought any final comments which they may not have had the chance to express earlier in the survey and invited people to supply an email address if they were willing for a member of the research team to contact them again for greater detail.

### **1.5.3.2 Method of analysis**

Descriptive statistics were used to identify trends and patterns amongst staff in relation to a range of key variables including their AfC pay banding, role, and location. In addition, inferential statistics were performed to explore any significant differences between attitudes and experiences of staff in terms of length of time qualified and between those who had entered the profession pre- and post-AfC.

All free text responses to key questions were read, analysed and themed, thus providing a means of quantifying the qualitative data. To strengthen internal consistency, the themes were double checked by different members of the research team.

#### **1.5.4 Follow-up interviews**

All free text comments submitted in response to the final question ('Additional comments') were read and interpreted by members of the research team. The majority of additional comments echoed those which had been made at earlier stages in the questionnaire, and required no further investigation. However, based on the nature of some specific comments, seven participants who provided email addresses were invited to take part in follow-up interviews conducted by telephone. Four accepted. Consent was obtained on acknowledgement of the invitation to contribute further and on provision of a contact telephone number to a member of the research team. Clarity was required on some themes highlighted in the survey including the perceived advantages of AfC over Whitley Council terms and conditions, and inequity both amongst radiographers and when compared to other health professions in terms of career progression under AfC.

Details of the findings from both the telephone interviews and survey are presented in chapters three and four.

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## 2. Literature Review

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### 2.1 Introduction

AfC introduced a modified system of career progression and conditions of work for all directly-employed NHS staff, except those covered by the Doctors' and Dentists' Pay Review Body and some senior managers. This represented the first major overhaul since the adoption of Whitley Council conditions in 1948. The AfC system was applied to twelve "early implementer" sites<sup>1</sup> for evaluation in the Spring of 2003 and then rolled out across the whole of the NHS in England and Wales from October 2004 to December 2006. Nurses had already been subject to a review of clinical grades, from April 1988, which resulted in a system of grades A to I and had generated a large number of appeals. These grades would be incorporated within the new NHS-wide AfC system.

NHS Employers (2006) remarked that AfC was designed to support a cultural shift in health provision, based on a highly flexible workforce, with reduced demarcation between teams and with staff in possession of transferable skills developed along the patient or care pathway. They saw AfC as providing a set of high-level workforce tools, "*beyond being simply a new pay system*". The main role for the graduate healthcare professional would be to "*facilitate, educate, enable and lead others to develop healthcare, whilst carrying out those tasks that they alone cannot do, such as more complex assessments and interventions*". AfC, as announced by the Department of Health (2002), also embraced several key aspects of practical working conditions: job evaluation and basic pay; career progression linked to the KSF; enhanced pay in high cost localities; recruitment and

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<sup>1</sup> James Paget Healthcare NHS Trust; Guy's and St Thomas' Hospital NHS Trust; City Hospitals Sunderland NHS Trust; Papworth Hospital NHS Trust; Aintree Hospitals NHS Trust; Avon and Wiltshire Mental Health Partnership NHS Trust; South West London and St George's Mental Health NHS Trust; West Kent NHS and Social Care Trust; Herefordshire NHS Primary Care Trust; Central Cheshire Primary Care Trust; North East Ambulance Service NHS Trust; East Anglian Ambulance NHS Trust.

retention premia; revised working hours and overtime payments. However, chief amongst its provisions was the use of “job weight” to determine career band on a scale of 1 to 9, with job weight being calculated on the basis of the knowledge and skills required to do a job; the responsibilities involved; any physical, mental or emotional efforts expended and any extra demands imposed by the working environment. The job weighting was intended to allocate jobs to one of the nine common pay bands, with work of equal value receiving fair and equal pay. The Equal Pay Act, in 1970, had previously outlawed any pay discrepancies between male and female employees doing the same work and from 1984 was amended to cover work of “equal value”.

In conjunction with the calculation of job weightings under AfC there was a “pay uplift” worth 10% over three years, intended to cushion the transition to the new system. The transition period also brought about the creation of “job profiles” for standard NHS posts with common features, on a national basis, designed to ease the process of assigning staff to one of the new pay bands. The profiles were not intended to be descriptions or person specifications for individual jobs. They were loosely defined as *“the outcomes of evaluations of jobs”* and as *“rationales for how national benchmark jobs evaluate as they do”* (DH, 2004c). There was also a clear expectation that the new KSF would be integral in steering annual development reviews and personal development plans. It would permit staff to receive clear and consistent development objectives, plus development opportunities linked to identification of the extra knowledge and skills needed for career progression. Two “gateways” within each AfC career banding were introduced, in order to allow assessment of knowledge and skills prior to further progression.

Another aspect of the commonality which AfC sought to achieve was the phased implementation of a 37.5 hour working week for all staff, which brought about a decrease in hours for some, such as pharmacists, and an increase for others, such as radiographers. There was also a standardised annual leave entitlement. The Department of Health (2002) remarked that the new system *“has been designed to ensure that as many staff as possible move to pay bands that provide a higher maximum pay than now, whilst ensuring a phased approach that is consistent with affordability.”* The NHS Staff Council was established in 2003 to oversee the new national system and to replace the previous General Whitley Council and separate Whitley Councils.

The final agreement document (DH, 2004b), set out the wider-ranging aims of AfC, which included: quicker patient treatment and improved quality of care through identification of new ways of working; enhanced efficiency; improved staff retention, recruitment and morale through facilitation of career development; attainment of the right workforce for the needs of

the NHS; equal opportunity and diversity, especially in terms of career and training opportunities and working patterns that are responsive to family commitments. This would be facilitated by local partnerships. A twelve month period of “preceptorship” was confirmed for newly qualified staff directly entering band five, enabling accelerated progression through the first two pay points, subject to satisfactory performance. This was later developed into ‘Annex T’ of the AfC mechanisms.

The expectation was that allowances would be replaced by higher basic pay for the majority of staff, with extra discretionary awards being available for staff undertaking statutory regulatory duties outside those required by their job descriptions. There would be extra local allowances to enable employers to recruit in areas of special need and, where market forces dictated, enhanced pay (Annex H<sup>2</sup>) with a need for recruitment and retention premia being identified for dental nurses, biomedical scientists, pharmacists and new entry midwives, amongst others, but omitting nurses, radiographers and physiotherapists. In addition, under Annex K (DH, 2007) NHS Foundation Trusts and three star NHS organisations would be able to act independently with regard to specified “local freedoms” such as accelerated progression, alternative benefit packages, expenses, bonuses, recruitment and retention premia.

In addition, the agreement document announced that personal development plans would be implemented for all NHS staff, based on annual reviews set against the NHS KSF, by no later than October 2006. This would result in an annual documentary record of performance measured in terms of the KSF post outline. Where training and development needs were identified, the expectation was that employers would provide financial support and developmental time to staff, and would be unable to defer pay progression if they failed to do so.

In April 2003, a large turnout of 97,884 Royal College of Nursing members voted on the proposals, with 88% of the poll voting to accept the AfC proposals (Didovich, 2003). This result was paralleled in the same year by over 90% of midwives, 81% of UNISON members, and 86% of physiotherapists casting their votes in favour of AfC (CSP, 2009). By contrast a first ballot of radiographers returned a “yes” vote of only 49% (SoR, 2003), partly due to misgivings about increased working hours and reduction of on-call earnings. This result was emphasised more dramatically by a second ballot, in which only 17% of radiographers voted for AfC (SoR, 2004). Radiography was unique amongst the major health professions in its

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<sup>2</sup> Details of recruitment & retention premia are provided under Annex H in the DH AfC Final Agreement document (2004) and under Annex J in the DH AfC service handbook (2007).

membership's rejection of AfC. However the Society of Radiographers, following a lengthy period of negotiation, believed that AfC would be applied to radiographers regardless of the membership vote. In view of this, the SoR determined to remain within the collective bargaining process, in order to ensure representation for radiographers (Paterson, 2005).

Since the inception of AfC, a number of studies have examined its impact on the NHS workforce. Their findings are analysed in the following sections of this chapter by topic aspect rather than date of publication. It should be noted that comparatively few of these published enquiries have considered the specific position of radiography staff.

## **2.2 Expectations of Agenda for Change**

The Shadow Executive of the NHS Staff Council (2004), in a review of experience at early implementer sites for AfC, commented that beneficial developments would include: new roles, such as assistant practitioners in radiography; changing roles, for example in medical records; extended roles, including emergency care practitioners; improved team working through harmonisation of terms and conditions; new ways of working; improved recruitment and retention.

Agenda for Change however, received a mixed reception from members of the health professions. Walmsley (2003), reporting from a nursing perspective, noted that AfC would include the possibility for rewarding staff for the work they actually *do*, and should benefit nurse specialists, but would be threatened by funding shortages. He expressed a desire to see AfC as the *"light at the end of the tunnel"*, not *"the lamp on the front of an oncoming train"*. Many commentators were pre-occupied with pay and working conditions. Pollard (2003) remarked that although his initial impression had been that it was a *"recipe for confusion"* on repeated reading the package for nurses was coherent, fair and transparent. He felt that many nurses on low pay should benefit from the changes and welcomed the standardisation of other professions' working hours to the 37.5 per week already undertaken by nurses.

Parish (2004), writing just prior to the national roll-out of AfC, commented that many national job profiles had not yet been created and that this was stalling the implementation process. He also found that the job evaluation process, requiring a 39 page questionnaire, had proved more time-consuming than expected, even at early implementer sites. Nevertheless, he noted that UNISON and other trade unions were broadly in favour of AfC. The Chartered Society of Physiotherapy took the view that *"although not perfect, Agenda for Change represented a considerable improvement on the old 'Whitley' system and was a good deal for physiotherapy, physiotherapists and physiotherapy assistants"* (CSP, 2009).

However in 2003, Henderson reported that many radiographers were unhappy about the increase in working hours, but felt the AfC proposals represented the best that could be achieved by negotiation. He commented that radiographers who wanted to progress would have the opportunity to further themselves under AfC, while those who saw radiography as a job rather than a career would have fewer opportunities to progress. Harker (2005) expressed disappointment that most senior II radiographers at her local NHS trusts had been assimilated into band 5, despite having several years of post-qualification experience. The SoR (2005) stated that *“Agenda for Change must facilitate accelerated career progression to enable radiographers to deliver the Government’s health agenda, and to secure the support of the profession”*. The SoR also voiced the view that Annex T must apply to all newly qualified radiographers, permitting accelerated development in the first two years post-qualification and movement to band 6 within two years. This would require a period of preceptorship with appropriate support and funding, elevating skills and knowledge to that expected of a band 6 practitioner.

The general expectations and aspirations of allied health professionals, particularly with regard to recruitment and retention, were explored by Arnold et al (2006) in a large study for the University of Loughborough. They found that pay was not the salient motivational factor for most allied health professionals, although it was a significant one amongst reasons for leaving. This is pertinent, as AfC was largely conceived as a structure for pay re-organisation. Arnold et al (2006) also noted that the attitudes and perceptions of radiographers towards the NHS were more negative than those of other allied health professionals. However they also found that despite these negative attitudes, radiographers were more likely than other groups to remain in the NHS. The study further reported that amongst “stayers”, radiographers were less positive than any other AHP groups in terms of their perceptions of professional development within the NHS.

### **2.3 Transitions to Agenda for Change**

Much of the published survey evidence on the transition to AfC relates to the nursing profession. Ball and Pike (2006) in a postal study of 2,462 nurses, found that 55% felt AfC to be less fair than the previous system. Nearly two thirds (63%) felt that the transition to AfC was too slow and only 24% were satisfied with the way that AfC had been implemented in their organisation. However, 43% said that their employer had kept them well-informed about the transition to AfC. Nearly equal numbers of nurses, 40% and 41%, were satisfied or dissatisfied respectively with their AfC banding.

Ball and Pike (2006) also explored the views of NHS nurses on career banding. More than three quarters (77%) indicated that their job had been evaluated under AfC. Of these, just 3% provided positive comments while 19% felt that their band was too low, downgraded or failed to reflect their responsibilities, or was otherwise incorrect. Dissatisfied nursing respondents were most likely to have been placed into pay band 5 and commented that previous D or E grade staff had often been grouped together into this band, regardless of duties.

A further problem identified was the fact that the job evaluation process in many cases had failed to look at individuals and had focused instead on groups of nurses performing similar roles (Ball & Pike 2006). Previous E grade nursing staff now on band 5 represented the largest dissatisfied group. The prior grades of band 5 staff were D (51%), E (44%), F (5%) and G (0.5%). The prior grades of band 6 staff were D (0.5%), E (9%), F (56%), G (28%) and H (7%). Respondents who had been involved in implementing AfC in their organisations were more likely to have moved to relatively higher AfC bands than their colleagues who were not involved. Just over half (54%) of the nurses in the survey felt that their AfC banding was fair, while 40% did not. This compared with percentages of 45-47% who felt that their banding was not fair in previous RCN surveys prior to the advent of AfC. Only 31% of managers felt that their AfC banding was fair, while 75% of sisters/charge nurses were satisfied.

As part of an analysis conducted on behalf of the King's Fund of professional groups included in NHS Staff Survey data for 2003-2006, Buchan and Evans (2007) noted a steady decline in staff perceptions that their work was valued by the employer, and in perceived standards of patient care, during the transition period to AfC. However, staff job satisfaction scores rose slightly over this period, although expressed intention to leave was unchanged. Buchan and Evans (2007) noted that the Department of Health had estimated that the transition changes would result in an immediate pay increase for over 90% of staff under AfC and commented that the majority of staff would receive substantial increases between 2004 and 2007.

The National Audit Office (2009), in a further examination of data from the 2006 NHS Staff Survey, noted that nurses and midwives were more likely to feel positive about AfC than other groups of staff in acute trusts, with 46% of nurses and 41% of staff as a whole regarding their re-banding as fair. Since nursing staff comprised a large proportion of the hospital workforce, the percentage of non-nursing staff who felt positive towards AfC in this survey was likely to be markedly less than 41%. The National Audit Office (2009) also reported that average earnings for nurses rose by 4.2% per year since 2004, while those for

other staff groups rose by 5.8% per year. These increases placed financial pressures on the NHS.

The effect of the new AfC system on career progression and banding was followed with keen interest by NHS staff, as many hoped to benefit from the re-banding process, although some managers were apprehensive about the financial implications (MORI, 2006). Jenkins (2007) has commented that NHS staff who submitted job descriptions later in the evaluation process may have *“benefited from the experience gained by others”*. He reported that in Wales, a funding squeeze resulted in employers *“pressing within job evaluation panels for lower and more affordable outcomes than would otherwise be merited”*. Jenkins also commented that the “clustering” of job descriptions for staff undertaking similar roles, although not allowed for within AfC, may have offered an efficient solution for managers.

## 2.4 Opportunities for progression under Agenda for Change

The views of nursing staff towards career progression were also explored by Ball and Pike (2006) in an analysis of results from the 2005 and 2006 NHS Staff Surveys. This was the time period during which AfC was rolled out nationally. These findings are summarised in Table 1:

**Table 1: Percentages of nurses agreeing with positively framed items regarding career progression during the period 2005-2006 (Ball and Pike, 2006)**

	NHS 2005	NHS 2006
Opportunities for nurses to advance their careers have improved	58%	35%
I have a good chance to get ahead in nursing	37%	18%
Career prospects in nursing are NOT becoming less attractive	33%	16%
It will NOT be difficult for me to progress from my current grade	29%	15%
I DO know where my career in nursing is going	44%	33%
I can determine the way my career develops	57%	47%
I am NOT in a dead end job	73%	64%
I am interested in career progression	66%	60%
I know what I want to do in the future my career	55%	52%
There is open dialogue about my career with my manager	45%	42%

The table demonstrates that nurses became more negative in their views of likely personal career progression during the implementation period for AfC, with changes in positive framed attitudes ranging from minus 23% for career opportunities to minus 3% for open dialogue with managers. Ball and Pike (2006) also found that nurses working in trusts with a financial deficit were much less likely to respond positively to career progression items. For example, 69% of nurses in trusts where there was a deficit agreed with the statement that career prospects in nursing are becoming less attractive compared to only 53% in trusts that did not have a deficit.

Buchan and Evans (2007) felt that the main “losers” under AfC had been bands 4 and 5 administrative and clerical staff, while the big “winners” had been senior clinical nursing and senior allied health professional staff. Ancillary grades appeared to have done relatively well, by moving across to a new system with a lengthened pay scale and improved career progression. Cox, Grimshaw, Carroll and McBride (2008) found that new career opportunities existed for band 2 healthcare assistants to progress to bands 3 and 4 via NVQ level 2 and /or 3 awards and foundation degrees.

Regular staff appraisal is a key part of the AfC and should provide opportunities for staff progression. The National NHS Staff Survey for 2007 (The Healthcare Commission, 2008) found that 61% of staff had received an appraisal or performance review in the previous 12 months. This was not significantly different from the proportions of staff who had done so in 2006 (58%) and 2005 (60%), suggesting that the AfC had little or no impact on rates of staff appraisal in the NHS. In the 2007 survey, 41% of respondents said that they had received a KSF development review, while the remaining 20% had received some other type of appraisal. About half (53%) of those who had received an appraisal felt that it would help them improve how they did their job, while 76% said that it had provided clear work objectives. The National Audit Office (2009) found that the percentage of staff who had received a KSF development review had risen to 53% by September 2008, following a letter to all health organisations from the Parliamentary Under Secretary for Health Services on this topic. MORI (2006) in a qualitative survey of union members working within the NHS, including nurses and allied health professionals, found that there was uncertainty about KSF and how it would work in practice. There was a view that KSF had not been well-communicated and that it might create staff expectations that were unrealistic in the face of funding shortages. The National Audit Office (2009) has since commented that some managers and staff view the KSF as complex and burdensome.

Additional training forms an essential part of banding progression under AfC, linked to KSF-led development plans. The National NHS Staff Survey for 2007 (The Healthcare Commission, 2008), in a survey of 156,000 employees, found that 94% had taken part in at least one employer-led training, learning or development activity during the past 12 months. While this level was virtually unchanged from 2005 and 2006 (both 95%), a decrease in attendance on taught courses and an increase in on-line training was also observed. Furthermore, only 50% of staff stated that they had received the training that was identified in their personal development plan in 2007, compared with 53% in 2006 and 56% in 2005, suggesting that if anything, rates of training are falling under AfC. The percentage of staff saying that their line manager had supported them in accessing this training also fell over the period 2005-2007 from 68% to 59%.

## **2.5 Barriers to progression under Agenda for Change**

Use of staff appraisals based upon the KSF forms a key part of AfC implementation and should facilitate career progression. However the available evidence indicates that this process has been tentative. Buchan and Evans (2007), in their analysis of NHS staff survey data for the King's Fund, found that 67% of staff had a full KSF job outline, 33% had a KSF personal development plan and 27% had received a development review using KSF. Ball and Pike (2006), in their survey of nurses, found that only 29% of respondents had a completed KSF outline for their post, while 23% said that their outline was in progress. Nearly four in ten (37%) did not have an outline. Progress had been greater in community settings than in hospitals. Of those staff that had a completed KSF outline for their post, 75% said it was linked to their personal development plan and 54% indicated that they had been involved jointly with their employer in developing it. Comments centred on perceptions that KSF was time-consuming to implement and that many line managers did not understand it. Nearly a fifth (19%) felt the KSF was a waste of time, but more (46%) did not agree with this view.

Cox et al (2008) cautioned that in some trusts, healthcare assistants were not always being promoted after obtaining extra qualifications, due to lack of available on-site posts at the higher band. This created dissatisfaction amongst staff and contradicts the aim of AfC to recognise and reward increased skill levels as they are attained and utilised, rather than requiring individuals to wait for more senior staff to leave before moving into higher graded posts. In practice therefore staff may need to be geographically mobile in order to obtain the advancement opportunities available upon the "skills escalator". Kelly, Piper and Nightingale (2008) have commented on funding constraints that may restrict the numbers of advanced and consultant radiography practitioners reaching the top of the escalator. Price et al (2009)

noted that AfC was seen by some radiography managers as a step towards establishing advanced and practitioner posts, while others reported that funding shortages prevented them from providing band 7 status for experienced staff even though their role justified it.

Bogg et al (2005) found that a lack of training opportunities was the highest reported barrier to career progression amongst allied health professionals in the past and the second highest reported barrier to career progression in the future. Probst and Griffiths (2008), in a qualitative study, discovered that therapeutic radiographers found their continuing professional development (CPD) time restricted by work pressures, although good management could alleviate this and free up staff for training. The therapeutic radiographers also commented that they needed to be very “self-driven” in order to gain time off for CPD. Miller, Price and Vosper (2008), in a survey of radiography managers, found variations in the perceived availability and quality of training provision across the UK, together with a strong demand for training for some extended role activities. There were many examples of “in-house” courses which offered an alternative to university attendance, some being accredited and others not. Some respondents in the study expressed concerns about unaccredited courses and the extent to which they equipped individuals for extended role activities. Price et al (2009) noted an association between AfC banding and the possession of postgraduate qualifications in radiography, although it was not clear to what extent banding was driven by these awards. The focus group research undertaken within the same study indicated that it is not easy for radiography practitioners to access the relevant masters' level courses to help them advance through the CPF.

## **2.6 Working patterns, gender, ethnicity and age**

Some evidence suggests that perceived barriers to career progression, such as gender, age, ethnicity and part-time status, have not been vanquished by AfC.

### **2.6.1 Working patterns**

Bogg et al (2005) in a qualitative study of allied health professionals undertaken as part of the “Breaking Barriers in the Workplace Project” discovered that family commitments and part-time working patterns were the main perceived barriers to career progression amongst female AHP staff. They also found a *“continuing tradition of the low professional profile of AHPs, when compared to other female dominated professions such as nursing”*. The majority of AHPs interviewed expressed a wish to remain clinically focused within their careers. Opportunities for progression however, were often limited to managerial roles and there was a need for more clinical specialist and consultant positions. However the interviewees were positive about the availability of training opportunities in the NHS

compared with other organisations, particularly for CPD. A quantitative element of the same project by Bogg et al reported that 48% of AHPs reported a lack of opportunities for career progression, with proportionally more senior grade AHPs expressing this view.

Bogg, Pontin, Gibbons and Sartain (2007) in a questionnaire survey of 420 physiotherapists, found that two-thirds (63%) of respondents felt that the NHS could learn from other organisations in terms of effective methods of developing diversity and career progression. The same authors, in a study of 396 occupational therapists (Bogg, Pontin, Gibbons and Sartain, 2006), discovered that almost one third (32%) had experienced barriers to career progression, including lack of training opportunities, personal commitments and equality issues.

### **2.6.2 Gender and ethnicity**

A recent study by Thompson and Horan (2009), based on analysis of pay data from the 2004 and 2007 NHS Earnings Surveys commented that “*there did not appear to have been systematic bias due to gender or ethnicity*”. However male AHPs appeared to have done rather less well under AfC than their female colleagues, receiving a mean 14.9% pay increase, rather less than the 17.2% mean pay increase received by female staff. The mean pay of male AHPs in 2007 (£28,100) was also rather less than the mean pay of female AHPs (£29,300). These gender differences were more marked in the case of unqualified AHPs. Here the mean pay increase was 13.7% for male staff and 18.2% for female staff. Thompson and Horan found that qualified AHP staff did rather less well than registered nurses in terms of increased pay over the period, with a mean increase of 16.9% compared with 19.5% for the nurses. Unqualified AHP staff fared slightly better, receiving a 17.5% mean increase.

Other studies have examined career progression under AfC in the context of demographics such as age, gender, ethnicity and locality. Wray et al (2007), in an interview survey of nurses and midwives, found that many staff aged over fifty years experienced difficulties in gaining access to training opportunities. Some felt that they had been well rewarded under AfC, although others said that their experience was not as well regarded as paper qualifications. However, the National NHS Staff Survey for 2007 (The Healthcare Commission, 2008) reported that only 2% of staff over fifty felt discriminated against on the basis of age. In fact, there is evidence that younger staff feel more dissatisfied with the NHS as an employer than older staff. Bogg et al (2005) found that a high proportion (64%) of AHP staff aged twenty one to twenty five stated that they would not be working in the NHS in five years time.

Buchan and Evans (2007) reported that a higher number of women than men in acute trusts had thought that their AfC banding was fair, with nearly a half (44%) of women compared to just under a third (31%) of men believing that the band they had been assigned was fair. However, a slightly larger proportion of women employees (just over a third, 36%) compared to male employees, (just under a third, 32%) felt their banding to be unfair. A recent claim for sex discrimination under AfC, which alleged that male support workers were overpaid relative to female colleagues, failed in an Employment Tribunal hearing (Staines, 2009). However the National NHS Staff Survey for 2007 (The Healthcare Commission, 2008), reported that 2% of men but less than 1% of women felt discriminated against on the grounds of their gender. Bogg et al (2007) found that more male physiotherapists than female physiotherapists regarded gender as a barrier to their own career progression.

Black and minority ethnic staff may be more likely to believe they have been poorly treated under AfC (Buchan and Evans, 2007). Only 26% of black and minority ethnic staff regarded their AfC banding as fair, compared to 43% of white staff, with a further 30% of black and minority ethnic staff being unsure whether their banding was fair, compared to just 13% of white staff. Bogg et al (2007) noted that 72% of physiotherapists from non-white backgrounds agreed with the statement “minority groups do experience barriers to career progression”, while the Healthcare Commission (2008) found that 12% of black and ethnic minority staff across the NHS felt discriminated against on the basis of ethnicity.

## **2.7 Regional variations**

Buchan and Evans (2007) in their analysis of NHS Staff Survey results on behalf of the King's Fund, reported only minor regional variations in the perceived successful implementation of AfC. These are displayed in Table 2 below:

**Table 2: Variations in the perceived implementation of AfC by English health region (Buchan and Evans, 2007)**

English Region	Percentage of staff who thought that their banding was fair	Percentage of staff receiving a new job outline	Percentage of staff reporting a successful implementation of AfC	Percentage of staff reporting increased responsibility
East Midlands	42%	73%	22%	21%
Eastern	41%	71%	25%	19%
London	37%	71%	28%	25%
North East	43%	77%	22%	22%
North West	43%	75%	24%	23%
South Central	42%	71%	25%	20%
South East Coast	42%	75%	27%	20%
South West	41%	74%	24%	19%
West Midlands	44%	73%	25%	21%
Yorkshire and Humber	38%	69%	18%	18%

The most striking aspect of this breakdown of national figures is the consistency across regions. Across England, fewer than half of all staff believed that the AfC band they were assigned had been fair, and, across regions, there was only a few percentage points difference in this proportion. London had the lowest proportion of staff saying this (37%) and the West Midlands had the highest (44%). Similarly, only around a quarter of respondents across England felt that implementation had been successful, with the highest proportion being seen in London (28%) and the lowest proportion saying this in Yorkshire and Humber (18%). Buchan and Evans (2007) also found some differences in their comparisons between different types of NHS trust in the implementation of AfC. In acute teaching trusts, only 20% of staff felt that that AfC had been successfully implemented, while 28% did so in small acute trusts and 32% in specialist trusts. In acute teaching trusts only 37% of staff felt that their AfC banding was fair, compared with 44% in small acute trusts and 43% in specialist trusts.

## 2.8 Other developments since the introduction of Agenda for Change

The recent increase in the number of foundation trusts within the NHS has brought about more capacity for autonomy with regard to AfC in response to specific local needs. Arguably, this has potential for influencing career progression among healthcare workers through the

design of new ways of working and through offering alternative terms and conditions. The National Audit Office (2009) noted that as of January 2009 there were 169 acute trusts in England, 82 of which had foundation status. They also commented that the changing situation in the NHS could make the national AfC system redundant should trusts opt for local terms and conditions of service. They reported that one foundation trust had declined to introduce the KSF, and another was planning to move away from it. However The National Audit Office (2009) expressed the view that AfC would remain an important reference point for trusts in the changing NHS landscape.

## **2.9 Summary**

AfC was the greatest overhaul of pay and conditions since the inception of the NHS. It was designed to introduce equity, facilitate career progression for healthcare staff, and improve patient services. Due primarily to an increase in working hours, a large proportion of radiographers were antagonistic towards AfC from the start and, unlike other healthcare professions, voted against it. However, the literature reveals that dissatisfaction with AfC has been widespread within the NHS and not confined to radiographers as a staff group. Much of the dissatisfaction appears to derive from individuals having been assigned to bands lower than anticipated. In addition, there are differences between the different groupings within the workforce: women workers appear more likely to have felt that their banding following AfC was fair than do male workers, while workers from ethnic minority backgrounds are far more likely to feel that their banding was unfair than are white workers. Across the country, though, there are few differences in the proportions of workers who feel that AfC was poorly implemented, with around three-quarters of staff believing that AfC was not successfully implemented. Although AfC aims to reward clinical expertise, some studies indicate that a lack of vacancies and funding continue to prevent career progression.

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## 3. Interviews with stakeholders

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At the start of the project a series of interviews was conducted with key stakeholders. These interviewees included: SCoR industrial relations officers; SoR representatives at early implementer sites; members of the SCoR Council at the time of introduction of AfC; imaging and therapy managers familiar with Whitley and AfC grading; consultant radiographers; and experienced practice educators/CPD co-ordinators.

The reason for seeking their views were two-fold: first, to ensure that all relevant issues were addressed in designing the questionnaire; and second, to review staff attitudes towards AfC in relation to career progression opportunities at the time of implementation, and use this information to inform the design of the questionnaire.

Each individual was contacted initially by email, requesting an interview. Only one contact out of the 12 approached declined to be interviewed. With the eleven people who agreed to be interviewed a date and time was arranged for the interview. At the start of each interview the researcher gave assurances regarding anonymity and confidentiality and asked permission to record the interview as well as take notes during the discussion.

The discussion started by asking the interviewee about their role at the time of the debate about, and introduction of, Agenda for Change, and then covered six key questions:

- their recollection/memories of the introduction of AfC
- the interviewee's opinion of its effect now, and whether these had changed since its introduction
- whether there have been any unintended consequences of AfC
- whether AfC has had any impact on career progression for radiographers and support workers

- whether AfC is likely to have any further impact on radiographers and support workers in the future, and if so, what they believed those impacts would be
- whether AfC is meeting the aims which it was designed to address: to lift morale, aid recruitment and retention, and assist career progression

The majority of interviewees indicated that they would be happy to be identified in the report, but initial assurances of anonymity have been adhered to in reporting the outcomes of the interviews in the following sections.

### **3.1 Before and after implementation: was there a rationale for implementation?**

Many of the interviewees recognised that there had been problems with pay and grading within imaging services for some time, and at first they had believed that AfC represented a real opportunity to resolve those problems:

*Whitley wasn't working anymore and needed replacing – it did not recognise eg advanced practice. I remember thinking it [AfC] was a good idea since there was a total lack of standardisation for sonographers' pay at that time.*

*The Whitley scale was no longer fit for purpose. And people doing different work were on broadly similar pay rates. And there was the recognition that the existing structures were not conducive to modernising careers and modernising work practices.*

*Whitley had had its day and wasn't working for us.*

Interviewees had been aware that many of the workforce were unhappy at AfC – prompted largely by the increase in working hours – but believed that the broader intentions had been good:

*It was meant to lead to better training, and it had a good vision... it was meant to look at a range of things like...enabling better team working.*

#### **3.1.1 After implementation**

Interviewees recognised that, across all bands, the AfC pay scales offered more pay.

*The salary range for radiographers was about 20k to 50k tops with very few exceptions. The salary scale for radiographers now ranges from, well, it is still around 20k at the bottom but it goes up to nearly 80k...in terms of the potential pay there is a significant difference between then and now.*

However, disparities continued, with the anticipated standardisation of pay rates for jobs of equal value failing to materialise because of variations in practice at local level – one of the issues it had been expected that AfC would resolve. Some interviewees could see this difficulty increasing with the roll-out of Foundation status.

*It has had benefits for some but not for others, as some aspects are not being implemented by some Trusts. There has been a failure of some Trusts to adhere to the 'whole package' of AfC....they are actively leaving out the bits they don't like, such as Annex T.*

*AfC helped some but not others...there were disparities.*

*There is still a rash of local agreements which defeats the object of AfC. The new Foundation trusts also defeat the object since these Trusts are in charge of their own budgets and are able to band staff as they wish....therefore one assumes that this disparity is likely to continue to grow.*

Interviewees had seen problems arise from variations in the process by which job descriptions were agreed during the initial bandings for AfC. In some cases, people with the same level of responsibility before AfC were assigned to different bands, while in others, people with widely differing experience were assigned to the same band.

*People doing the same job are now on different pay bands.*

*There were two superintendent II radiographers here [prior to AfC] who were [subsequently] banded differently. People had similar roles before AfC but were banded differently. People were put in the wrong bands and mismatched.*

*In some cases these was misapplication of the process of matching to the criteria, or the criteria could arguably have been misapplied. So across the UK we have got some inconsistencies in matching outcomes, certainly between employers but more significantly the potential for inconsistencies in matching outcomes within individual employers, which has caused some difficulties.*

*Job evaluation has not been consistent. Matching has been poor, different bands for similar Trusts.*

The general perception was that AfC had been rushed through, with managers not receiving adequate training in undertaking job evaluations or writing job descriptions. As a result, the job evaluations had been time-consuming and often were not done as well as would be hoped. A proportion of the variation in banding decisions appears to have been attributable

to some managers being more skilled than others in drawing up job descriptions that fully encapsulated the roles within their departments.

*The job evaluation exercise consumed so much energy and resources of the people involved, it was not handled properly, and people didn't know what they were doing. There were a lot of training programmes to help prepare people for going through the exercise, and panels for implementation with trade union reps on, but there was not enough preparation, for it to work there had to be accurate and up-to-date job descriptions...if it had been done properly it would have been a fantastic opportunity. But one hospital told its line managers that they had to agree job descriptions with their employees within three months. What it flagged up was the problems and the different perceptions of what constituted an adequate job description – there were heads of nursing bringing in five page job descriptions and heads of estates bringing in just three lines. The process identified the problems and the training requirements of the line managers on what a job description was, but there was no time to do that. So the panels did heroic work but they were hamstrung by things that should have been done five years ago, the failures of management training in the NHS.*

*People were banded differently according to how clever their managers were at writing job descriptions and at ticking the boxes on the job evaluation questionnaires.*

Meanwhile, in other Trusts, managers appear to have been involved hardly at all:

*We were all asked to submit as individuals, which we did. However, initially all superintendents were lumped together as a group during the assessment stage – consequently every superintendent grade (diagnostic) was banded as a 7, taking no account of their experience, role, seniority or level of responsibility/accountability. The initial banding notifications came back with the wrong job descriptions – for example, RNI superintendents came back with MRI responsibilities!*

Interviewees believed that the end result of people witnessing such events had been a disastrous drop in morale, and a feeling that radiographers as a group had been let down by the implementation process.

*I thought it had potential for unfairness right from the start and this has been borne out.*

*It has been really demoralising and in some cases morally wrong. For example diagnostic grades were banded a whole grade lower (except for new graduates) than their radiotherapy counterparts....some staff have also gained advantage under AfC,*

*especially in areas where there are staff shortages. But this too is morally wrong on experienced staff. In our case a radiographer was given a band 7 RNI post after only being qualified for two years – this put them on the same banding as both superintendents, who have many years' experience and responsibilities. This decreases morale and mocks experience.*

However, it should be noted that one interviewee did believe that at least some of the differences between the bandings following AfC reflected real differences in what people were doing previously.

*Two senior Is employed by the same employer after matching could come out in different bands. Now from their perspective they could see that as iniquitous, but the problem is that you are not necessarily comparing like with like.*

### **3.1.2 Continuing problems with contracts and working arrangements**

There was a wave of appeals following the banding decisions. However, further problems arose from trusts being selective and, some said, manipulative in the ways in which they chose to apply AfC.

*Appeals are still going on now. A colleague was awarded a band 7 late last year after a long fight. But she's a reporting mammographer so she should never have needed to go to appeal in the first place. She should have been banded 7 from the start.*

*In my department you had the choice of signing a Trust contract or an AfC contract and I went for the Trust option because I was led to believe it afforded me protection both in terms of hours (36hrs only) and pay. But soon after, I found I was not being paid enough and an agreed bonus that I had worked hard for was 'capped' by the Trust, who said I couldn't get the full amount since I was already at the top of my pay band. So I switched to the AfC contract instead. The Trust contract was supposed to mirror Whitley pay but the Trust never revealed its pay structure. There was a lot of confusion and uncertainty among staff about which contract was best for them.*

There had also been a range of different approaches amongst Trusts in implementing Annex T. Because of this, and despite the intentions of this part of the agreement, staff at some trusts still have to wait for vacancies to arise before progressing, regardless of skills, and contrary to intentions:

*In my trust Annex T has been implemented so that at 18 months radiographers do go up to the next band providing they have completed the requirements.*

*There has been a failure of some Trusts to adhere to the whole package of AfC. They are actively leaving out the bits they don't like i.e. Annex T.*

*There have been vague attempts to introduce extra pay points and most staff have gained a few increments, but this is irrelevant compared to the feelings of disappointment in AfC. This is especially true of Annex T and link grading. Previously our Trust had link grading for radiographer grades (into senior II), however this is not acknowledged now (despite Annex T being an integral part of AfC). This means band 5 radiographers have to wait for vacancies – leading to a decrease in motivation to progress or to staff moving away to other Trusts with vacancies.*

In part these problems were seen as arising from the poor drafting of sections of AfC, which meant that, as a consequence, Annex T was being individually negotiated at each Trust. Secondly, the loose wording of the Annex had subsequently allowed these local implementation agreements to vary a great deal:

*[It was] a badly-drafted agreement, so there are lots of anomalies and confusion, there are contradictory paragraphs – a paragraph that says one thing on one page and it's followed by a paragraph on the next page that says the opposite...Under Annex T they can spend the first two years acquiring fast track experience and authority in order to progress onto Band 6 without having to wait for a vacancy to arise. But we are struggling to get that implemented in every trust as it is poorly drafted and it is being left to each trust to negotiate with the trade unions.*

In addition, while AfC was intended to remove the problem of split posts these had in fact continued at some sites:

*Even though I was in that role, leading that service, it has taken me until this year to get my band 7 – well I did get band 7 payments after the introduction of AfC, but it was only per session, I was on a split grade.*

*One person left because of an issue about split bands.*

*I hear a lot of people talking about being on split posts but AfC says quite clearly that this should not happen under any circumstances. Therefore, this has got to be a misinterpretation at Trust level.*

There had been further problems arising from the way in which the change to hours had been implemented. In many cases, managers had failed to take into account the additional time that many radiographers gave voluntarily in advance of the contractual change brought in under AfC. As a result there had been a significant loss of goodwill at some sites:

*People have generally got used to the hours thing. But it has been abominably badly introduced since December<sup>3</sup>. We are hearing about for example one manager who has said 'You've got to start 12 minutes early every day' - yet radiographers work over their hours anyway – if you are halfway through x-raying a patient at 5 o'clock you don't just walk away. There has to be some give and take surely?*

*[There have been] problems with introducing the extra hours. It is complicated for part-time staff due to the method of calculating it and therefore difficult to police. I now calculate annual leave in hours rather than days.*

*It is a real nightmare now, working out when and how these hours will be used, working out staff working arrangements and things like holidays, because they are all arranged pro rata.*

*I have found it hard. A lot of unrest has been to do with the 37½ hours, people are still struggling with this.*

*Previously people would come in a bit early, then think 'Well I'm here, I may as well make a start', and most likely with the extra bits of time and the willingness they were probably working around 37½ hours anyway. Now they don't come in until bang on 9 o'clock and they go home prompt at 5.*

In addition, one interviewee reported that in some cases newly qualified radiographers had been started on the 37½ hour working week while other, more senior staff, were still on 37 hours, due to transition arrangements for phasing-in of AfC working hours for existing staff. The interviewee said that as a result this had sometimes meant that:

*Very junior staff were working unsupervised. There was a certain amount of resentment against colleagues on protected hours. It was also difficult to incorporate this into out of hours' shifts.*

### **3.1.3 Banding and recognition**

While people widely acknowledged the improved pay on offer under AfC, other aspects of the rewards arising from the job were less appreciated. One of the key psychological benefits which individuals gain from employment is the status arising from, or attached to, their position. The bringing together of two previously different grades in the hierarchy into one broad band had therefore led to a real sense of grievance amongst some individuals, who felt that their authority had been eroded.

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<sup>3</sup> The change to hours had commenced in December 2008, partway through the research

*So there was a larger pay scale with more room for progression, and it was intended to have the advantage that people no longer had to apply to be promoted from senior II to senior I, but instead people say "I am a senior I, and they're a senior II and do less than me, but they're on the same pay band as me!" People still see themselves as 'senior Is or senior IIs' and Senior Is don't want to see people 'catching them up'.*

*The title changes have caused confusion and upset and in some cases caused problems with command chains and the team.*

*The system means that senior I radiographers were put into Band 6, the same as senior II radiographers when they had more responsibility.*

At the same time, this change had also brought difficulties in terms of management structure for some departments.

*In addition now with the banding there are unclear lines of authority within departments. Previously when we had basic grade, senior I, etc., there was a clear authority structure. Now it is band 7s in charge and everyone else is band 6; people who are newly qualified very quickly get a band 6 and we have them working alongside more established staff. There is no differential for experience etc.*

*I also think that Band 6 is too broad. It captures too many people. Lots of senior Is and senior IIs are all in the same pay band and this is wrong since it doesn't reflect properly their experience and responsibility.*

Similar issues were identified relating to the Band 7 band, particularly in the context of sonographer responsibilities:

*Band 7 is too wide for sonographers. Most sonographers are on band 7 whether they just come in, do the minimum and go home again, or whether they are stars leading services and advancing practice.*

Clearly, although pay improved under AfC, individuals perceived AfC as failing to adequately recognise seniority and the different levels of skills and responsibilities held by individuals.

### **3.2 Impact on career progression**

Comments in response to the question of career progression were inextricably linked to the views previously expressed regarding initial banding and the appropriateness of the various bands (especially bands 6 and 7). In particular interviewees returned to the question of the nature of the rewards and recognition sought by individuals in these jobs, and it is clear that in many cases, pay was not the sole issue involved in individuals' decisions:

*The problem is with the old senior IIs, they say 'Where do I go? More money is not enough. Where are the opportunities for me?' I don't know if it is better for them under AfC. But there is not enough room for everyone to progress beyond band 6.*

As a consequence, the interviewees believed that there had not been as much impact on career progression as had perhaps been expected at the outset. As has been evidenced by the comments reported in the earlier sections of this chapter, many staff still have to wait for vacancies regardless of skills, while for other groups there simply is no obvious further progression route.

*There is no career progression for sonographers – they are all stuck near the top of band 7 with nowhere to go.*

While some would argue that it has been good for senior IIs (and potentially very good for the newly qualified at sites where Annex T is recognised) interviewees also saw Agenda for Change as having impacted negatively on the career progression options for senior IIs (and for new graduates at sites where Annex T has not been implemented). At those sites where the system is working as was planned interviewees felt there was clear evidence of benefits. It was acknowledged though that this was not universally the case:

*In this trust as people develop their roles, their increased duties are added onto their job descriptions and then sent to the AfC panel for re-assimilation to the next band. They do not have to wait for jobs to become vacant. So it has helped in that way. Things are added at appraisals, therefore with rebanding the staff go up a band. It happens at this trust but may not be happening a lot a lot of trusts.*

Another interviewee confirmed that this was not the case at all Trusts:

*Specific vacancies depend upon 'dead men's shoes'. People will not be re-banded without vacancies; the funding is just not available. There has to be a vacancy before anyone can be re-banded.*

Some interviewees believed that, potentially at least, AfC made career progression more of a possibility for radiographers.

*AfC has highlighted that people can expand roles.*

*The AfC pay and grading structure much better enables the four tier structure and the pay and grading structure correlates with the four tier structure so it facilitates that better, arguably this is because the pay is better than under Whitley, [so] it is a better enabler than Whitley.*

However, not all agreed with this view, and some perceived AfC as having had a significant negative impact, particularly on progression into specialist areas of practice:

*It has held back role development and recruitment in mammography. At the moment a band 6 radiographer in the main dept can earn a good wage and supplement it with on-call. However, if they transfer to mammography and study for a postgraduate certificate they are still only graded at 6 and are no longer able to enhance their wage with on-call duties! Who would, in effect, take a pay cut and give themselves a lot of additional studying for no pay or status reward? I have to say, when I joined mammography prior to AfC one of the incentives for me was a Senior I post. That has gone now.*

### **3.3 Motivation, morale, recruitment, retention and the future**

Whilst a few of the interviewees felt there had been no real impact on motivation and morale, and in one case the interviewee noted that negative and positive views amongst the profession were often related to the banding awarded by the trust, the majority felt that AfC had been deleterious to both morale and motivation.

*Yes there has been a decrease in motivation. AfC was meant to reward skill and experience, [but] no initial gradings were deserved and experience was not taken into account at all. Staff felt undervalued and de-motivated. This consequently gave no incentive to progress, expand knowledge or expand practice.*

*Has it lifted morale? Definitely not! Maybe in the odd case yes, but mainly no. Will it have any real impact on recruitment and retention? Perhaps, but I'm doubtful. Will it help with career progression? Only in those places where there are extended roles and the opportunities to [extend roles] and where advanced practice is supported.*

*Now that AfC is in the swing there is no positive effect on morale, there possibly was a slight negative effect on morale because people were led to believe it would solve problems but it has not.*

*Morale is much the same for most but for the lucky ones yes it has improved.*

*Lift morale? No, everyone is rather disillusioned with the whole thing I think.*

Few of the interviewees believed that AfC had had any significant positive impact on recruitment or retention.

*Has it improved recruitment and retention? I don't think so. People come into the profession because they want a clinical career and it has not made the clinical prospects of radiographers better than those of anyone else.*

*The offer of role extension keeps some people. Others have moved in order to get promotion.*

### **3.4 Implications for the survey**

In general, it is clear that the interviewees held mixed views. Most were clear about the benefits accruing to the new pay structures; however, for most, these benefits had been obscured by the problems arising from radiographers' dismay at changes to hours, offence to their sense of "fair play" and natural justice and the failure for any real support for progression to emerge. Only a minority felt that the anticipated benefits for radiographers' career opportunities had emerged and many felt that, perversely, there were now disincentives to further advancement. Indeed, some felt it was now harder to progress than previously. Discrepancies between the actions of different trusts meant that local circumstances may have continued to have more impact than AfC itself.

However, the main aim in undertaking these preliminary interviews was not to draw firm conclusions but to take soundings from informed individuals in the profession to assist in the design of the survey instrument. Gaining a better understanding of the range of opinions across the profession assisted the research team in drawing up lists of response options that would make the survey questionnaire as comprehensive and easy to complete as possible. Therefore, the content of these interviews were drawn on in designing the sets of response categories for each of the substantive questions in the online survey<sup>4</sup>.

The interviews served a further purpose, in suggesting hypotheses that could be tested out in analysing the survey. For instance, one interviewee felt that views following implementation of AfC were related to how individuals felt they had been treated in the initial banding negotiations. This therefore served both to inform design of the questionnaire (for this reason respondents were asked if they had had to appeal their initial banding) and the later analysis stage.

We return to the issues raised here in Chapter 5.

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<sup>4</sup> It should be noted that, in each case, respondents were also given the option of giving their own free response where they felt the options offered did not fully represent their view.

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## 4. Results from the survey

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This chapter reports the outcomes of the survey. For clarity, the results are presented in six sub- sections:

**Section one** presents demographic information relating to the survey participants.

**Section two** explores the experiences and attitudes of diagnostic radiographers in terms of the three key aims of the study: expectations of, opportunities for, and barriers to career development. Imaging sub-specialties are included.

**Section three** explores the experiences and attitudes of therapeutic radiographers in terms of the three key aims of the study; expectations of, opportunities for, and barriers to career development. Therapeutic sub-specialties are included.

**Section four** explores the experiences and attitudes of assistant practitioners and healthcare assistants in terms of the three key aims of the study: expectations of, opportunities for, and barriers to career development.

**Section five** considers the experiences and attitudes of the combined workforce by highlighting key trends related to time qualified.

**Finally, section six** covers the findings relating to Annex T, on-call arrangements and split contracts.

Initial analysis of the results revealed that there were many factors which influence staffs' career progression. What might be considered a significant obstacle or incentive by diagnostic radiographers may not be viewed the same by therapeutic staff. Similarly, those in lower pay bands or who qualified recently may have different expectations to those in higher pay bands or who qualified some time ago. For this reason, each set of data was analysed in order to examine whether there were any variations between staff sub-groups and to provide a comprehensive analysis of the outcomes of the survey.

## 4.1 Section 1 Demographic data

A total of 2373 participants took part in the survey. The majority (97%, n = 2299) were radiographers. Figures obtained from the NHS Information Centre (2009) and the Health Statistics & Analysis Unit of the Welsh Assembly Government (2009) indicated that there were 17003 radiographers working in the NHS in England and Wales in 2008. This indicates that the present survey obtained a response rate of approximately 13%. Further breakdown of respondents indicates that 18% of the potential therapeutic radiography workforce and 12% of the potential workforce of diagnostic radiographers responded. Only 74 assistant practitioners and HCAs participated in the survey. This number accounted for just 3% of the survey and considerably less than 1% of the available workforce. In view of the relatively low response rates of both radiographers and support workers, it is difficult to make generalisations from the study findings. Nevertheless, the survey provided the largest sample of the radiographic workforce to date and provided good indicators of its experiences and career progression under AfC.

Four fifths of survey responses came from diagnostic imaging staff and the remaining 20% from those working within radiotherapy. Data were obtained from participants working in every Strategic Health Authority region in England and Wales, every type of institution, and from all categories and across pay bands 2 to 9. The majority of staff worked in an institution located in a city or town, while only 5% described their location as rural.

The demographics of the respondents to this survey were directly comparable with profiles obtained from the Society of Radiographers' membership data base and from the NHS Information Centre. However, the data relating to staff banded at 8d or 9 must be treated with caution since very few individuals in these categories were present within the sample. Similarly, trends relating to ethnicity are hard to identify since only 8% of respondents were non-white British. However, a small proportion of non-white respondents was not unexpected since, in England, ethnic minorities account for only 12% of the radiographic workforce (NHS Information Centre 2009).

Analyses revealed no significant differences between the types of centres in which the participants worked and their attitude towards AfC. Participants reported similar experiences and perceptions irrespective of whether they worked in, for example, a teaching hospital, foundation trust or cancer centre. Even though foundation trusts have the capacity to implement alternative employee banding, pay and benefits schemes there was no difference in distribution of pay bandings compared to other institutions. Foundation trust workers did not have different attitudes towards implementation of the career progression framework (CPF), types of opportunities or barriers to career development, or towards AfC. It should be

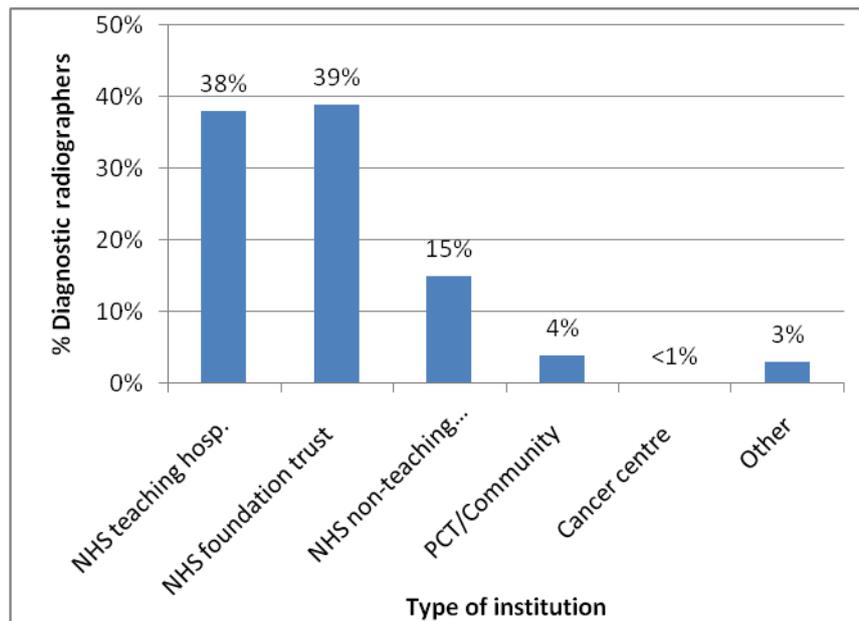
noted that, while several participants in the survey commented that foundation trusts fuelled inequity (see comments below), statistical analysis of the survey results did not support this contention:

*AfC was supposed to standardise the pay nationally, however, this has not happened, especially in foundation trusts where they appear to be able to cherry pick which bits of AfC they implement. Diagnostic radiographer, band 5*

*Being a foundation trust is used often as an excuse not to follow some AfC terms and conditions. Diagnostic radiographer, band 6*

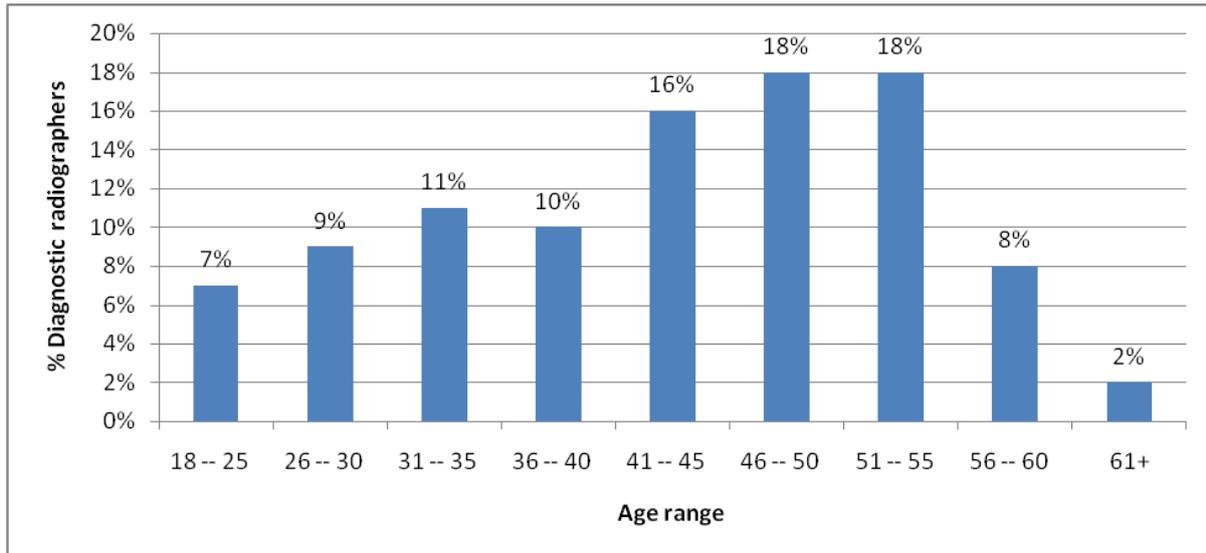
## 4.2 Section 2 The diagnostic imaging workforce

A total of 1845 diagnostic radiographers responded. The majority worked in teaching hospitals or foundation trusts (Figure 1). Less than 1% were located in cancer centres. Females accounted for 84% of diagnostic radiographers in the study, with only 16% being male.



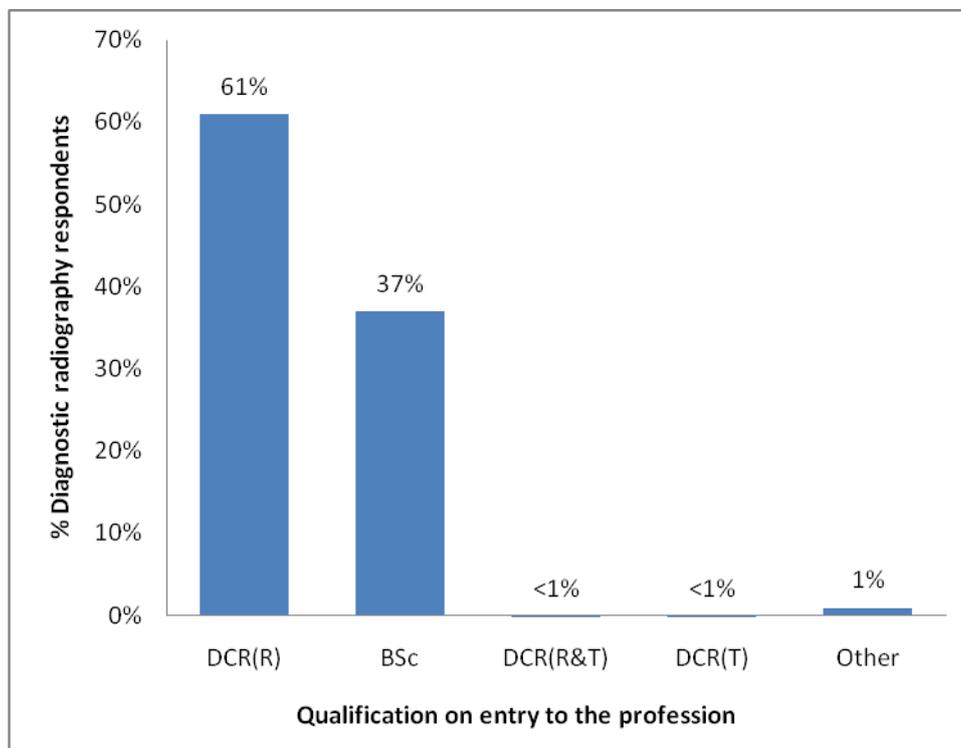
**Figure 1: Distribution of diagnostic radiographers in terms of place of work**

Over half (52%) of diagnostic radiography respondents were aged between 41 and 55. The years during which respondents qualified ranged from 1958 to 2008, and many (56) who qualified during the 1960s were still practising (Figure 2).



**Figure 2: Age distribution of diagnostic radiographers**

When asked about their original qualification on entry to the profession, the majority (61%) of diagnostic radiographers who responded said that they held the Diploma of the College of Radiographers, with just over a third (37%) saying that they had a degree in radiography. A small number of participants chose not to answer (Figure 3).



**Figure 3: Qualification held by diagnostic radiographers on entry to the profession**

Diagnostic radiographers had multiple duties and practised in a range of disciplines. The most common areas of practice are displayed in Figure 4.

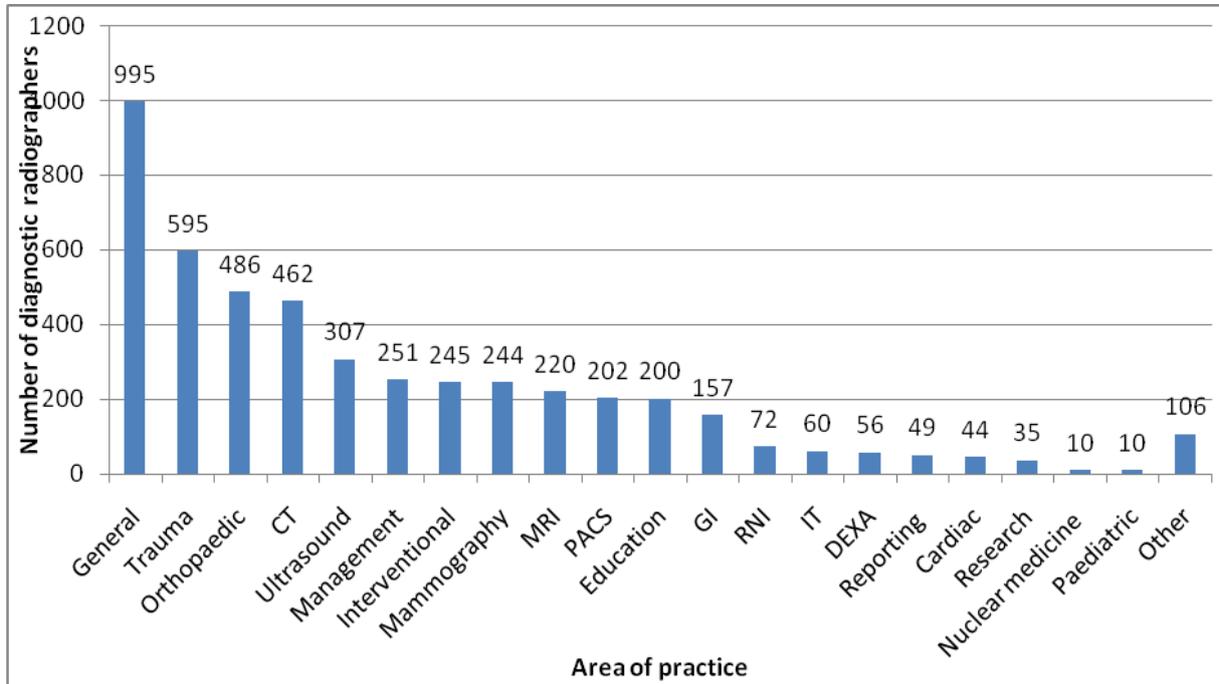


Figure 4: Common areas of practice for diagnostic radiographers

#### 4.2.1 Agenda for Change current pay banding

The majority (71%) of the diagnostic workforce who responded to this survey were in pay bands 6 and 7 (Figure 5).

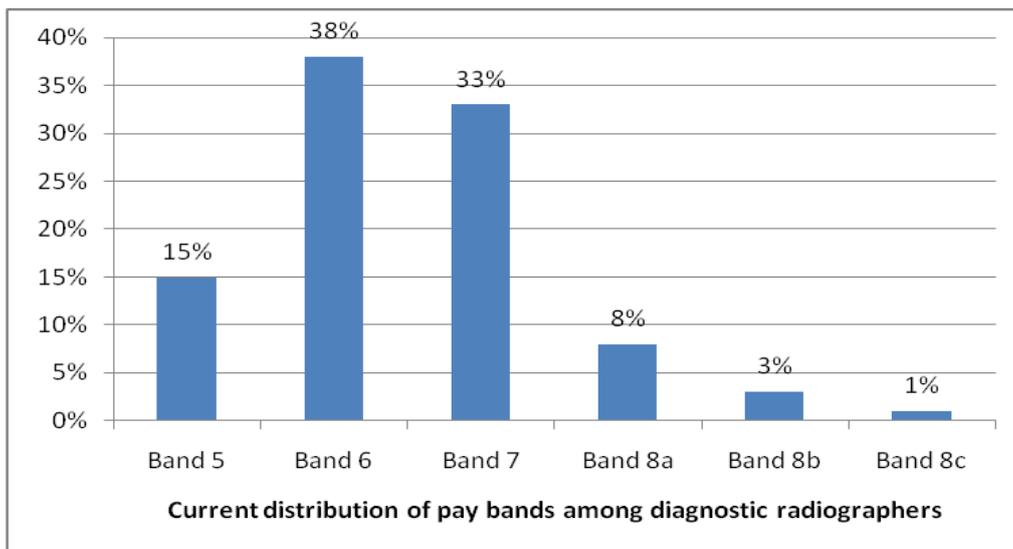


Figure 5: Distribution of pay bands for diagnostic radiographers

More than 48% of diagnostic radiographers had been in their current pay band since the implementation of AfC terms and conditions and there was no difference identified either between males and females or between those employed with the different Strategic Health Authority regions in relation to AfC banding. The distribution was similar throughout England and Wales. The length of time which diagnostic and therapeutic staff had spent in their current pay bands were very similar although slightly fewer therapeutic radiographers (40% compared to 48%) had been in their current pay band since the implementation of AfC (Figure 6).

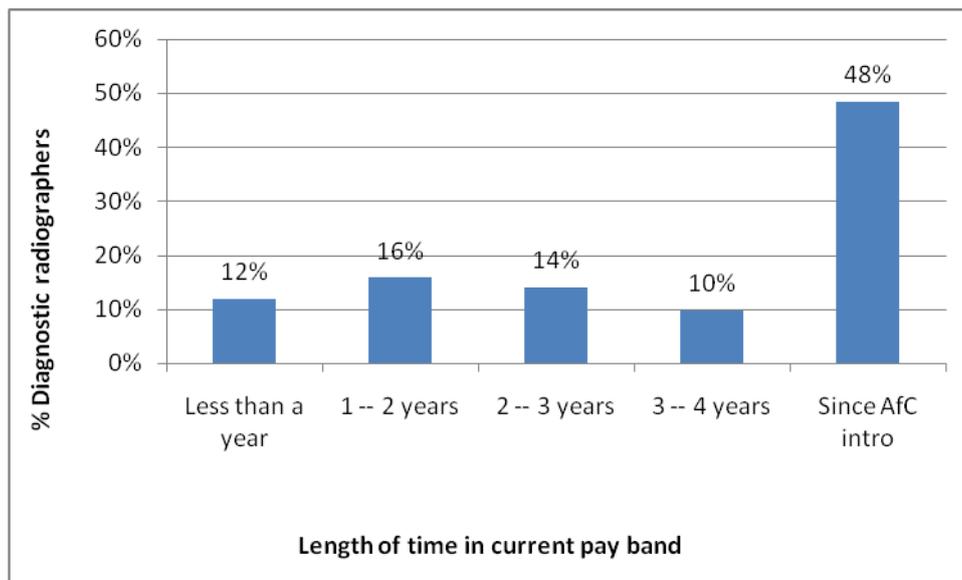
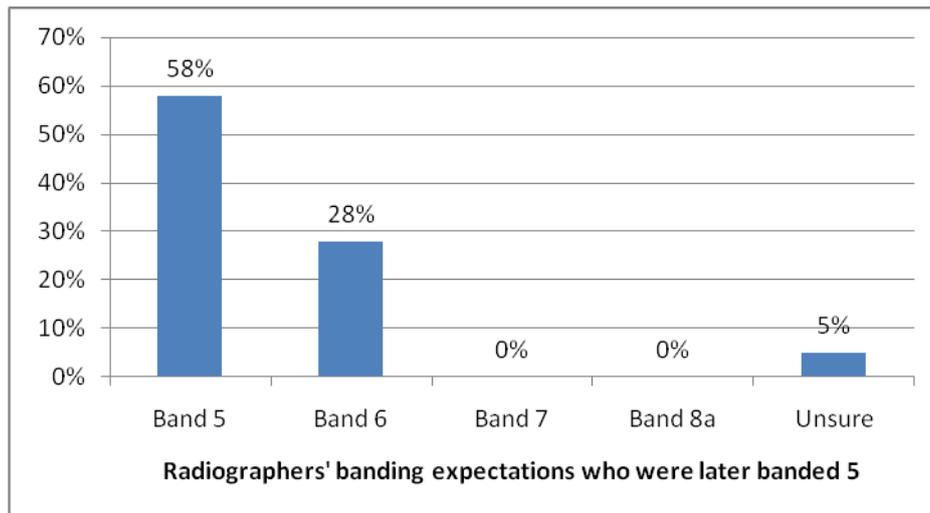


Figure 6: Length of time in current pay band for diagnostic radiographers

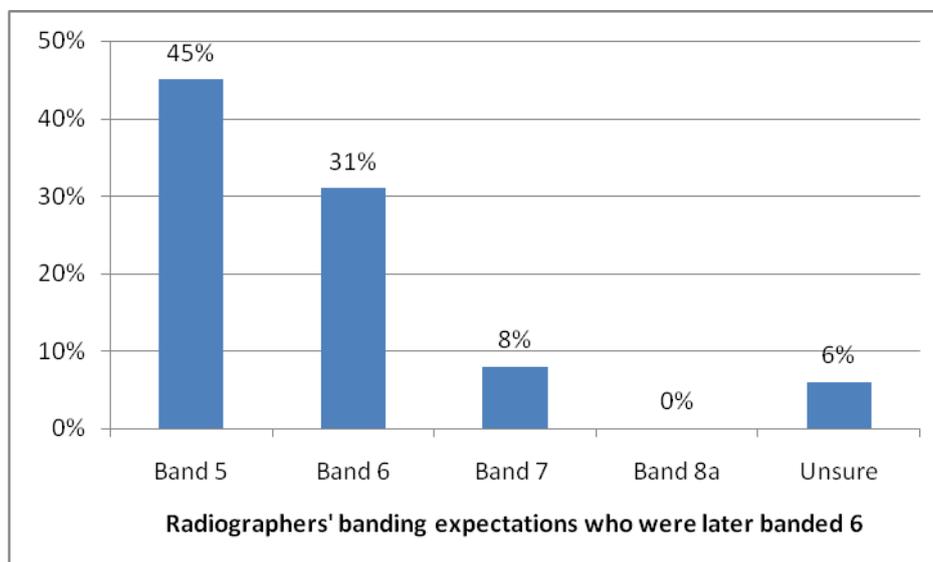
#### 4.2.2 Expectations of diagnostic radiographers in terms of career progression under AfC

Radiographers who were employed prior to AfC were asked about their former Whitley Council grading and band to which they had expected to be assimilated under AfC terms and conditions. This information was then compared to the band on which they were placed following implementation of AfC.



**Figure 7: Banding expectations of diagnostic radiographers who were later banded 5**

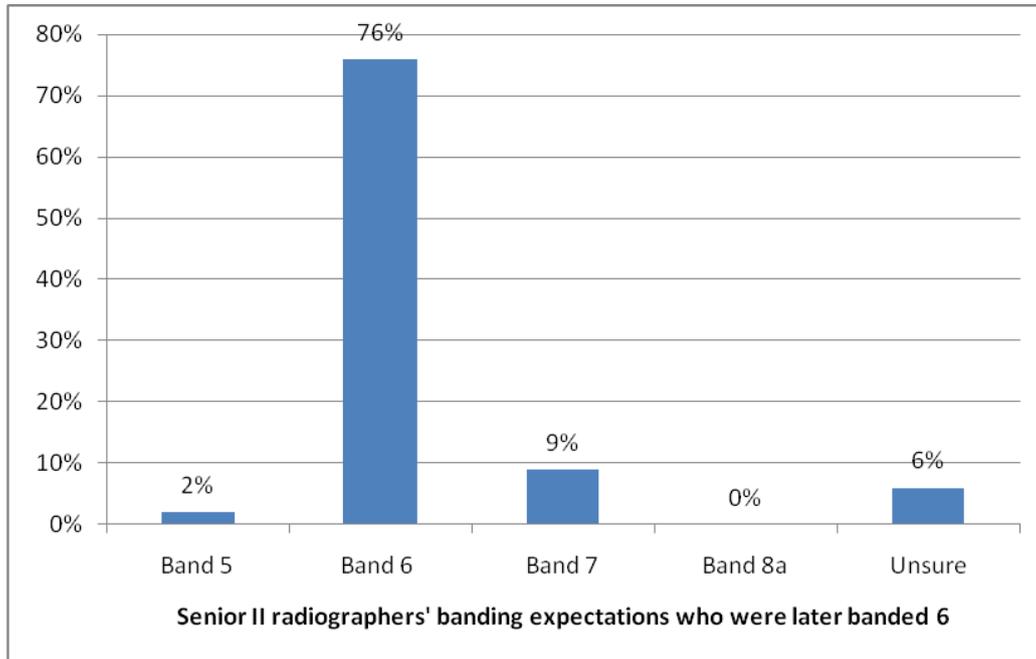
From this study, there were 43 band 5 radiographers who were Whitley 'radiographer' grade prior to AfC (Figure 7). The majority ( $n = 25$ , 58%) were placed where they expected to be. Just over a quarter ( $n = 12$ , 28%) were banded lower than they had anticipated. None found themselves on a higher band than expected, two were unsure and four eligible participants did not answer.



**Figure 8: Banding expectations of diagnostic radiographers who were later banded 6**

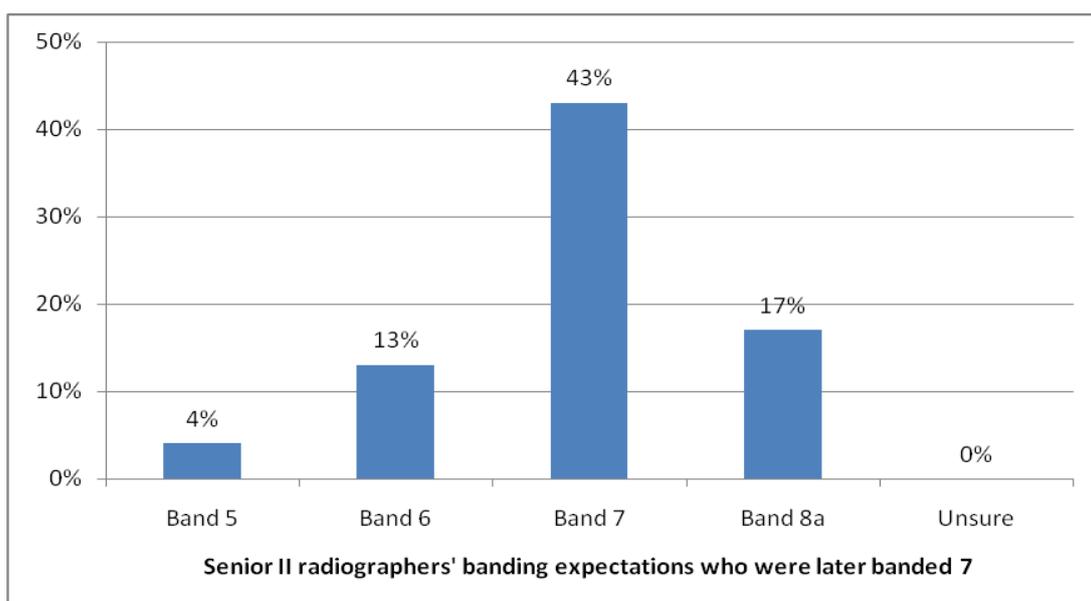
There were 49 Whitley radiographer grade staff prior to AfC and who were subsequently assigned a band 6 (Figure 8). A large proportion ( $n = 22$ , 45%) were banded higher than they had originally anticipated, since they had anticipated gaining only a band 5 position. Less than a third of those who had ended up being assigned a band 6 had expected this

band (n = 15, 31%). Four individuals had anticipated band 7. Very small numbers were unsure or chose not to answer.



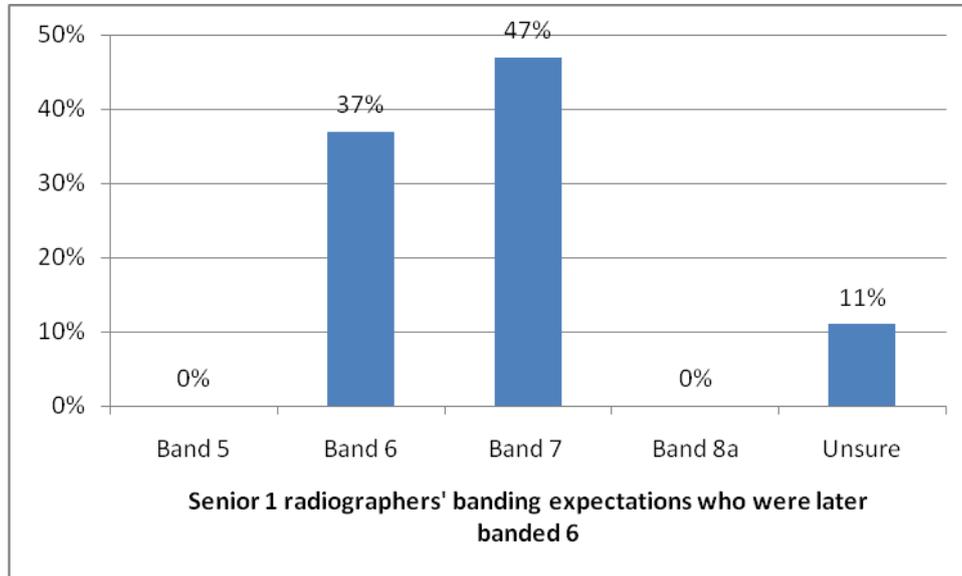
**Figure 9: Banding expectations of diagnostic senior II radiographers who were later banded 6**

Some 254 diagnostic radiographers responded who had been senior II grade prior to AfC and who were banded 6 following implementation (Figure 9). Here, the majority (n = 193, 76%) of this cohort were banded as they had anticipated. Two per cent (n = 5) were banded higher since they had anticipated being assimilated to band 5. Only 9% (n = 23) anticipated band 7. Again, small numbers were unsure or did not answer.



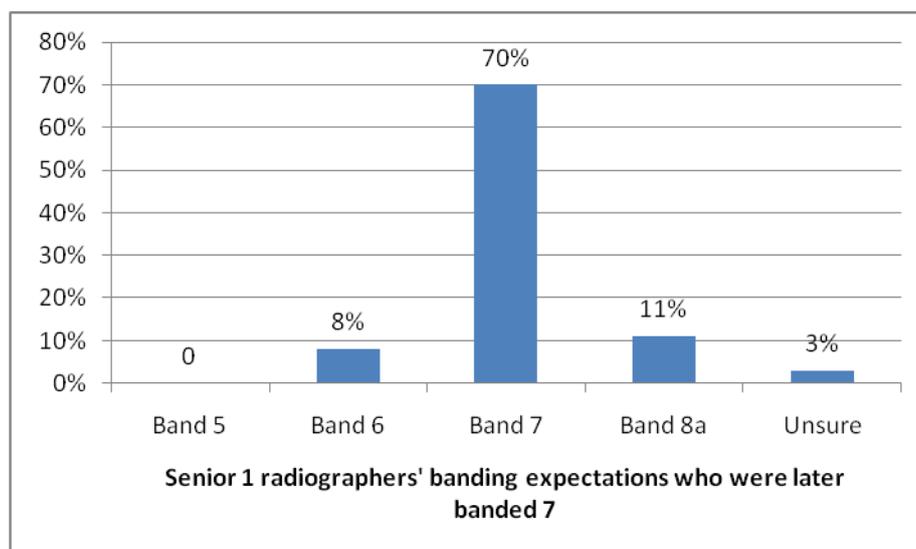
**Figure 10: Banding expectations of diagnostic senior II radiographers who were later banded 7**

Only a small number of the respondents (23) reported having been senior II diagnostic radiographers before AfC and banded 7 after implementation (Figure 10). Of these, 60% (n = 14) were banded as expected or higher than expected. Only four (17%) had anticipated assimilation to band 8a. Five (22%) of this small cohort did not answer.



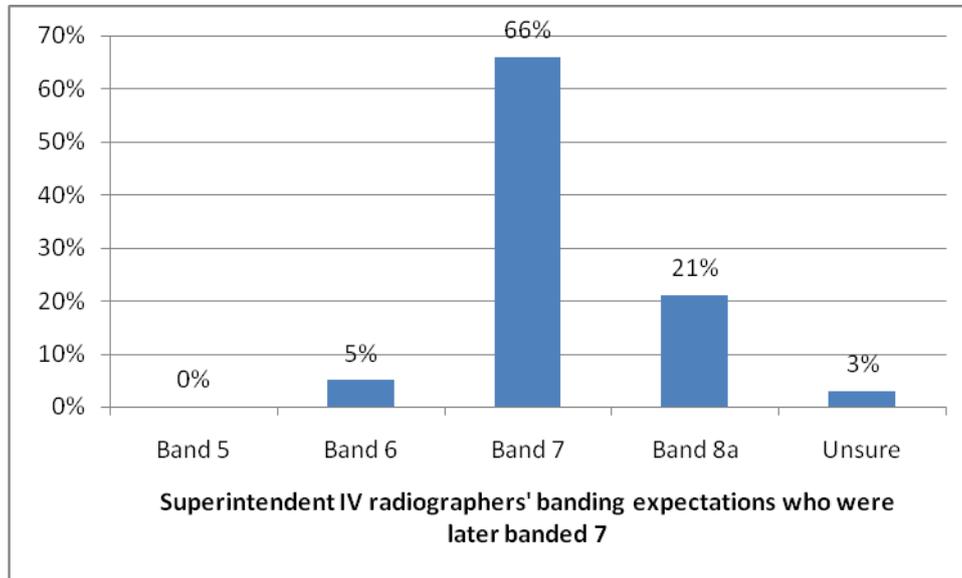
**Figure 11: Banding expectations of diagnostic senior I radiographers who were later banded 6**

There were 245 diagnostic radiography respondents who had been senior 1 grade prior to AfC and banded 6 following implementation (Figure 11). Of these, nearly half (n = 115, 47%) had expected to be banded higher, at 7 rather than 6. Just 37% (n = 91) had expected to receive the banding (band 6) they were allocated. Eleven per cent was unsure and five per cent did not answer.



**Figure 12: Banding expectations of diagnostic senior I radiographers who were later banded 7**

Senior I diagnostic radiographers who were later banded 7 also responded to the survey in large numbers (299) as seen on Figure 12. Of these, the majority (n = 209, 70%) were placed in the band expected, while 8% (n = 24) were banded higher than expected and only 11% (n = 33) had anticipated a band 8a grade. Small numbers were unsure (3%) or did not answer (6%).

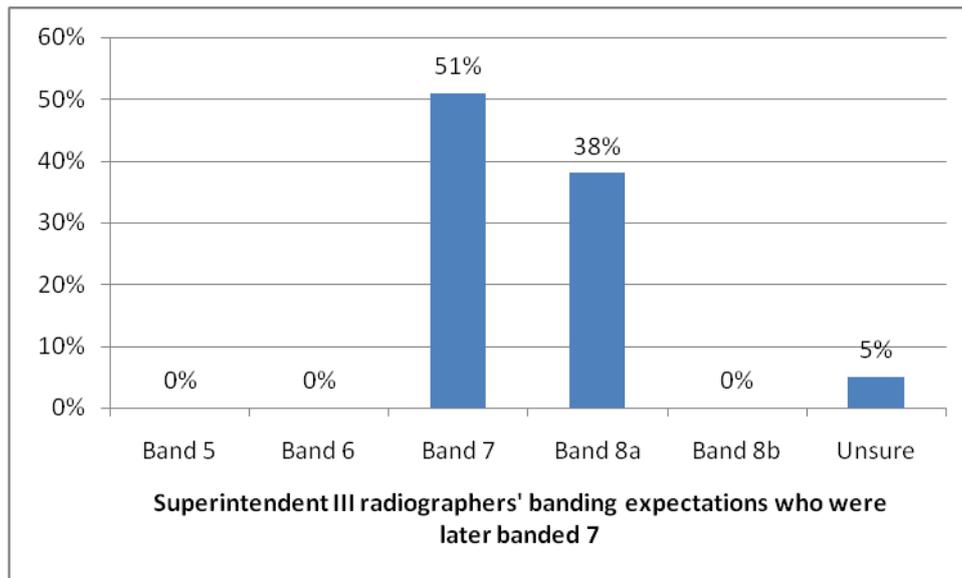


**Figure 13: Banding expectations of diagnostic superintendent IV radiographers who were later banded 7**

Only 38 participants were Whitley superintendent IV grade prior to AfC and then banded 7 after AfC (Figure 13). Of these, 66% (n = 25) were banded as anticipated and only two had expected to be banded lower at 6. Eight had anticipated a band 8a assimilation. One or two were unsure or did not answer.

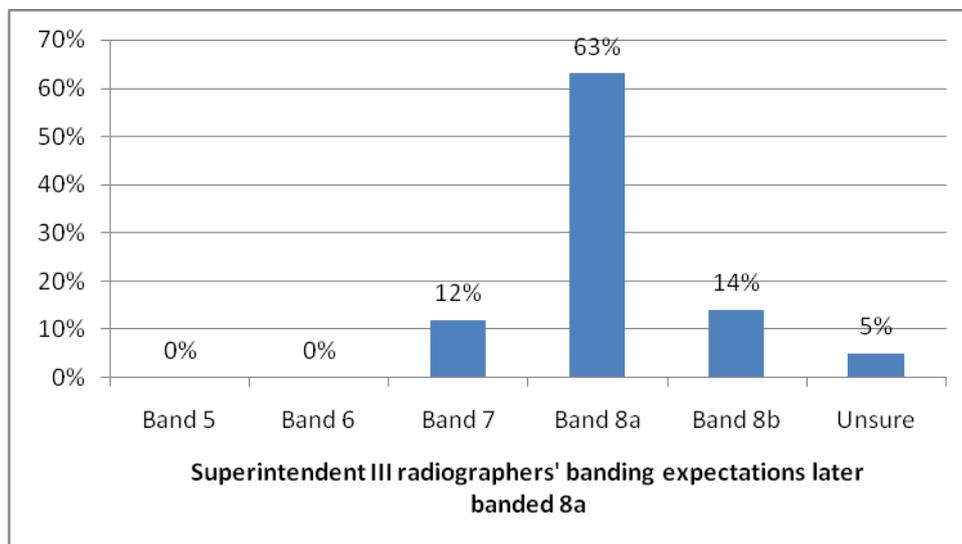
Thirteen superintendent IV diagnostic radiographers in the survey reported being banded at 6 after AfC. Of these, none had expected this and all had anticipated being assimilated onto a higher band: 11 had expected band 7, one an 8a assimilation and one was unsure. Conversely, five more superintendent IV staff reported being banded 8a of which just one had expected this, with the other four anticipating moving across to a lower band 7 grade.

There were 128 superintendent III radiographer respondents who were banded 7 after AfC (Figure 14). Whilst half (n = 65, 51%) were banded as expected, over a third (n = 49, 38%) had anticipated gaining a band 8a. Only 5% were unsure and 6% did not answer.



**Figure 14: Banding expectations of diagnostic superintendent III radiographers who were later banded 7**

On the other hand, 75% (n = 43) of superintendent III staff who were graded 8a were banded as expected or higher than expected; 63% (n = 36) had anticipated 8a and 12% (n = 7) had anticipated band 7. Only eight (14%) had expected to be assimilated to the higher band of 8b. One or two respondents were unsure or did not answer (Figure 15).



**Figure 15: Banding expectations of diagnostic superintendent III radiographers who were later banded 8a**

The figures obtained for superintendent II diagnostic radiographers were too small to support analysis but the data implied that banding was frequently lower than expected.

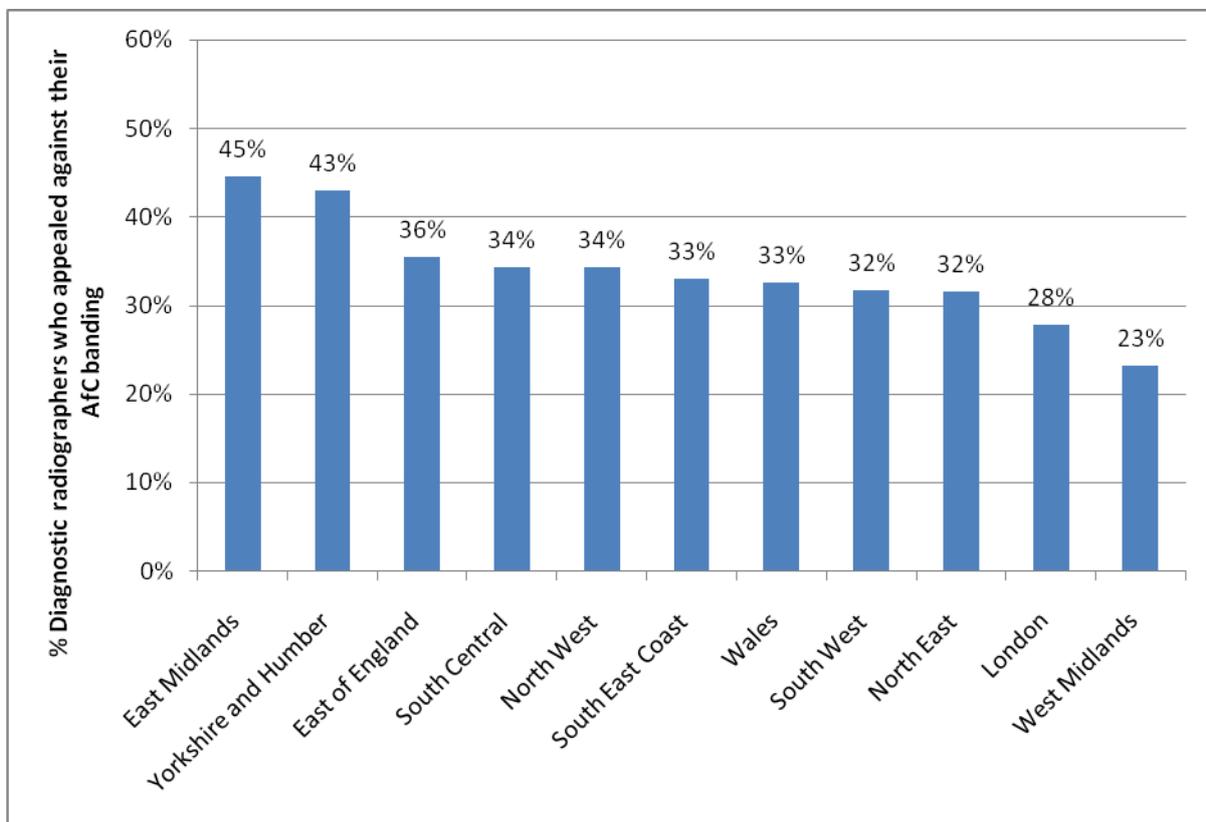
### 4.2.3 Appeals

Just over a third (34%) of diagnostic respondents had appealed against their banding compared to 37% of therapeutic staff.

#### *Appeals by diagnostic staff*

The data from diagnostic radiographers regarding appeals were analysed to identify any differences between regions, grades, and employment status (full time or part time).

There were differences in the number of appeals reported by respondents across regions. The highest numbers of appeals by diagnostic radiographers were reported by respondents in the East Midlands and Yorkshire and Humber Regions. Respondents in London and the West Midlands reported the least number of appeals (Figure 16).

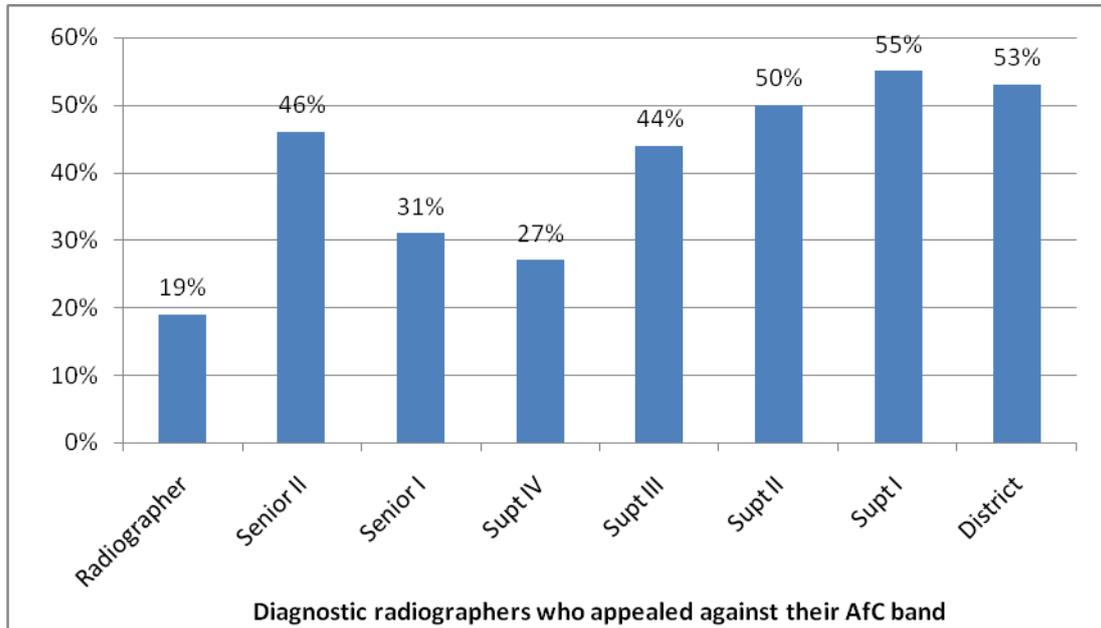


**Figure 16: Strategic health authority distribution of diagnostic radiographers who underwent appeal**

### 4.2.4 Appeals in terms of staff grade

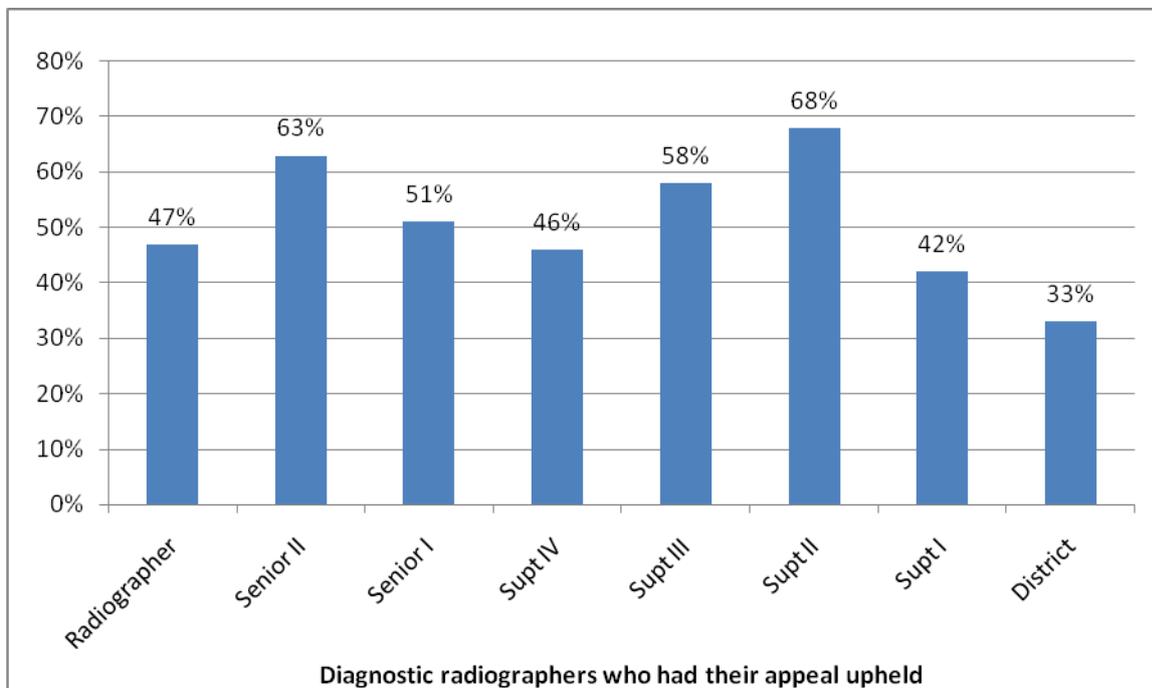
The responses indicate that overall a higher percentage of more senior grade staff appealed against their banding compared to those in lower grade posts (Figure 17), although it should

be noted that whilst many former senior I staff claimed to have been banded lower than anticipated (as presented in Figure 11) they did not necessarily appeal.



**Figure 17: Distribution in terms of Whitley Council grades for diagnostic radiographers who appealed against their AfC banding**

#### 4.2.5 Successful appeals in terms of staff grade



**Figure 18: Successful appeals against AfC banding by diagnostic radiographers in terms of their previous Whitley Council grades**

The analyses indicate that senior II and superintendent II staff were the staff groups which most frequently had their appeals upheld (Figure 18). The highest grades appealed more frequently, but they were, in general, less successful. However, numbers obtained for superintendent I and district superintendents were small.

#### 4.2.6 Successful appeals for part time versus full time staff

Overall, just over a third of all staff appealed against their banding following implementation of AfC. There was very little difference between the proportions of full time and part time staff who reported having appealed against their AfC banding (see Table 3 below). There were also negligible differences between the numbers of full time and part time diagnostic radiographers who reported that they were supported by their managers during the appeal process, although a few participants could not remember whether they were supported or not, hence the figures in Table 3 do not add up to 100%. However, a considerably higher proportion of full time staff had had their appeals upheld compared to part time staff (72% of fulltime staff compared to 65% of part time workers).

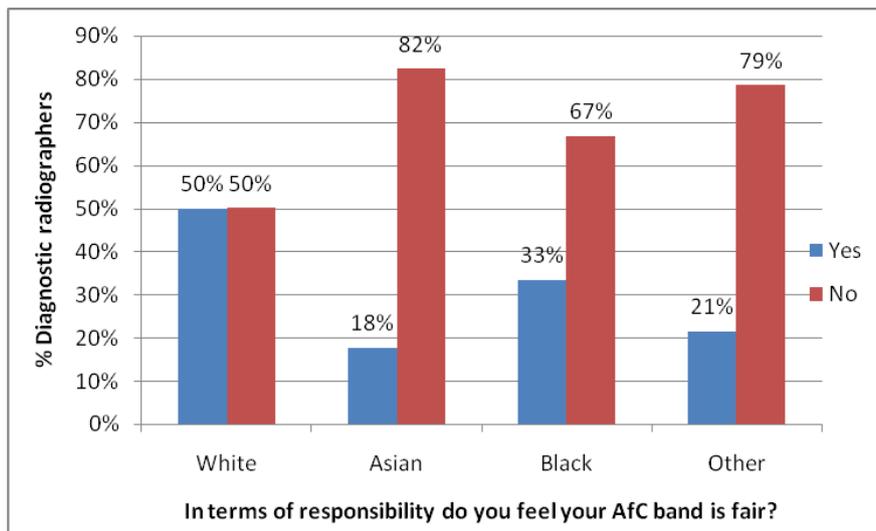
There were also strong correlations with those who were supported by their managers during their appeal and with those who had their appeals upheld. Of those who were not supported by their managers there was no obvious difference between those winning or losing their appeals. For both part time and full time staff three out of four (75%) not supported by their managers lost their appeals, 22% of full time staff won, and 19% of part time staff won. Again, figures do not add up to 100% since small numbers are still awaiting outcome of their appeals.

**Table 3: Appeal outcomes for full time and part time diagnostic imaging staff**

	Full time		Part time	
	Yes	No	Yes	No
Did you appeal?	33%	67%	35%	65%
Were you supported by your manager?	Yes 68%	No 18%	Yes 63%	No 16%
And did you win?	<b>72%</b>	<b>22%</b>	<b>65%</b>	<b>32%</b>

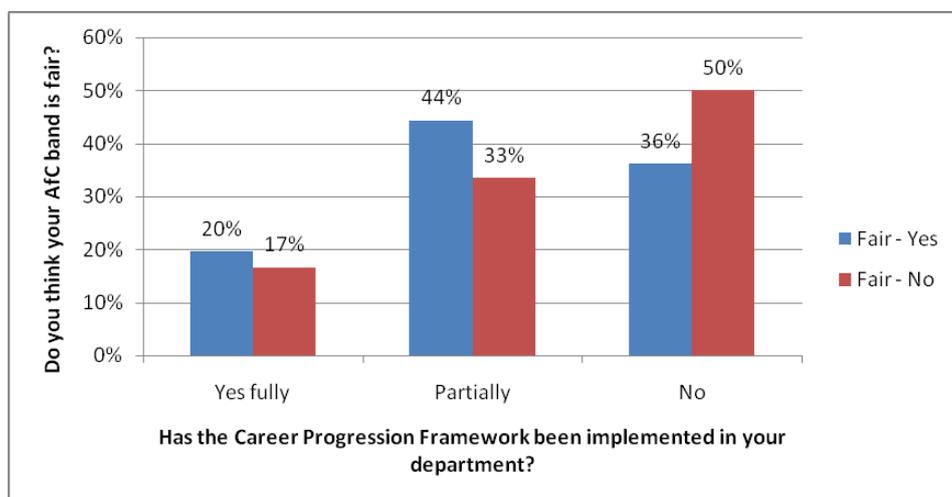
### 4.2.7 Perceived fairness of banding

Overall, 44% of all respondents believed that the banding they had been allocated had been fair and reflected their level of responsibility. Analyses revealed some differences in the opinions of different sub-groups within the diagnostic workforce. Whilst half of white radiographers (50%) felt their band reflected fairly their responsibility only 29% of radiographers from ethnic backgrounds felt this was the case (Figure 19).



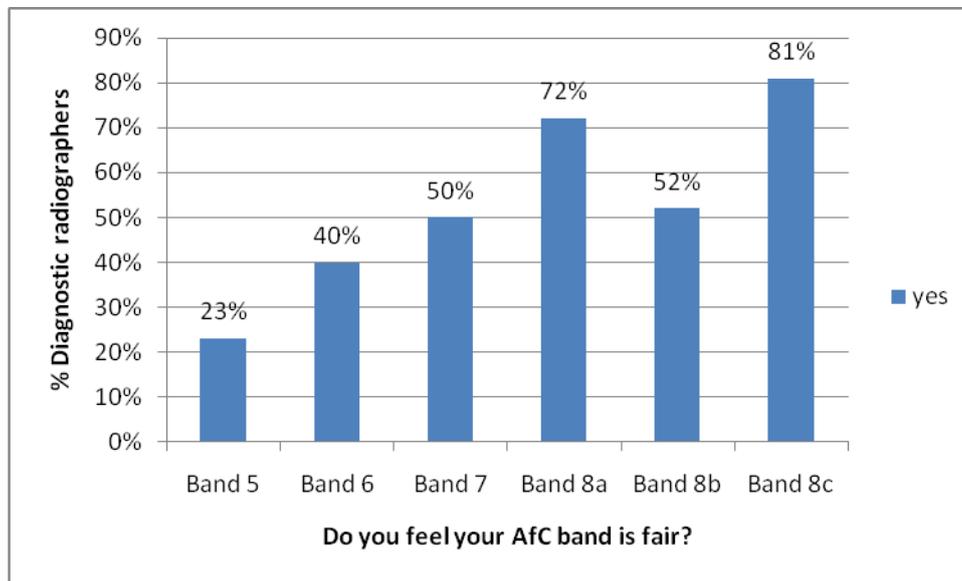
**Figure 19: Perceived fairness of AfC band in terms of the ethnicity of diagnostic radiographers**

There were also differences in perception of fairness depending on whether the CPF was in place at their site (Figure 20) and depending on their banding (fig 21). Only 13% of diagnostic radiographers reported that the CPF was fully implemented where they worked, with another 27% saying it was in place partially. However, where the CPF was implemented, radiographers were more likely to think their band was fair. Where the CPF was not in place radiographers were far more likely to be dissatisfied with their banding.



**Figure 20: Diagnostic radiographers' perception of fairness of band in terms of the CPF**

The majority of the higher band staff felt their banding was fair. Satisfaction increased steadily with each successive level except for those respondents banded at 8b (Figure 21). Here 52% felt their band was fair, 39% felt it was not and 9% were unsure.



**Figure 21: Fairness of their AfC band as perceived by diagnostic radiographers**

The most common reasons identified by both diagnostic and therapeutic staff for feeling that their band did not reflect their level of responsibility were: a belief that their level of autonomy and decision-making exceeded their banding, discrepancies and inequity between trusts in job matching, and that their experience and/or qualifications were not sufficiently recognised. Issues relating to senior I and II staff being grouped together in band 6 were also identified by many respondents as being unfair. The themes are summarised in Table 4.

**Table 4:** Common reasons why diagnostic and therapeutic respondents collectively felt that their AfC pay band was unfair

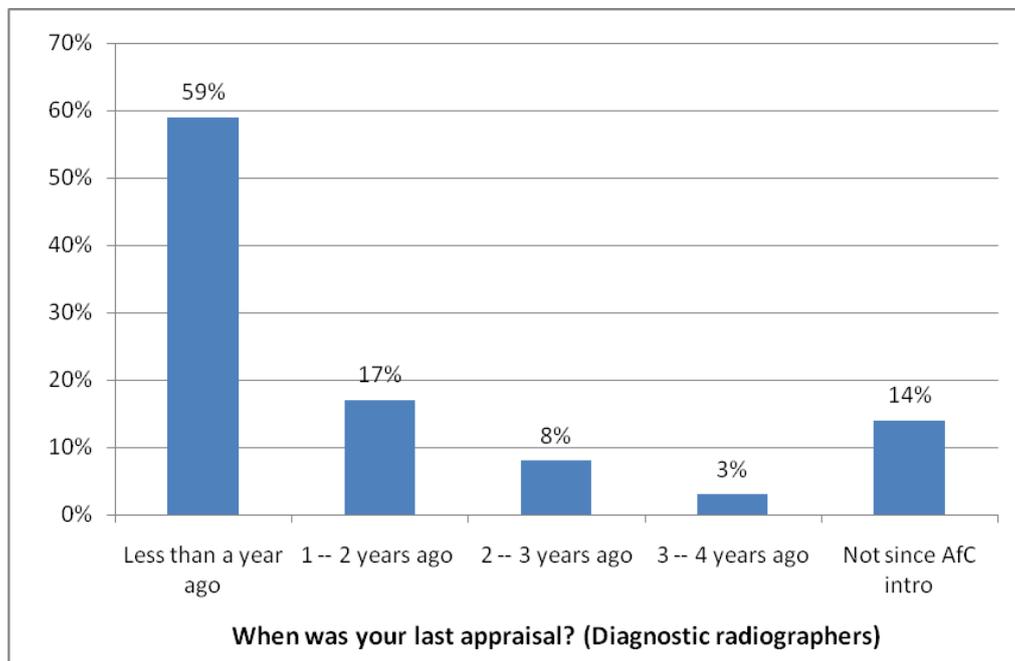
Common reasons why participants felt their banding was unfair	Number of respondents
Lack of recognition of autonomy and high level decision-making	439
Inequity between roles	108
Lack of recognition of experience	67
Lack of recognition of qualifications	61
'Stuck' at top of pay band with nowhere to progress	42
Band 6 is too broad and incorporates both senior I and II grades	37
Other	23

### 4.2.8 Career Development Opportunities for diagnostic radiographers

This section of the survey began by exploring radiographers' experience of appraisals and the NHS Knowledge and Skills Framework since these form a key element of AfC and are the basis for identifying career development opportunities.

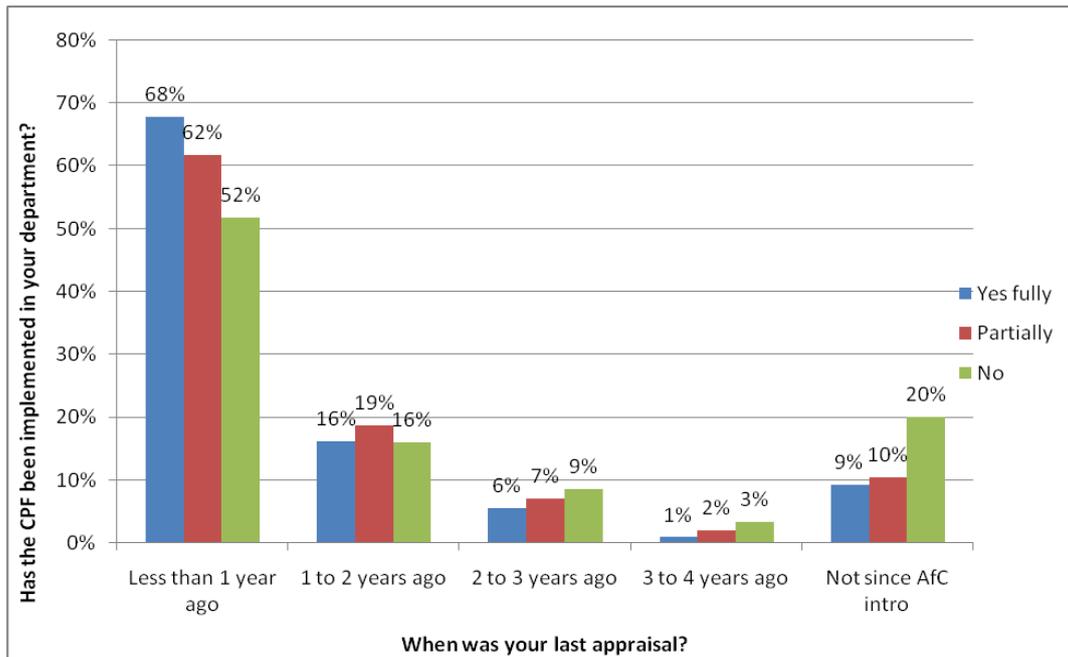
### 4.2.9 Appraisals

The majority of diagnostic radiographers who answered this section of the survey had had an appraisal in the last year (Figure 22). There was no difference between full-time and part-time staff in the frequency with which their appraisals were carried out.



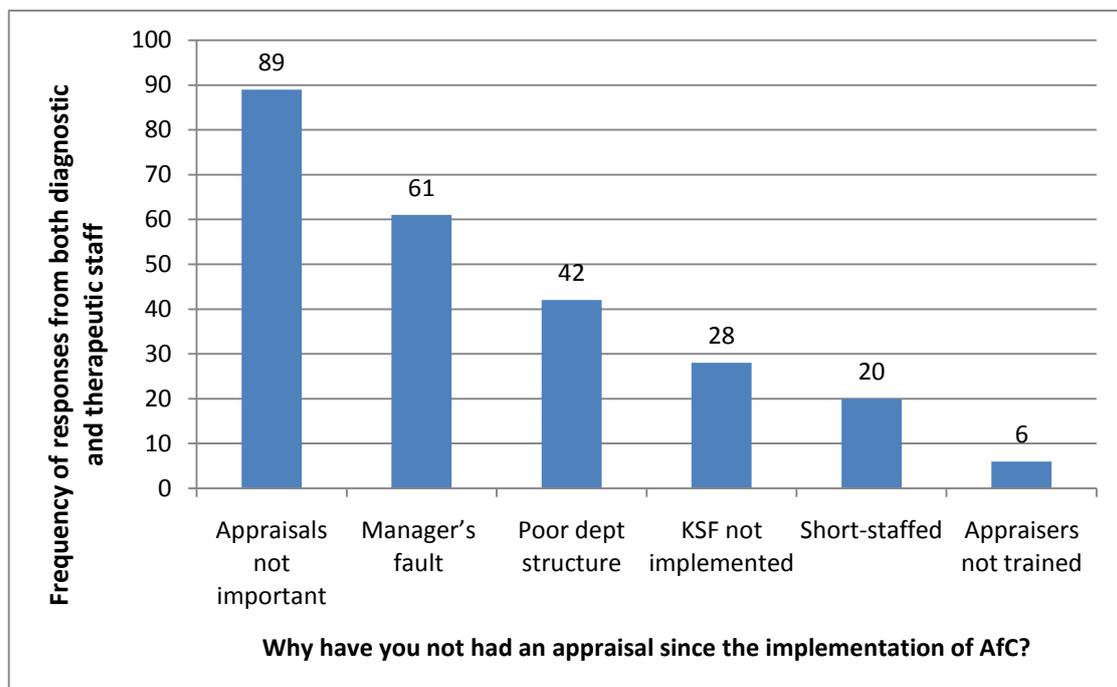
**Figure 22: Time elapsed since last appraisal**

Diagnostic radiographers were, however, more likely to have had a recent appraisal in centres where the CPF was in place (68% compared to 52%)(Figure 23). In support of this finding, twice as many radiographers claimed not to have had an appraisal since the implementation of AfC in locations where the CPF was not integrated (20% compared to 9%). Almost a third (30%) of diagnostic radiographers did not know whether the CPF was in place at their site or not.



**Figure 23: Time elapsed since last appraisal in terms of whether the CPF is in place in the diagnostic radiographers' department**

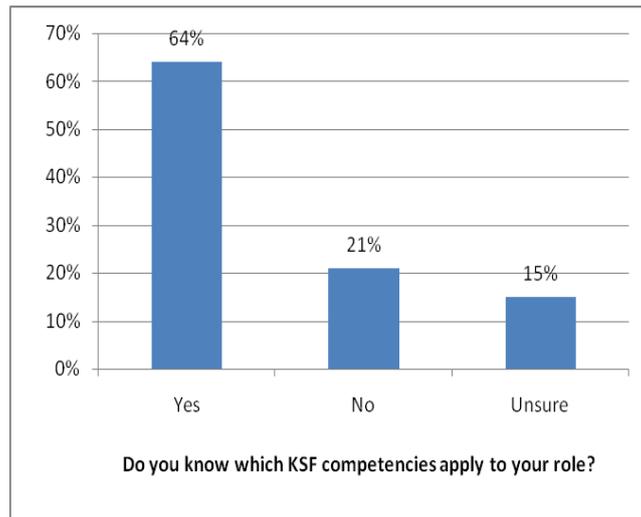
For those who had not had an appraisal since the inception of AfC a number of reasons were given and were similar regardless of the professional background of the radiographer (Figure 24). The most frequently cited reasons were that appraisals were not taken seriously in their department and that their managers were not interested in completing them.



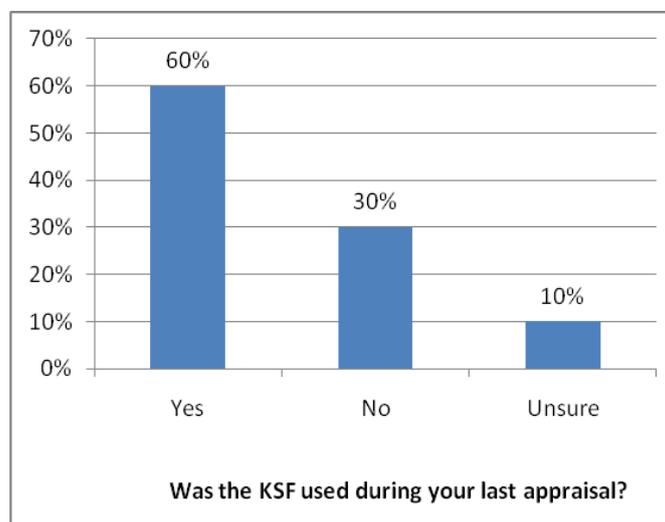
**Figure 24: Common reasons for not having had an appraisal since the implementation of AfC**

#### 4.2.10 The use of the NHS Knowledge and Skills Framework

The majority (64%) of diagnostic radiographers were aware of which KSF competencies were needed to carry out the tasks expected in their role (Figure 25). The majority (60%) also reported that the KSF was used during their last appraisal although a significant proportion (30%) claimed it was not and 10% were unsure one way or the other (Figure 26).



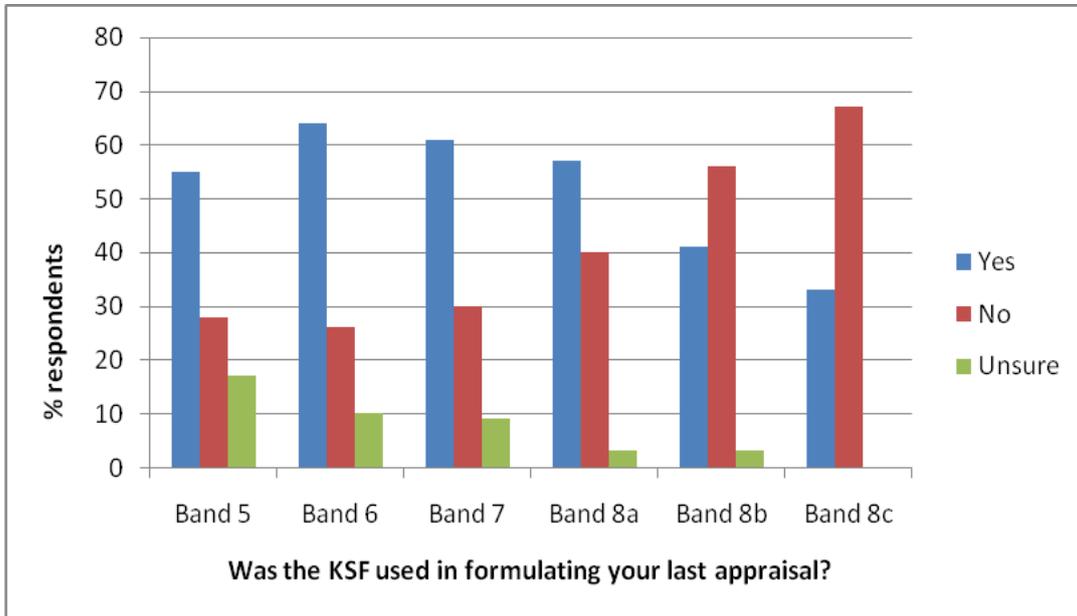
**Figure 25: Diagnostic radiographers' familiarity with the KSF competencies for their role**



**Figure 26: Diagnostic radiographers who had had an appraisal which involved use of the KSF**

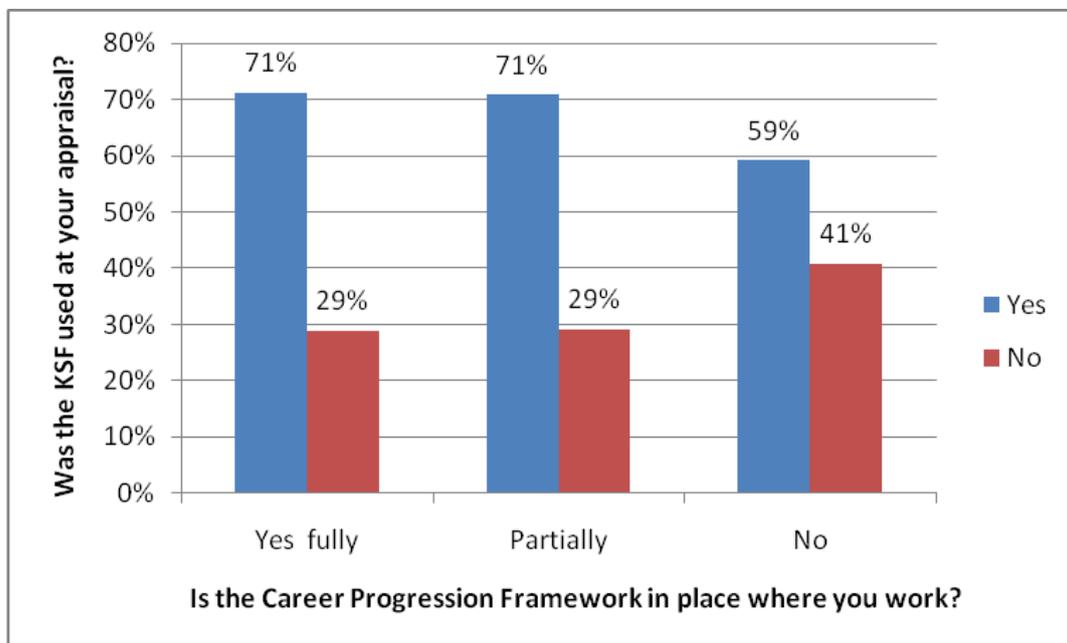
There was no significant difference between respondents of different ages in terms of their reports of whether the KSF had been applied in formulating their last personal development plan. There were differences, however, in the application of the KSF in relation to their AfC band. Generally, the higher the band the less often the KSF was applied during their

appraisal. Equally, as the banding increased, there was less uncertainty about whether the KSF had been used (Figure 27). More of the respondents from lower bands were unsure regarding whether the KSF had been used.



**Figure 27: Use of the KSF at appraisal for diagnostic radiographers in bands 5 to 8**

In places where the CPF is in place, either totally or partially, the KSF is more likely to be used at appraisals for formulating career development goals (Figure 28).

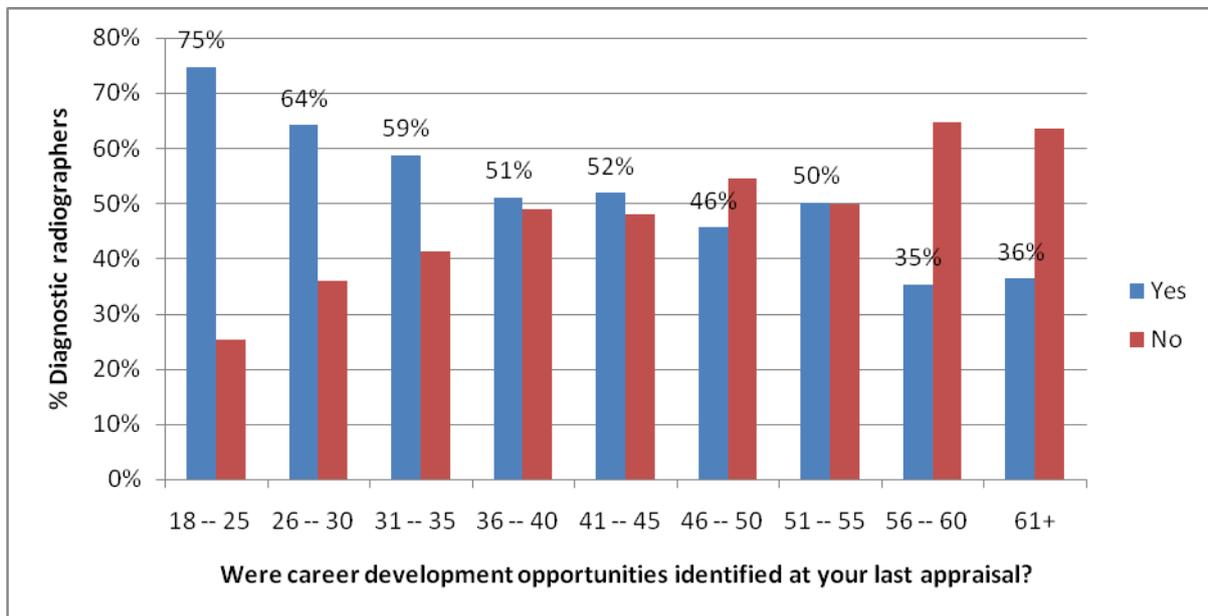


**Figure 28: Use of the KSF at appraisal in terms of whether the CPF is in place in the diagnostic radiographers' department**

#### 4.2.11 Opportunities identified at appraisal

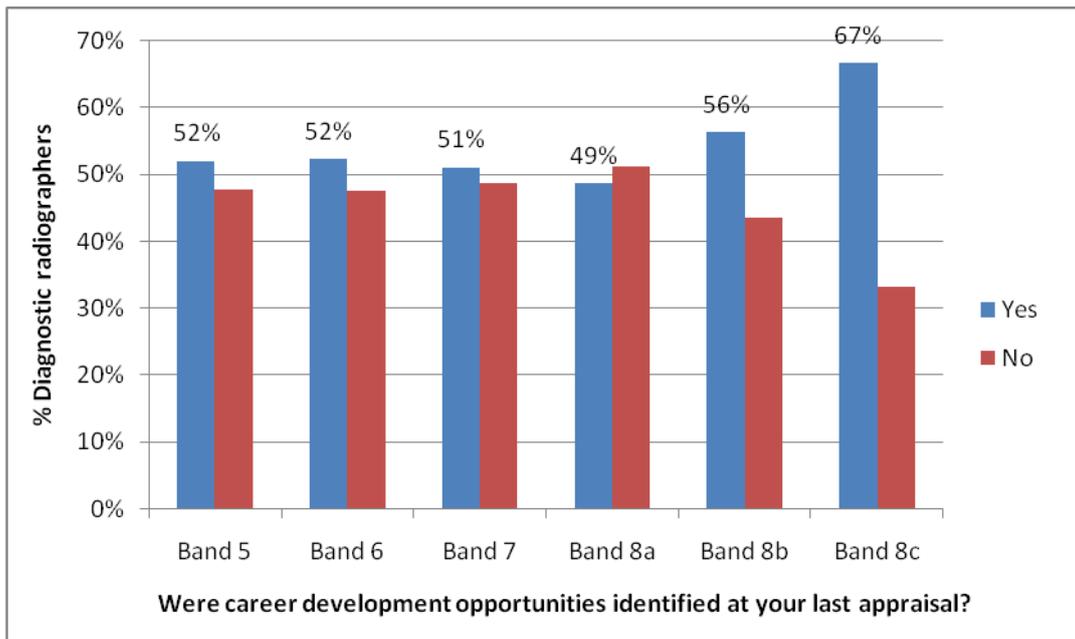
Just over half (52%) of all diagnostic radiography respondents reported having had career development opportunities identified at their last appraisal. There was minimal difference in the extent to which identification of career development opportunities was reported by female or male diagnostic radiographers, with some 47% of males and 53% of females agreeing that career development opportunities had been identified for them at their last appraisal. Similar proportions of part time and full time members of staff also reported having had career development opportunities suggested for them at appraisal.

There were, however, more career development opportunities identified for younger diagnostic radiographers compared to those in older age groups (Figure 29). Three out of four staff under 26 years old have had opportunities identified for them at appraisal, however, this falls to just one in three for the over 55s. There was no significant difference between age groups, however, when assessing the type of career development opportunities offered, whether they were what the respondent had wished for, and whether they were achieved during the following year. Furthermore, there was no correlation between proportion of respondents being denied access to development opportunities and their age.



**Figure 29: Career development opportunities in terms of diagnostic radiographers' age**

When career development opportunities were measured in terms of AfC banding, a slightly higher proportion of radiographers in the senior bands stated that opportunities were identified at appraisal compared to those in the lower bands (Figure 30). (Average = 52%).



**Figure 30: Career development opportunities in terms of diagnostic radiographers' banding**

There were some small differences depending on area of practice (Table 5). For the full table comparing experiences of the specialties see Appendix 2: Key responses from the specialties.

**Table 5: Diagnostic specialties in terms of career development opportunities and expectations**

Specialty (numbers of individuals)	Full survey (n = 2373)	MRI (n = 223)	Ultra-sound (n = 307)	Mammo-graphy (n = 247)	RNI (n = 73)	Diagnostic manager (n = 251)
<b>OPPORTUNITIES</b> Career development opportunities were identified at my last appraisal	53%	57%	49%	58%	48%	56%
<b>EXPECTATIONS</b> I believe these identified opportunities may aid my progression to the next band	21%	17%	13%	29%	17%	19%
These development opportunities are the ones I wanted and will support my long term goals	54%	54%	57%	60%	52%	59%

#### 4.2.12 Types of career development opportunities

Diagnostic radiographers described a vast range of career development opportunities which were identified for them at their appraisal. More than a quarter of diagnostic respondents also said that career development opportunities were identified all year round, not just at the annual appraisal. There was no difference between the types of opportunities identified either at, or outside, appraisal. These opportunities spanned the full spectrum of activities including formal academic courses, reporting, study days, and the acquisition of new clinical or managerial skills.

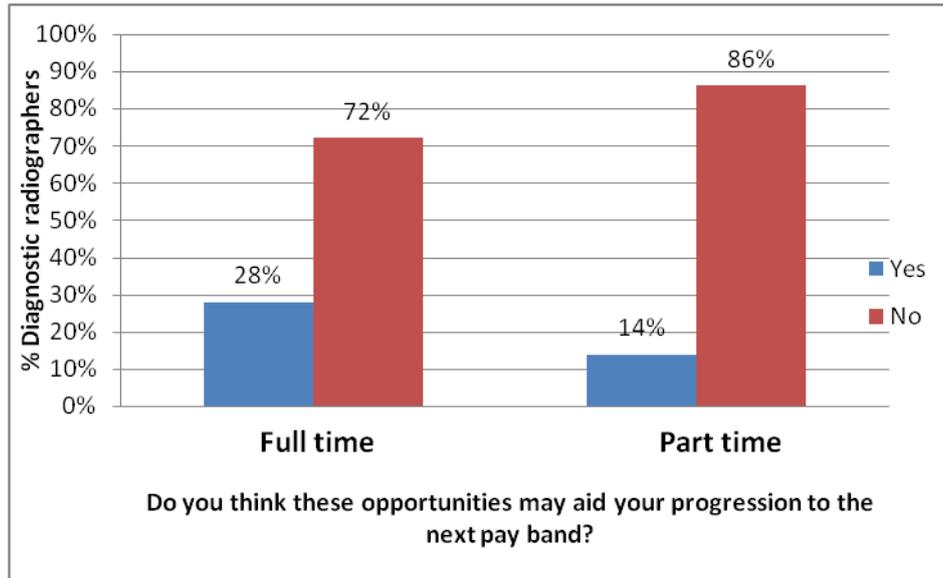
Career development opportunities were more likely to be identified in departments which recognised the CPF (Table 6).

**Table 6: Comparison of frequency of career development opportunities offered at sites with or without the CPF**

Combined responses from the survey	Is the CPF in place where you work?	
	Yes fully	No
Career development opportunities were identified at my last appraisal	61%	47%
No career development opportunities were identified at my last appraisal	39%	53%

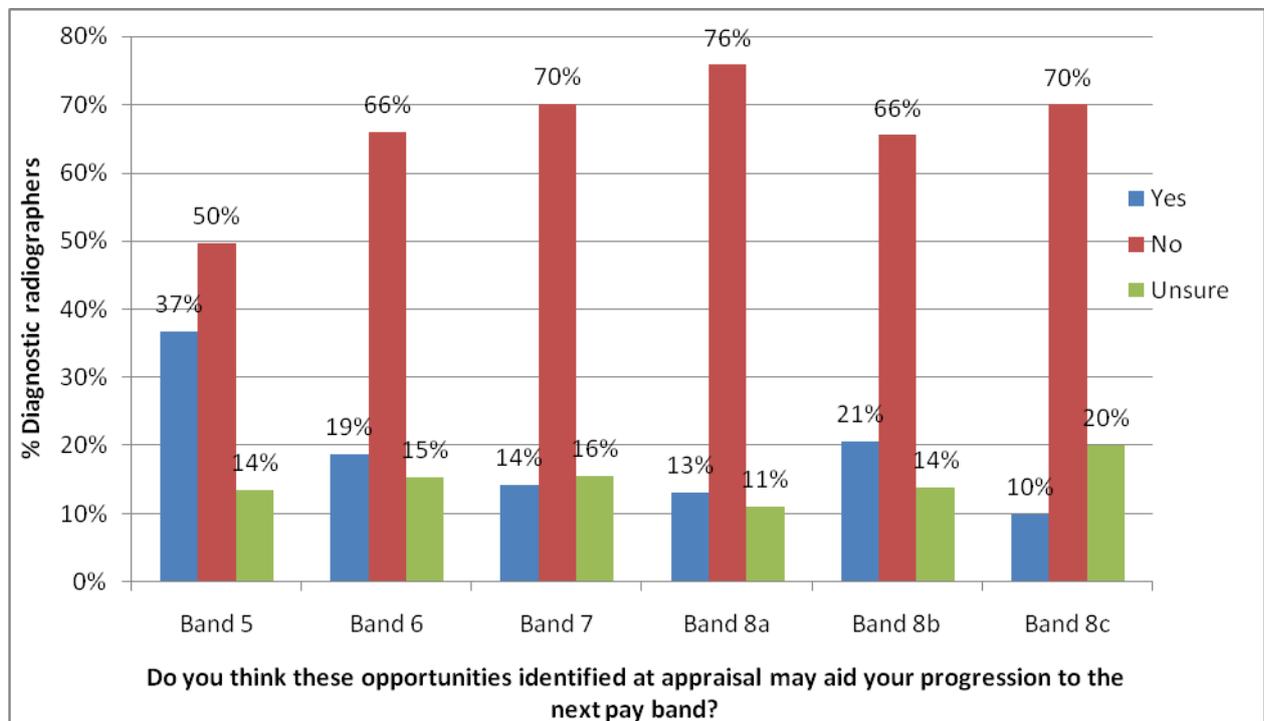
#### 4.2.13 Opportunities in terms of facilitating progression

However, few of the respondents thought that these opportunities would aid their progression into the next pay band. Overall, only one in five diagnostic radiographers (19%) thought they might but two thirds (66%) did not anticipate being up-graded. Out of the various staff groups, mammographers (29%) and full time radiographers (28%) were slightly more optimistic that this would be the case, but only half this proportion (14%) of part time staff felt the same (Figure 31).



**Figure 31: Expectation of whether development opportunities might lead to pay band progression in terms of part time versus full time status for diagnostic radiographers**

In terms of banding, diagnostic radiographers in band 5 were the most optimistic about their prospects for progression following development. The more senior staff members had lower expectations of progression (Figure 32).



**Figure 32: Expectation of whether development opportunities for diagnostic radiographers might lead to pay band progression expressed according to current pay band**

Common reasons why respondents thought the opportunities identified at appraisal were unlikely to facilitate progression were the same for both diagnostic and therapeutic radiographers and were most frequently related to the fact that they would gain access to the next band only if a vacancy arose and not as a consequence of acquiring additional skills. In some instances, however, staff reported that progression was limited due to trust strategies. Responses are summarised in Figure 33 and typical examples are outlined as follows:

*All the superintendents have been at the department for years and there are simply no jobs to apply for.* Therapeutic radiographer, band 6

*As far as I understand it, my progression to band 7 will involve the retirement of the current post-holder.* Diagnostic radiographer, band 6

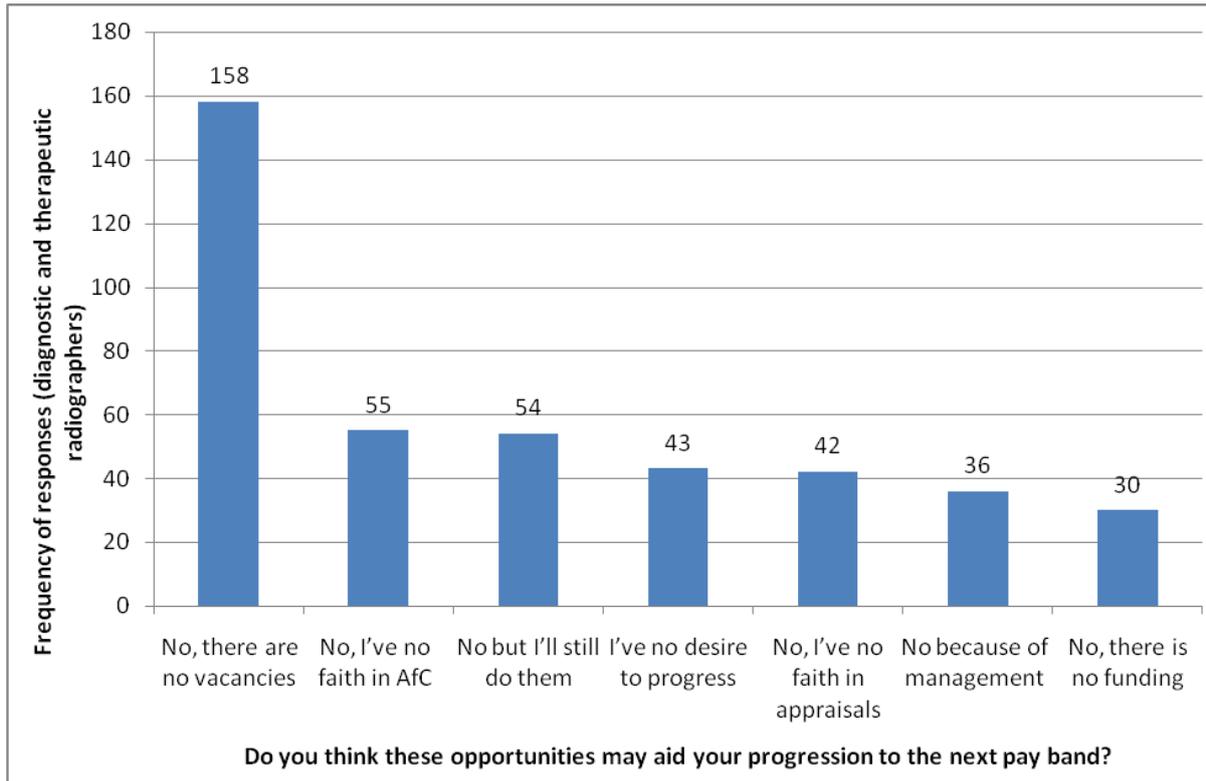
*Promotion to next band is only possible if post becomes vacant.* Diagnostic radiographer, band 6

*Implementation of AfC in the Trust has focused on limiting or avoiding any upward movement in staff development or remuneration.* Diagnostic radiographer, band 8b

However there were some examples of more optimistic comments from radiographers who thought their career development opportunities would aid progression to the next band, such as the following:

*Doing a PgD in clinical reporting so once finished should be band 7.* Diagnostic radiographer, band 6

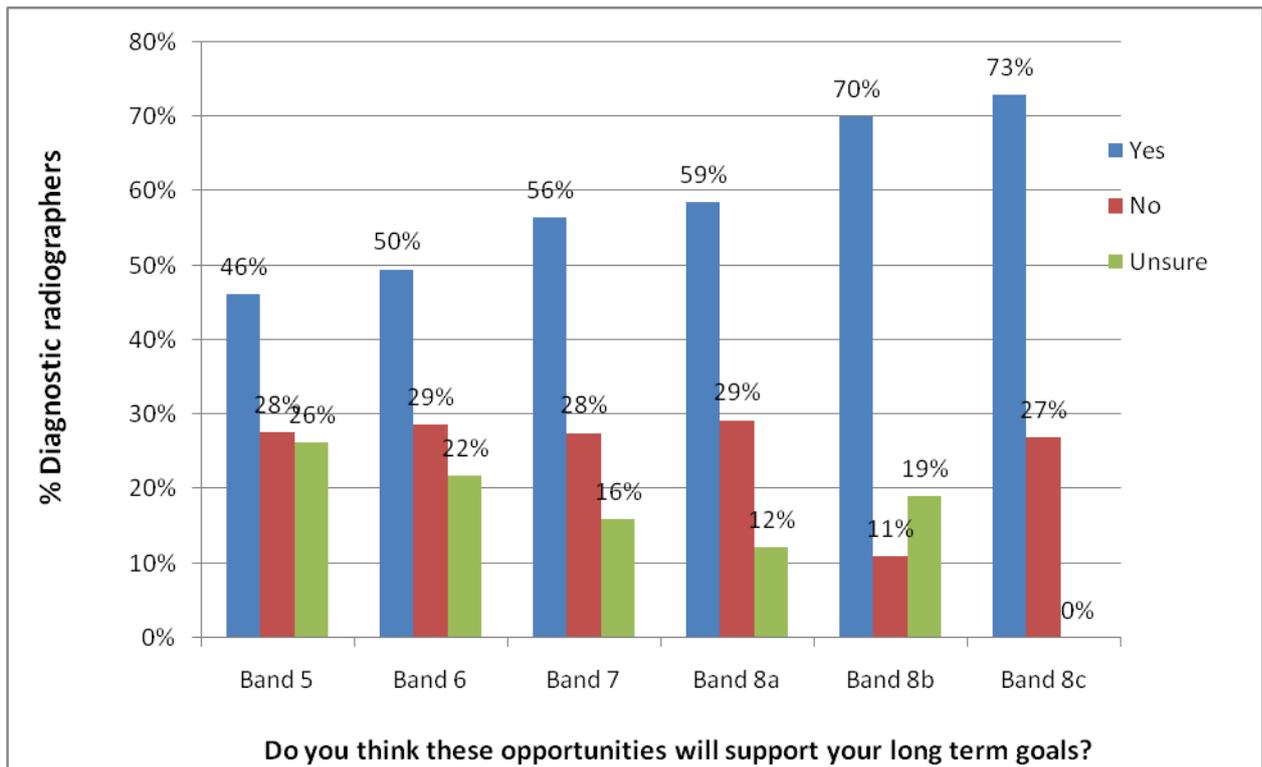
*Training in CT and MRI will aid in progression to a band 6.* Diagnostic radiographer, band 5



**Figure 33: Common reasons why diagnostic and therapeutic radiographers collectively feel that development opportunities identified at appraisal are unlikely to lead to progression to the next pay band**

Satisfaction in the type of opportunities identified increased steadily with the banding of the respondent. The majority of those in the higher bands felt strongly that the opportunities were what they personally wanted and would support their long term career plans regardless of whether they enabled them to advance into the next pay band or not. In fact, radiographers of all bands stated frequently that they still wanted access to development opportunities regardless of whether they would facilitate a rise to a higher band.

Uncertainty about their career future seemed to decrease in the higher bands. The percentage of radiographers who felt that the opportunities were not what they personally wanted remained fairly constant (approximately 28%) across all the AfC bandings 5 to 8c (Figure 34).

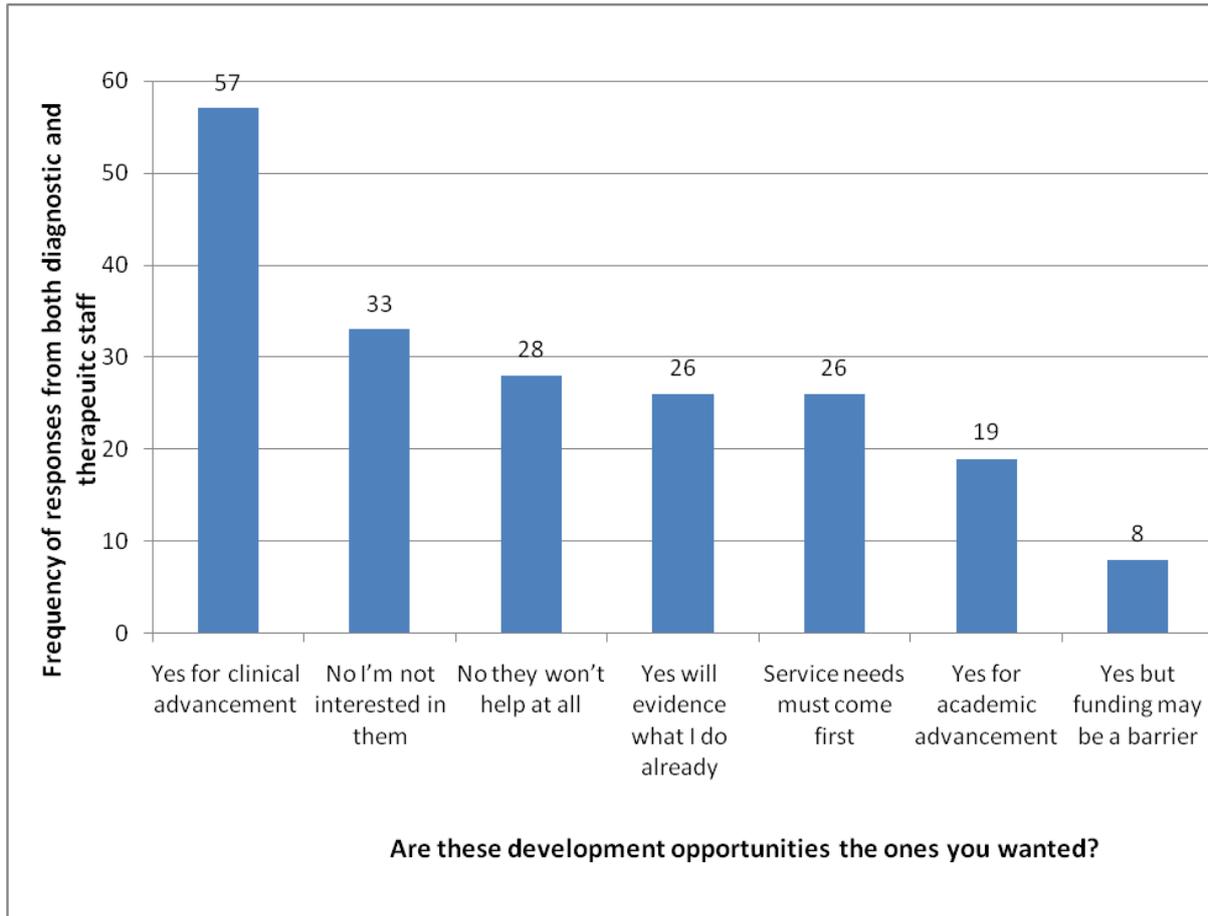


**Figure 34: Diagnostic radiographers' opinions on whether the development opportunities available are what they wanted to support their career development**

Many radiographers provided further information on how they felt about the career development opportunities identified at appraisal. When explaining whether the opportunities were what they personally wanted, a number of both positive and negative common themes emerged (Figure 35). Others were more pragmatic in their stance, believing that patient services will continue to drive and shape career development opportunities regardless of their own personal desires.

*Service needs have driven role extension.* Diagnostic radiographer, band 7

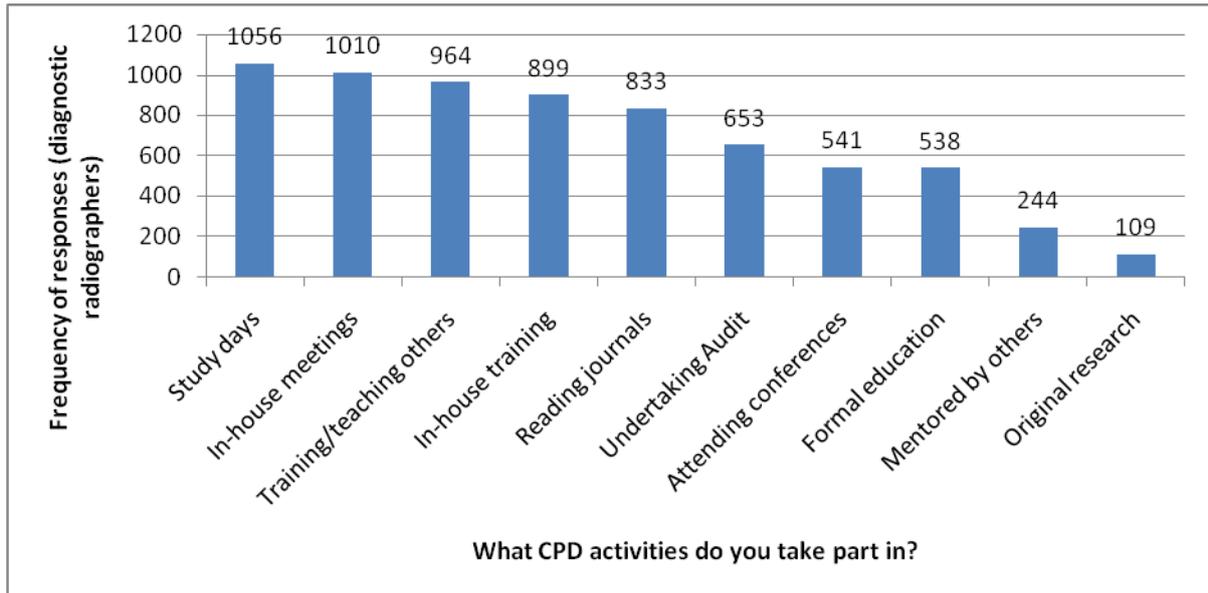
Of the diagnostic specialties, more mammographers (60%) reported that the development opportunities were what they wanted and would support their long term career plans, closely followed by managers of diagnostic departments (59%). Radionuclide imaging radiographers were least satisfied at 52% (Table 5).



**Figure 35: Opinions of diagnostic and therapeutic staff collectively towards the development opportunities identified at appraisal**

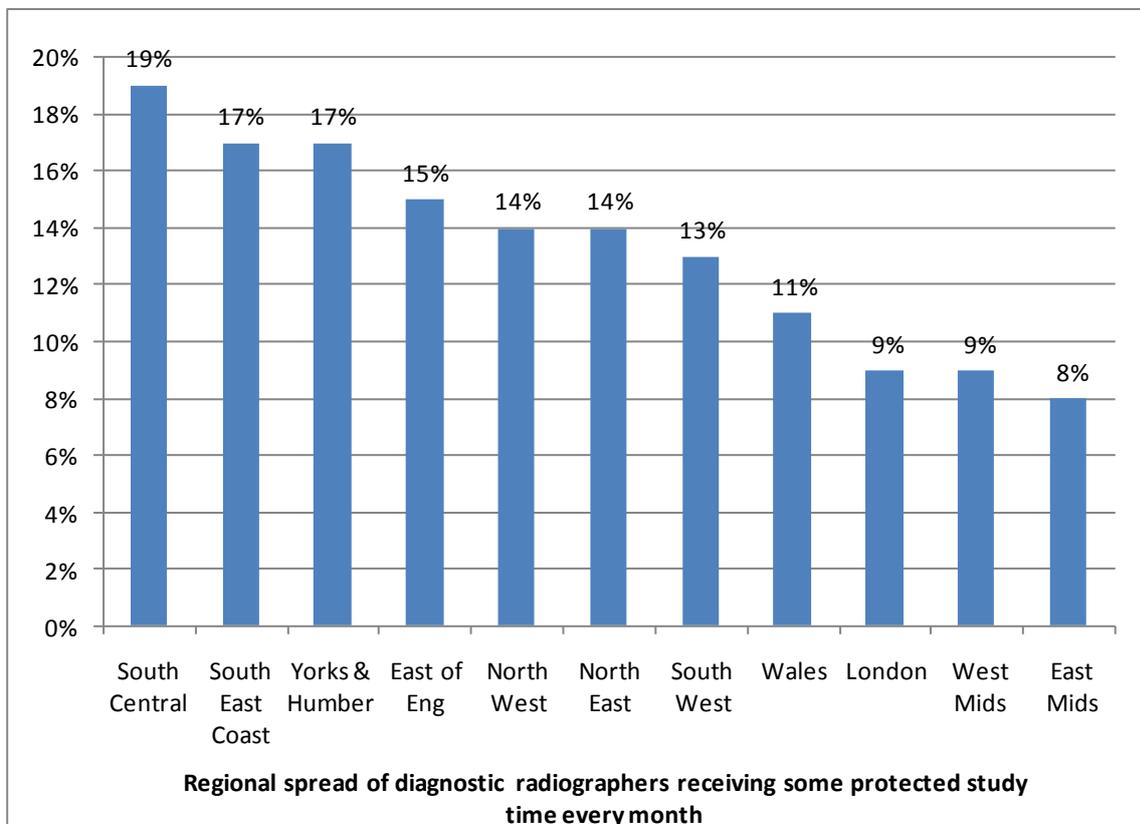
#### **4.2.14 Continuing Professional Development (CPD) activity**

More than three quarters (78%) of diagnostic radiographers recognised that they had CPD opportunities in the work place, and these activities were wide-ranging and varied (Figure 36). Study days and in-house meetings were most frequently cited by respondents. Conducting original research was the least frequently cited CPD activity. Although at least 109 diagnostic radiographers claimed to be participating in original studies, few (35) cited research as one of their main duties (Figure 4).



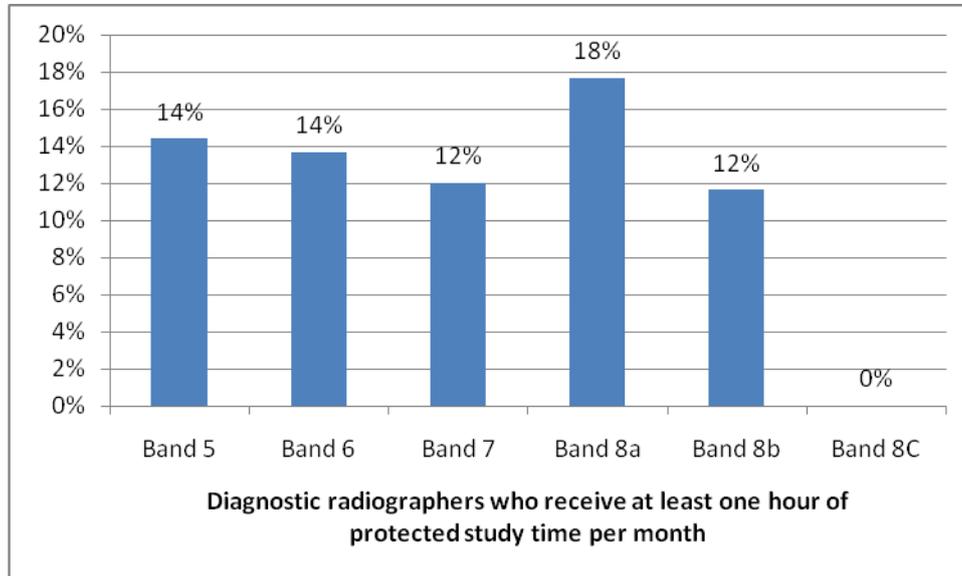
**Figure 36: CPD activities commonly cited by diagnostic radiographers**

On average, only 13% of respondents claimed to receive any regular protected study time. From our survey, departments in the South Central SHA are most likely to offer protected CPD time, with those in London and the Midlands least likely to (Figure 37).



**Figure 37: Distribution of diagnostic radiographers receiving protected study time by SHA region**

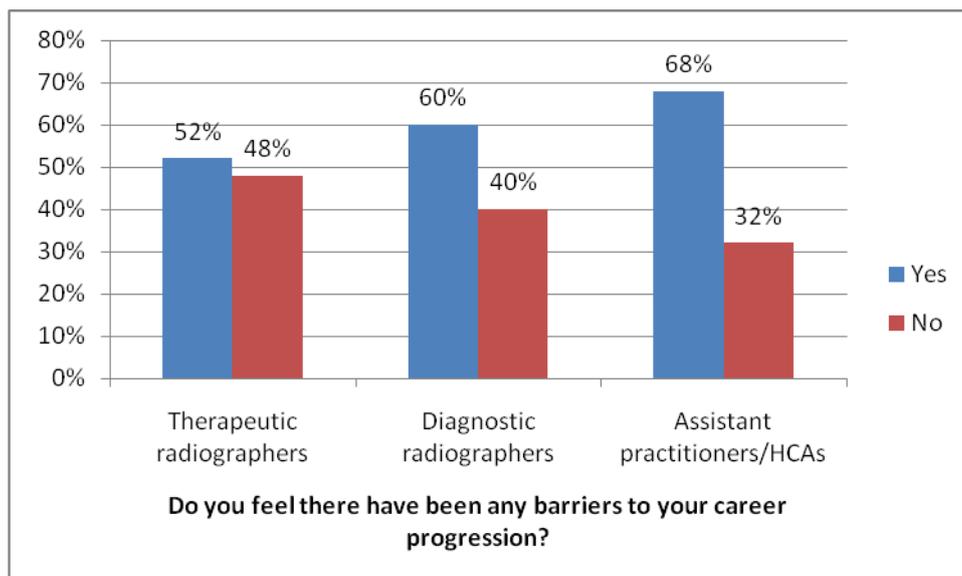
There was very little difference between allocation of protected study time and radiographers' banding. However, band 8a radiographers were slightly more likely to enjoy regular CPD time (24 out of 136) whereas, although the sample size was small at a total of just 16, none of the band 8c respondents claimed to be given any time at all (Figure 38).



**Figure 38: Distribution of diagnostic radiographers' protected study time by pay banding**

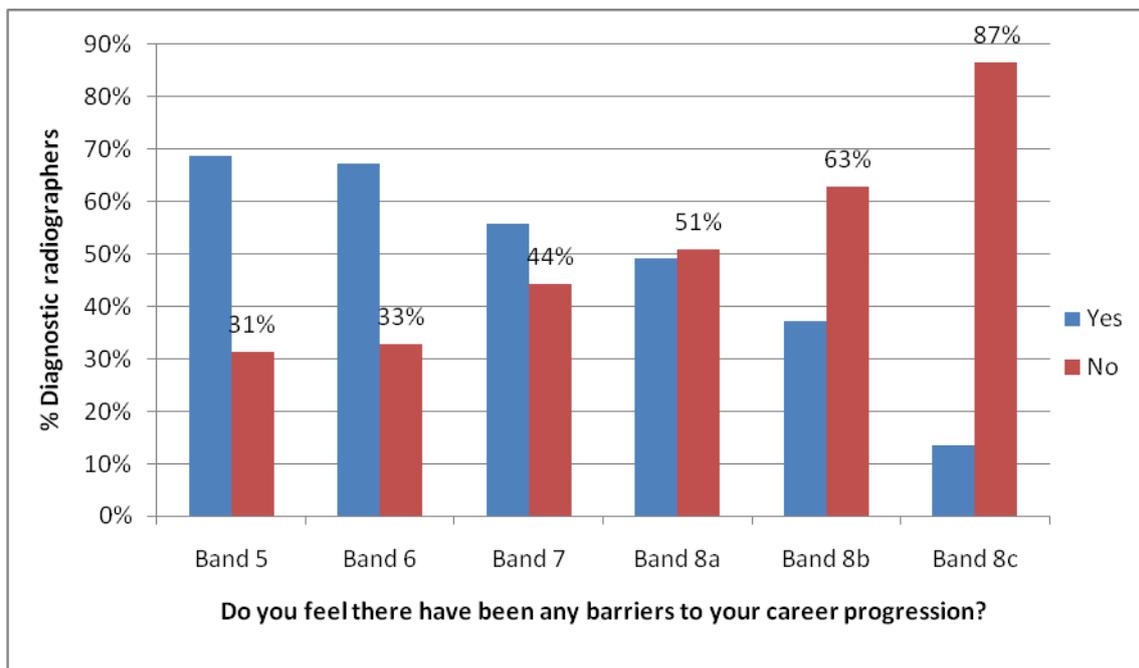
#### 4.2.15 Barriers to career development

The majority (60%) of diagnostic radiographers felt that they had encountered barriers which hindered their career progression (Figure 39). The percentage among therapeutic radiographers was less (52%), but higher (68%) among assistant practitioners and HCAs.



**Figure 39: Distribution of all staff group responses in terms of perceived barriers**

Perhaps unsurprisingly, there was a clear trend indicating that those already in higher bands felt that they had encountered fewer barriers (Figure 40). This trend was maintained irrespective of whether the radiographer was full time or part time indicating that, in general, part time staff did not feel disadvantaged in this area when it came to career progression. However, it should be noted that there were no part time participants in the survey who were banded 8c.



**Figure 40: Perceived barriers for full-time diagnostic radiographers in terms of their pay banding**

Of the diagnostic specialties, radiographers performing radionuclide imaging felt they had encountered barriers most frequently (45%), although of the remaining specialisms which were assessed separately from the main survey approximately one third reported encountering barriers (Appendix 2: Key responses from the specialties).

The most common reasons offered by all staff when asked to explain barriers were operational issues including under-staffing and a continuous drive to meet government targets, poor support from managers and peers, and a lack of available funding even if staffing levels were high enough to allow time off (Figure 41). Radiologists were also still perceived as a hindrance to advancement by some diagnostic radiographers.

*I went through a gruelling banding appeal and successfully got my banding changed from 6 to 7 only to have my manager veto the change and have me put back to band 6.* Diagnostic radiographer, band 6

*We have to meet targets and all our time is taken up with scanning patients.*

Diagnostic radiographer, band 7

*Management supportive but no money and short staffed.* Therapeutic radiographer, band 8a

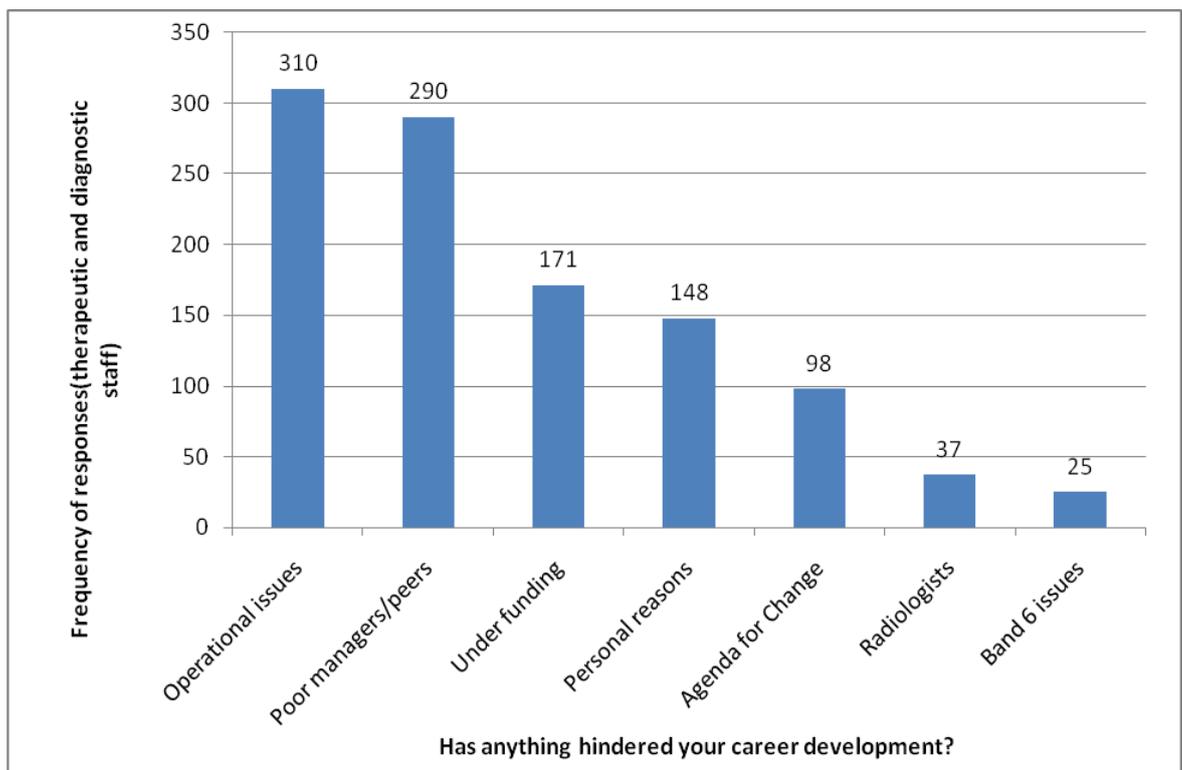
*No money or time off for anything other than mandatory training. Barriers were not around when I took my GI reporting course 7-8 years ago, but they are now.*

Diagnostic radiographer, band 6

*Shortage of staff and meeting targets mean that the first thing to be ignored is CPD needs. Also there has been no identification of a radiographer consultant post.*

*Management still don't think there is a need to move somebody into a more advanced clinical role.* Diagnostic radiographer, band 7

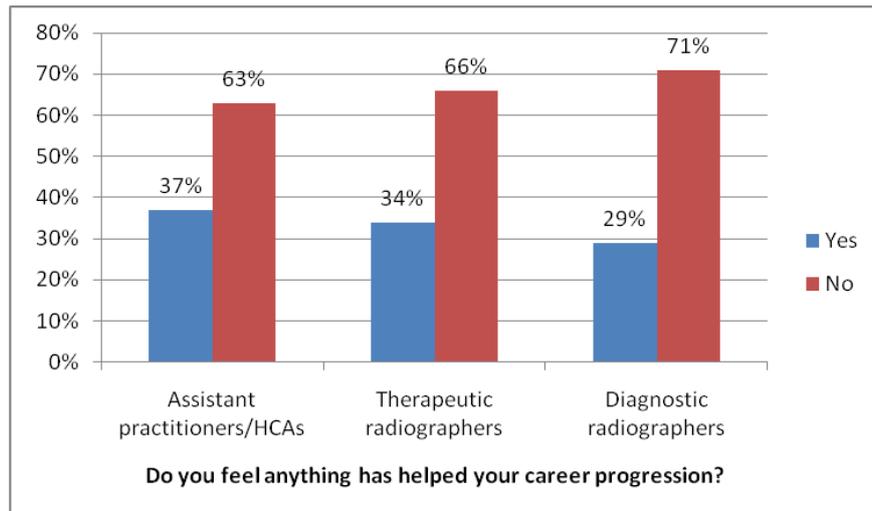
*Radiologists are still very protective of their role and no consultant radiographers are employed in our trust.* Diagnostic radiographer, band 7



**Figure 41: Reasons given as barriers to career progression by diagnostic and therapeutic staff collectively**

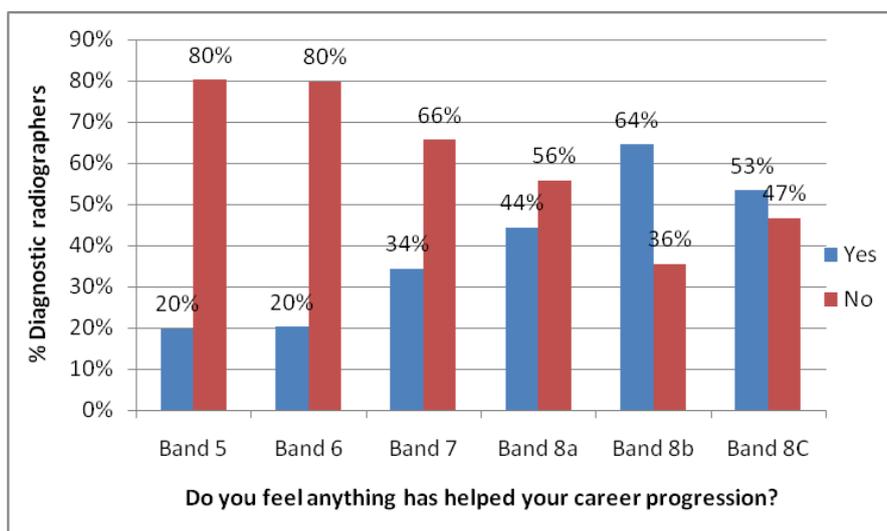
### 4.2.16 Incentives

Participants in the survey were asked if anything had helped their career progression, and the views of the majority, irrespective of whether they were therapeutic or diagnostic radiographers or assistant practitioners, were that nothing had assisted them. Only one third felt that some factor had helped their career progression, while two-thirds felt they had not had any help. Of the three cohorts, diagnostic radiographers were the most likely (71%) to say that they had found nothing helpful during their career progression (Figure 42).



**Figure 42: Distribution of responses in terms of assistance with career progression for all staff groups**

Once again, in terms of banding, and in support of the evidence gained in the section that explored barriers to progression, more of those in the higher bands reported that they recognised that some factor during their career had assisted their progression (Figure 43).



**Figure 43: Diagnostic radiographers' perception of assistance with career progression in terms of pay banding**

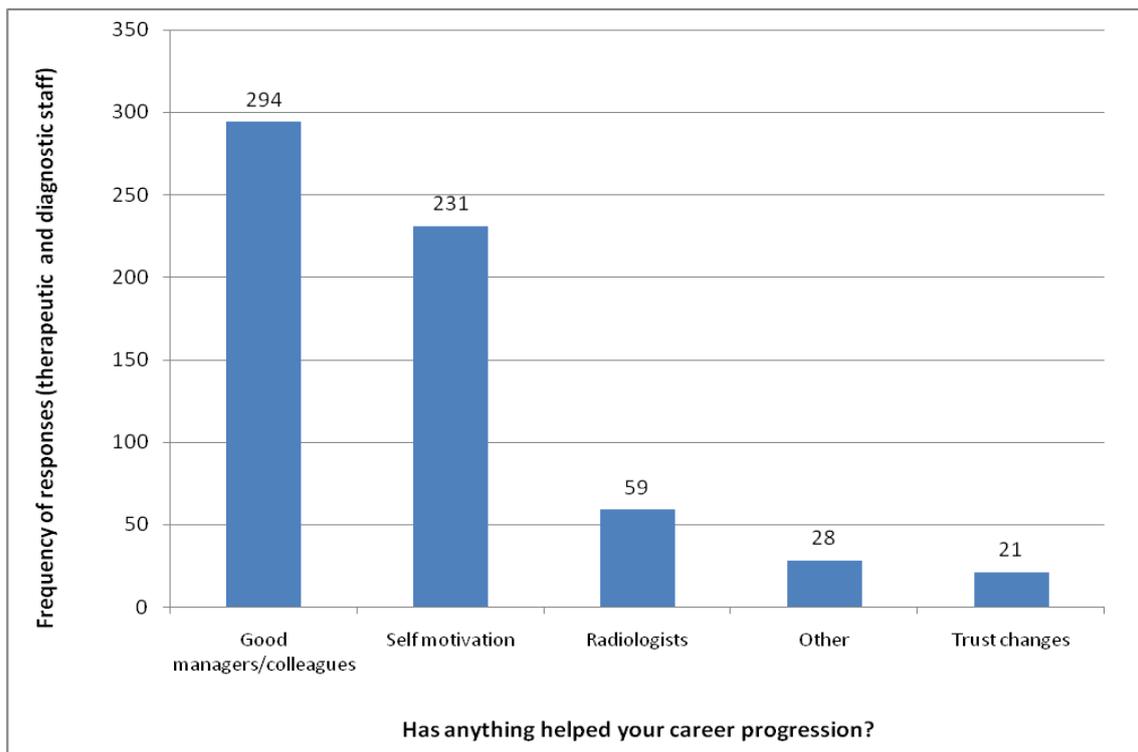
Those who said that something had helped their career progression were asked for further details. The most frequently cited responses from all staff bands when describing factors which they believed had helped them were: receiving support from managers and colleagues, self determination and self motivation, supportive radiologists in imaging departments, and changes in trust or department structures which had enabled promotion or progression (Figure 44).

*Supportive radiologists and colleagues.* Diagnostic radiographer, band 8a

*I have a supportive manager who believes in succession planning.* Diagnostic radiographer, band 8a

*Self motivation to be the best at what I do. To ensure the service users get the best possible service.* Diagnostic radiographer, band 6

*Encouragement from head of department.* Therapeutic radiographer, band 6



**Figure 44: Reasons cited by diagnostic and therapeutic staff collectively which are perceived to have assisted career progression**

#### 4.2.17 Morale

To gain a holistic view of diagnostic radiographers' attitudes towards AfC and their career progression, participants were asked if their morale had changed since the implementation of AfC. The majority, some 62%, said it was lower (Figure 45). Among the specialties, MRI radiographers were most negative, with 72% reporting a reduction in morale, followed closely by RNI radiographers at 67%. Respondents were able to give further details of the reasons for their view:

*The way in which AfC rewards service managers is appalling - and needs to be addressed. I have made the decision to leave the profession after many years as a MRI superintendent. MRI radiographer, band 6*

*I was told that with AfC linked to KSF it would be possible to advance beyond the top of band 6 to band 7 by recognition of academic qualification and not just in a managerial role. My radionuclide imaging diploma has been ignored in the AfC process but I am expected to know "everything" when in the work place. RNI radiographer, band 6*

*I'm in contact with radiographers at other hospitals. London hospitals place radiographers with much less knowledge, skills and responsibilities at the same or higher band than myself. I've seen those role profiles and there is no evidence to support their bandings. There's little consistency between hospitals, even hospitals only few miles down the road. RNI radiographer, band 7*

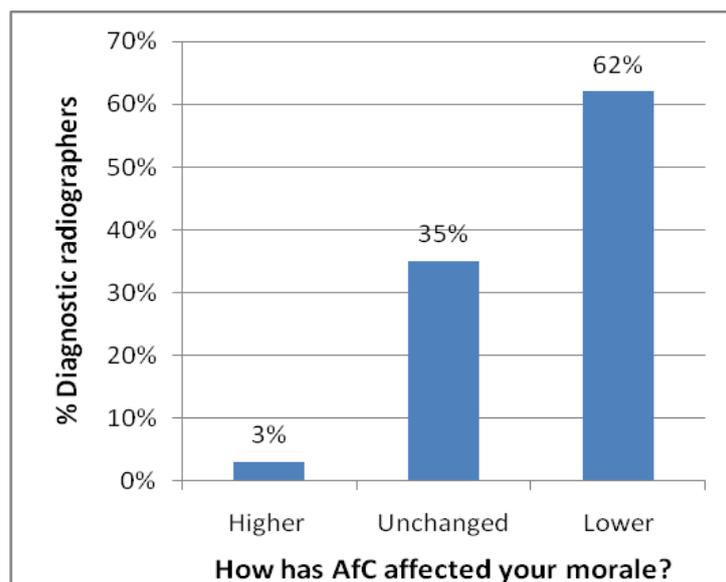


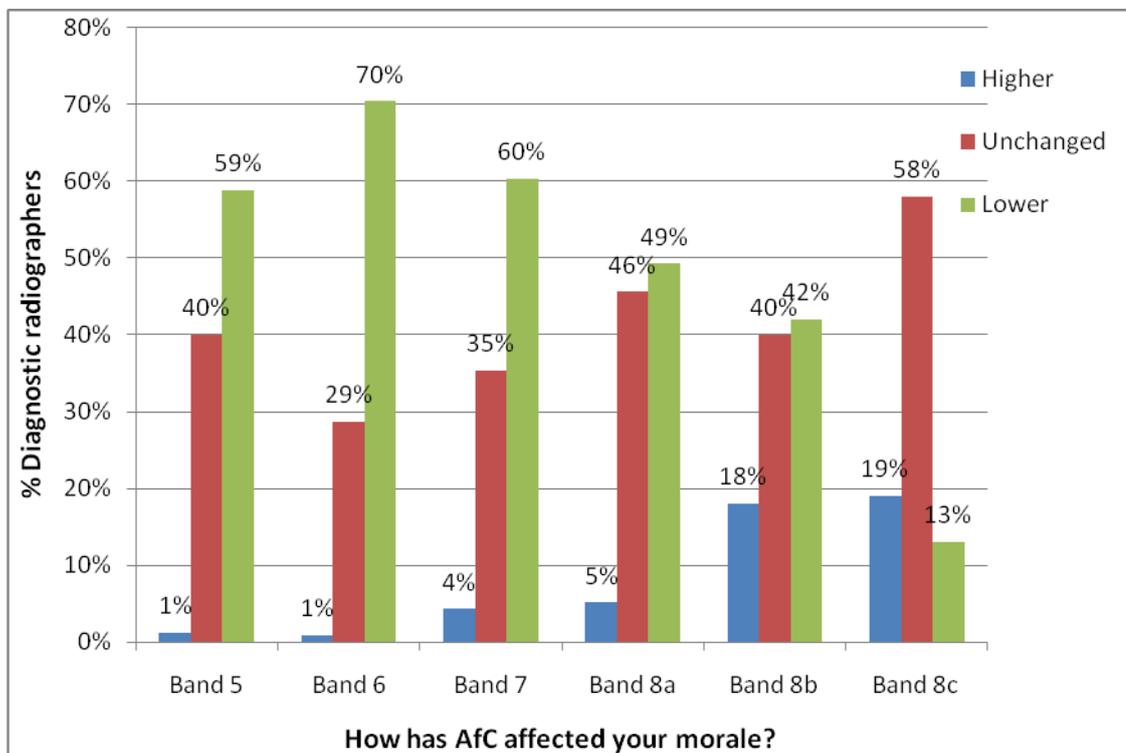
Figure 45: Diagnostic radiographers' change in morale since AfC

Over a third (35%) of respondents felt their morale had been unaffected by AfC, and there was a general trend towards those in higher bands believing their morale had increased under AfC. Equally, and in support of this finding, the higher the band, the less negative in general were the attitudes reported towards AfC. Noticeably, it was those in bands 6 and 7 who most frequently reported that their morale had been lowered by AfC (Figure 46).

*I have now reached the top of my band with nowhere to go. Inexperienced staff are on the same pay as me with no responsibilities.* Diagnostic radiographer, band 6

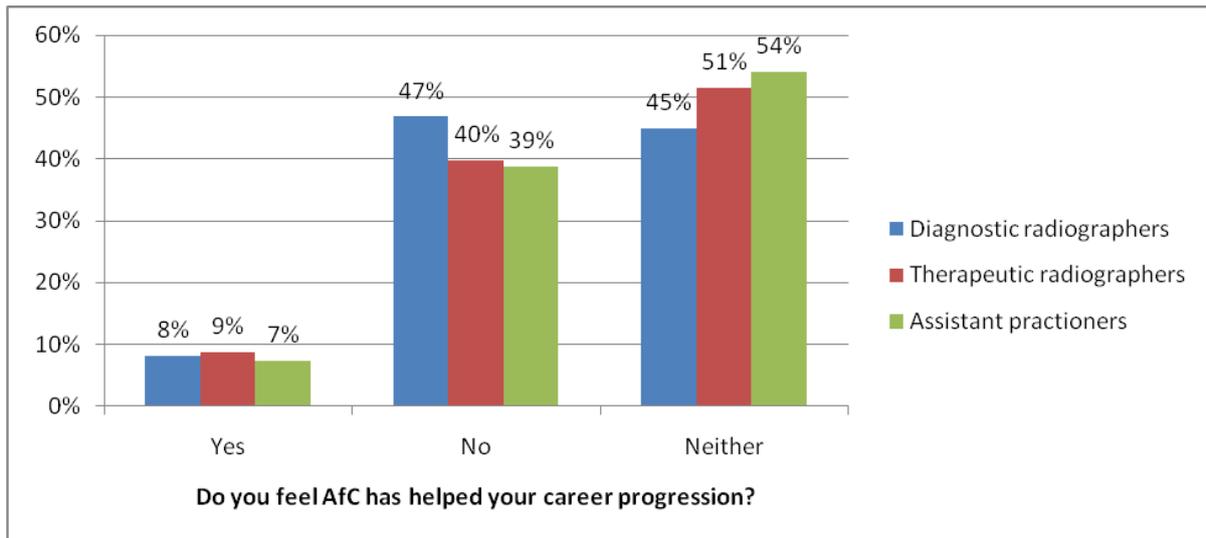
*I went straight onto the top of Band 7 through protected pay and I will probably be there for the next 20 years.* Diagnostic radiographer, band 7

*AfC has improved my financial position, but not my career progression.* Therapeutic radiographer, band 8a



**Figure 46: Effect of AfC on diagnostic radiographers' morale in terms of pay bands**

When asked if they felt AfC had assisted with their career progression, very few staff from any sectors felt it had. However, a large proportion felt it had had no influence either way (Figure 47).



**Figure 47: Perceived impact of AfC in assisting career progression for all staff groups**

Common reasons cited by staff when justifying their opinion on AfC included poor implementation, issues related to band 6 being too broad and the view that it should not contain both senior I and II staff, and a belief that AfC was designed to save money and not to facilitate career progression (Figure 48).

*AfC has condensed the grades. Now there is no distinction between senior 2 and senior 1 grades, so what is the point in completing further post grad qualifications?*  
Diagnostic radiographer, band 6

*Banding Senior 1s & Senior 2s together on band 6 has been a retrograde step for the profession & we are back where we were in the 1970s when it was radiographer, senior & superintendent grades.* Diagnostic radiographer, band 6

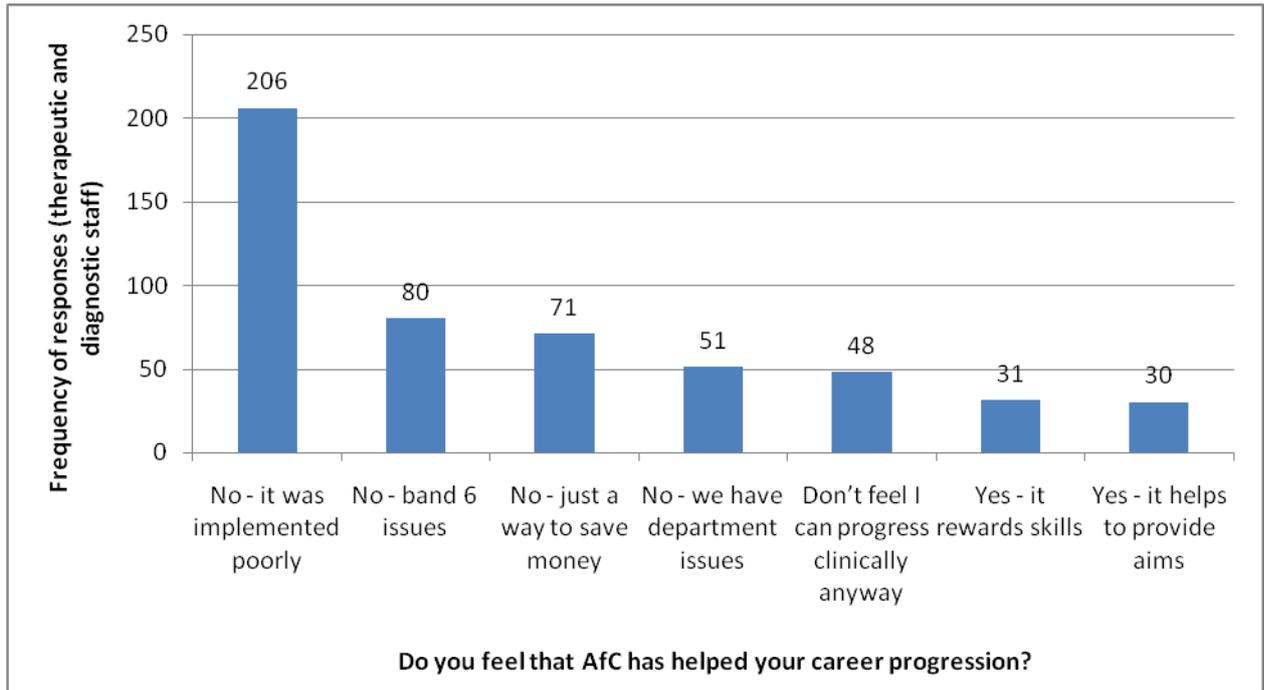
*From my perspective it was used as a cost cutting exercise by my trust.* Diagnostic radiographer, band 6

*I have no reason to apply for the current lead interventional post as that is also a band 6 post. More responsibility with no increase in pay.* Diagnostic radiographer, band 6

There were however some comments from respondents who felt that AfC had helped their career progression:

*It gave me an unexpected band 8.* Diagnostic radiographer, band 8a

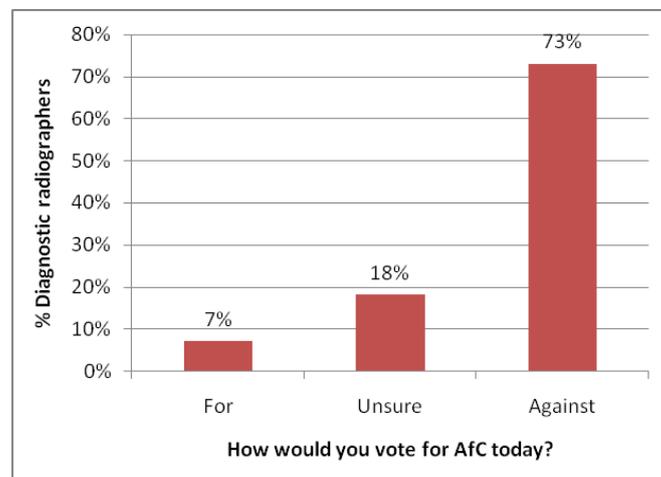
*I don't believe I would be reporting if AfC hadn't come in.* Diagnostic radiographer, band 7



**Figure 48: Reasons cited by diagnostic and therapeutic staff collectively as to whether AfC assists with career progression**

#### 4.2.18 Voting intentions

The majority (73%) of diagnostic radiographers would vote against AfC if given the chance to vote today (Figure 49). However, when responses were analysed in terms of staff bands it was clear that diagnostic radiographers in higher bands were less negative towards the AfC initiative (Figure 50). They were more likely now to vote in favour of AfC, although this still only amounts to a third of respondents in band 8c, the band with the largest proportion willing to vote in favour now.



**Figure 49: Present-day AfC voting intentions of diagnostic radiographers**

Those most frequently against AfC were MRI and RNI radiographers (Appendix 2: Key responses from the specialties) and those in bands 6 and 7. Perceptions of morale and voting intentions matched closely.

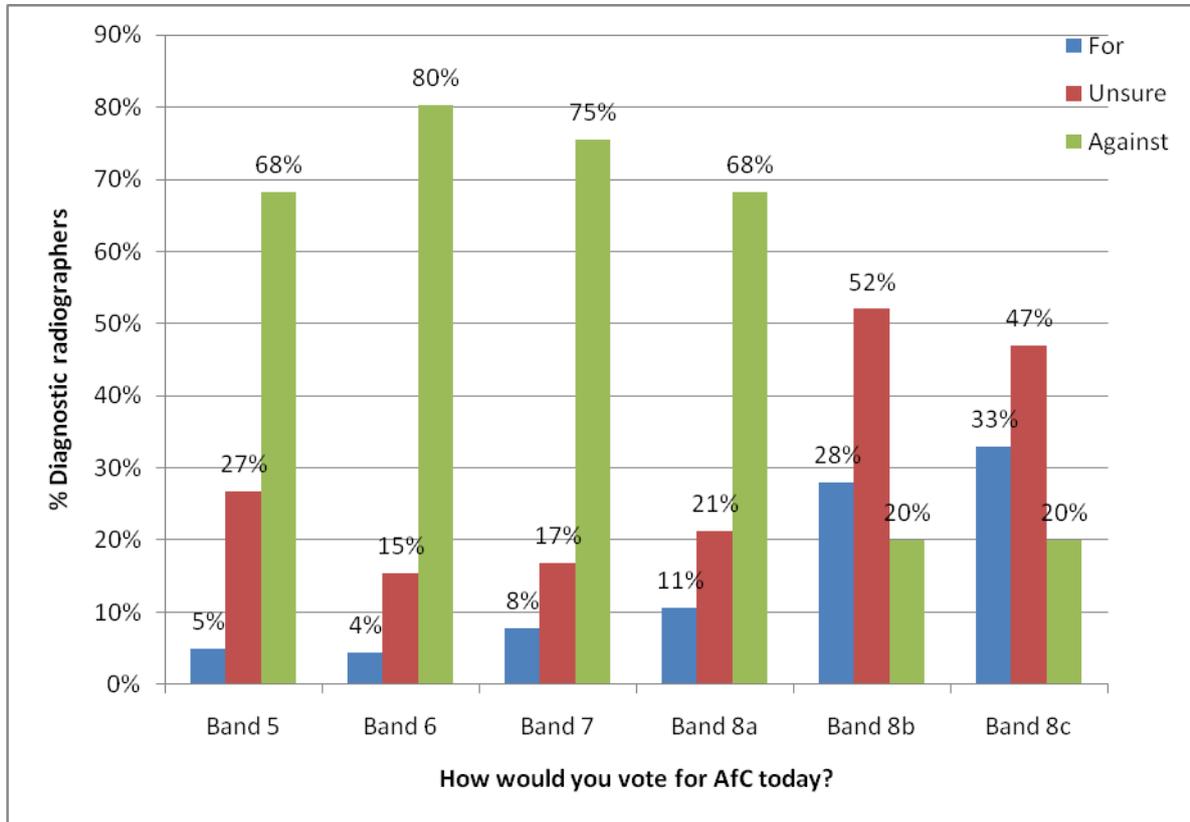


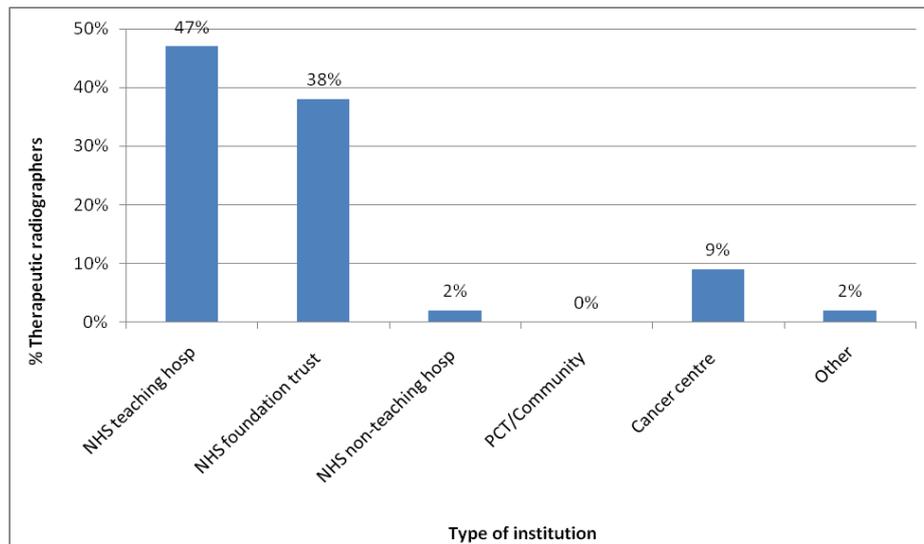
Figure 50: Present-day AfC voting intentions of diagnostic radiographers in terms of pay band

#### 4.2.19 Summary of attitudes and experiences of radiographers in terms of sub-specialties

Diagnostic radiographers' responses were analysed in terms of whether their specialist area of practice had influenced their experience of AfC compared to the main survey results. Further data is presented in Appendix 2: Key responses from the specialties. Those in MRI, ultrasound and RNI had the lowest expectations in terms of career progression. In particular, almost half (45%) of all those practising RNI felt that had experienced barriers to career progression. Staff in mammography were the most optimistic regarding their progression and fewer numbers of these individuals would vote against AfC given the chance. There were no large differences between the groups when it came to deciding if the opportunities identified at appraisal were the ones wanted by the appraisees. The majority of all the groups said that these opportunities were wanted and would be taken to support long term goals even if they were unlikely to facilitate progression to the next pay band.

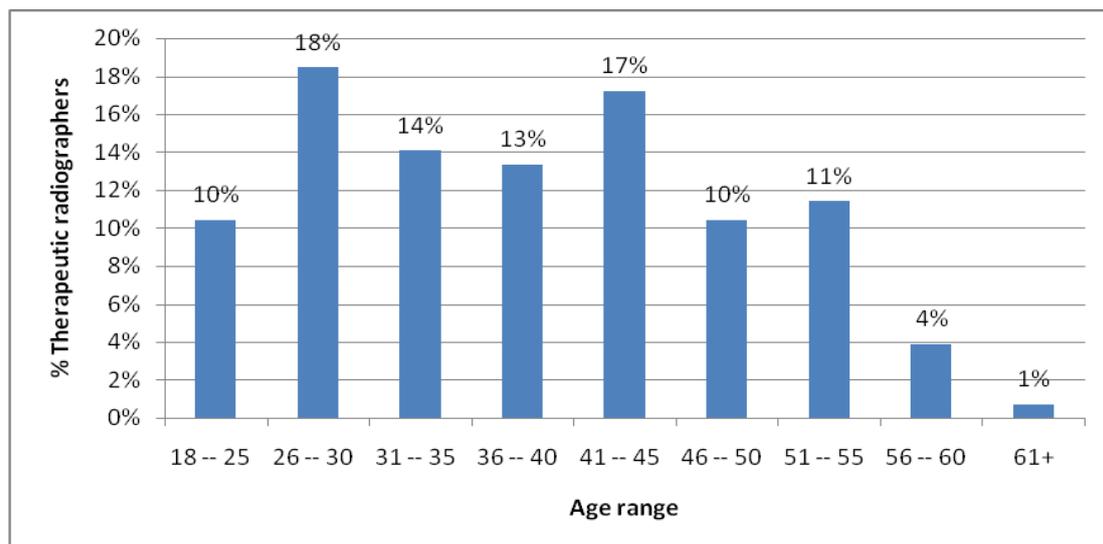
### 4.3 Section 3 The radiotherapy workforce

A total of 441 therapeutic radiographers responded. As with diagnostic radiographers, the majority of therapeutic radiographers worked in teaching hospitals or foundation trusts (Figure 51). Around 9% were located in cancer centres. Females accounted for 87% of therapeutic radiographers participating in the study, with only 13% being male.

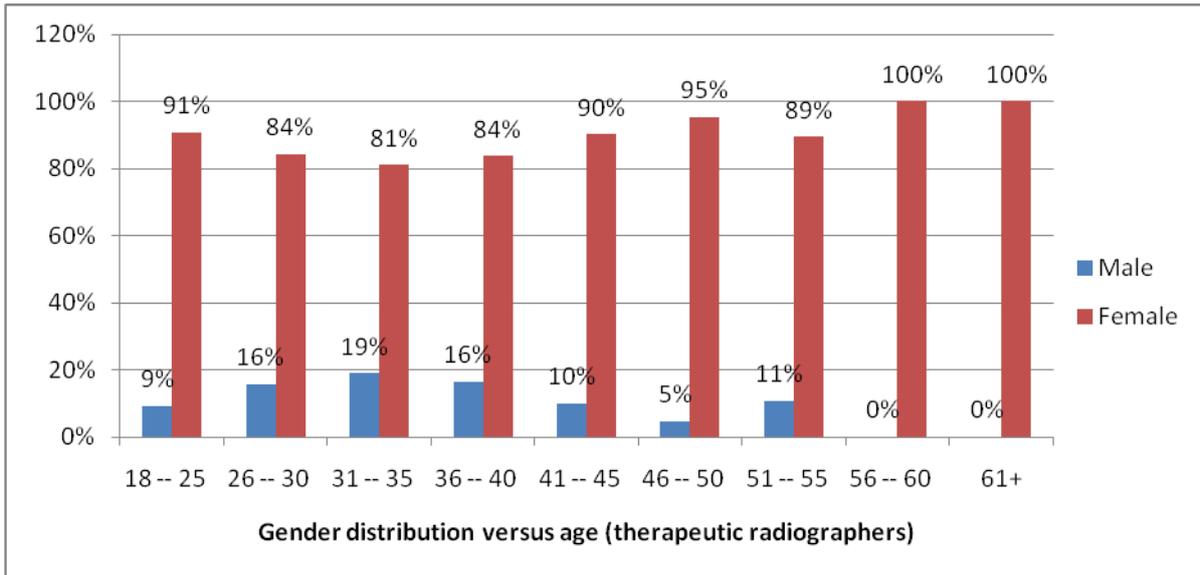


**Figure 51: Distribution of therapeutic radiographers**

The age distribution of the therapeutic workforce differed from that of the diagnostic workforce in that it was predominantly younger, with proportionally more staff in their late twenties and fewer over the age of 50 (Figure 52). No male therapeutic radiographers above the age of 50 responded to the survey (Figure 53). The year of qualification ranged from 1964 to 2008.

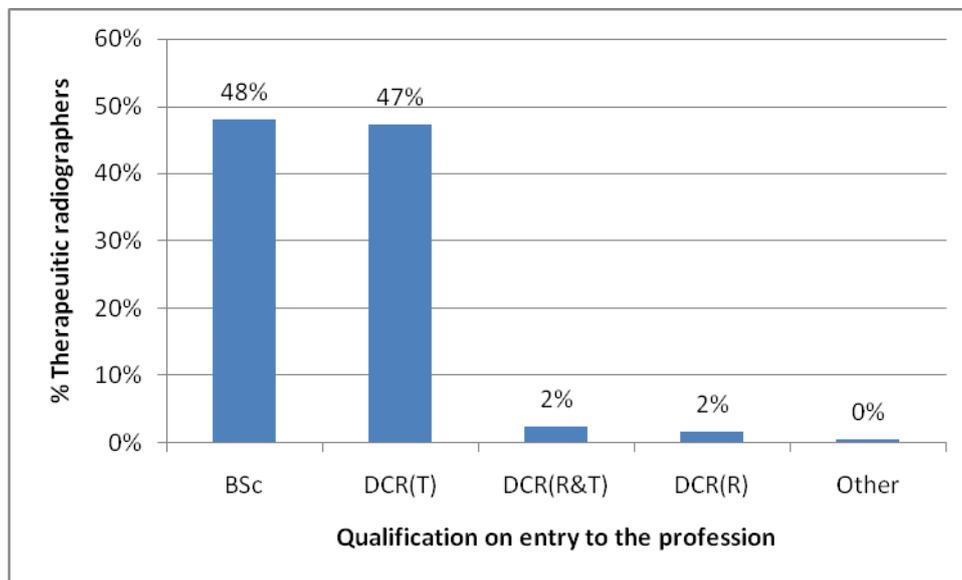


**Figure 52: Age distribution of therapeutic radiographers**



**Figure 53: Gender and age distribution of therapeutic radiographers**

When asked about their original qualification on entry to the profession, virtually equal numbers of therapeutic radiographers who responded held either the Bachelor of Science degree (48%) or the Diploma of the College of Radiographers (47%). Just 2% were dual qualified in both imaging and radiotherapy (Figure 54).



**Figure 54: Qualification held by therapeutic radiographers on entry to the profession**

Therapeutic radiographers had multiple duties and practised in a range of disciplines. The most common areas of practice are displayed in Figure 55.

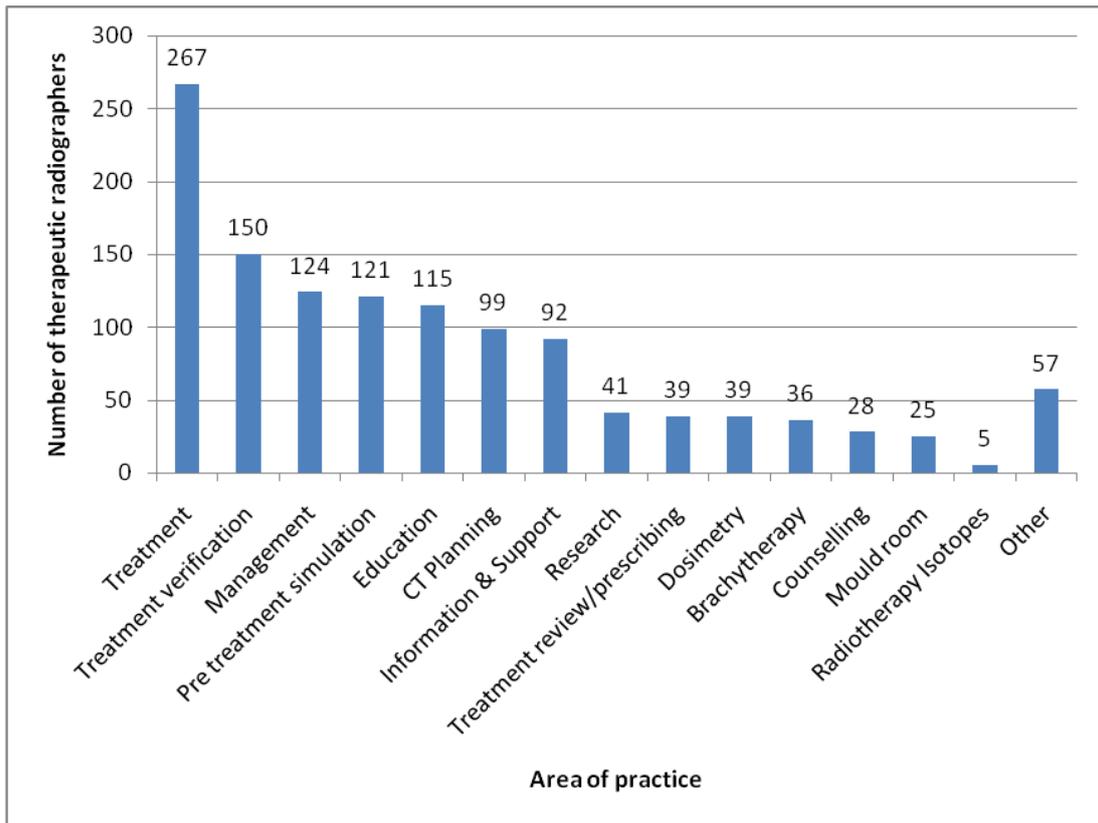


Figure 55: Common areas of practice for therapeutic radiographers

### 4.3.1 Agenda for Change current banding

The majority of the therapeutic workforce who responded to this survey were in bands 6 and 7 (Figure 56). There was no significant difference identified between males and females or between the Strategic Health Authority regions in relation to AfC banding profile. The spread of banding was uniform throughout England and Wales.

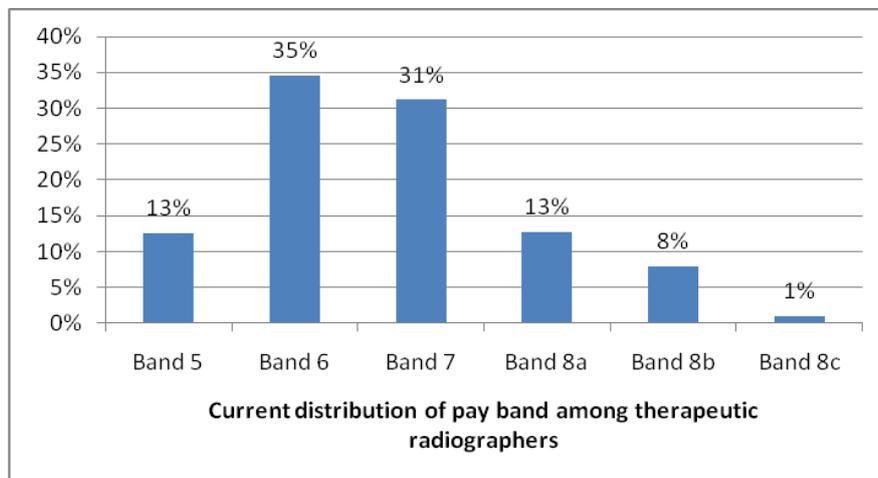
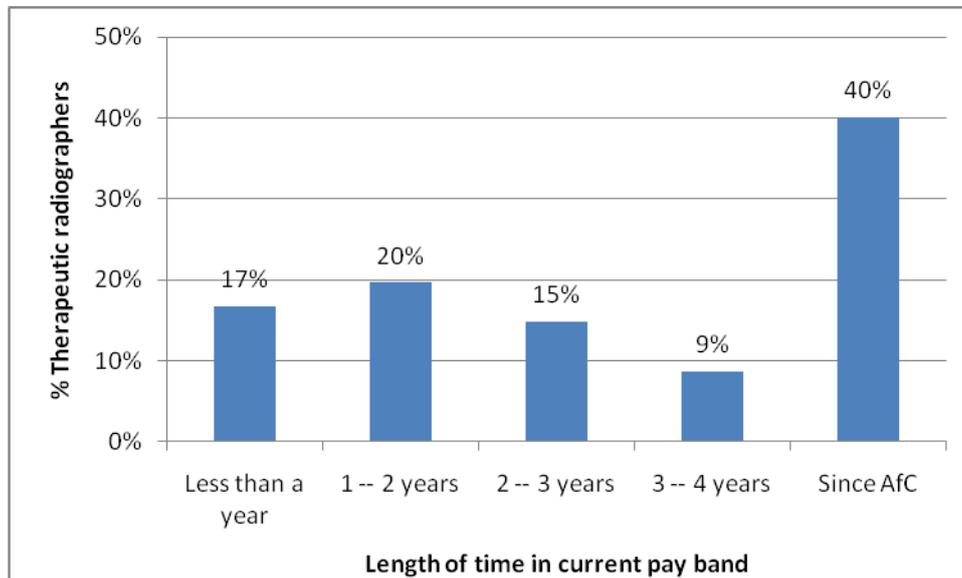


Figure 56: Distribution of pay bands for therapeutic radiographers

Slightly fewer therapeutic radiographers (40%) compared with diagnostic radiographers (48%) had been in their current pay band since the implementation of AfC (Figure 57).

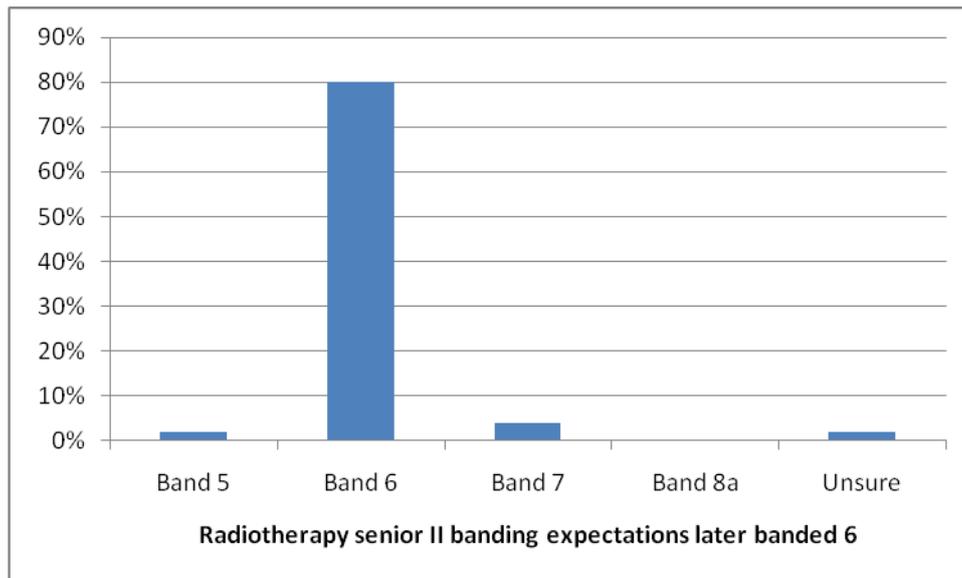


**Figure 57: Length of time in current pay band for therapeutic radiographers**

#### **4.3.2 Expectations of therapeutic radiographers in terms of progression under AfC**

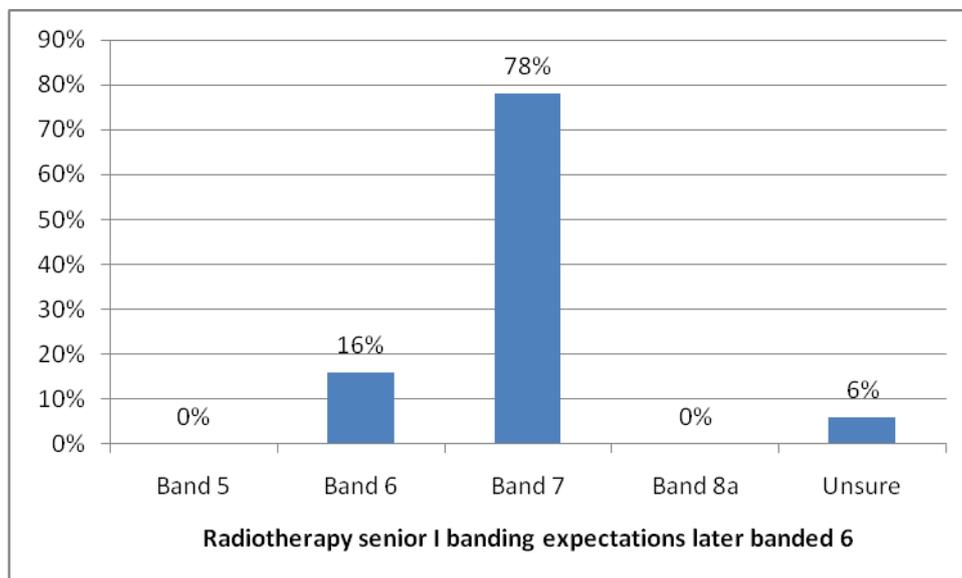
Therapeutic radiographers who were employed prior to AfC were asked about their Whitley Council grading and to what band they had expected to be placed on under AfC terms and conditions. This information was then compared with where they were actually placed after implementation of AfC.

Only 13 therapeutic radiographers responded to this survey who were 'radiographer' grade prior to AfC and therefore generalisations cannot be made about their experiences. Numbers were also very low for superintendent IV and superintendent II therapeutic radiographers. Reasonable sample sizes were obtained, however, for staff graded as senior II, senior I and superintendent III prior to AfC.



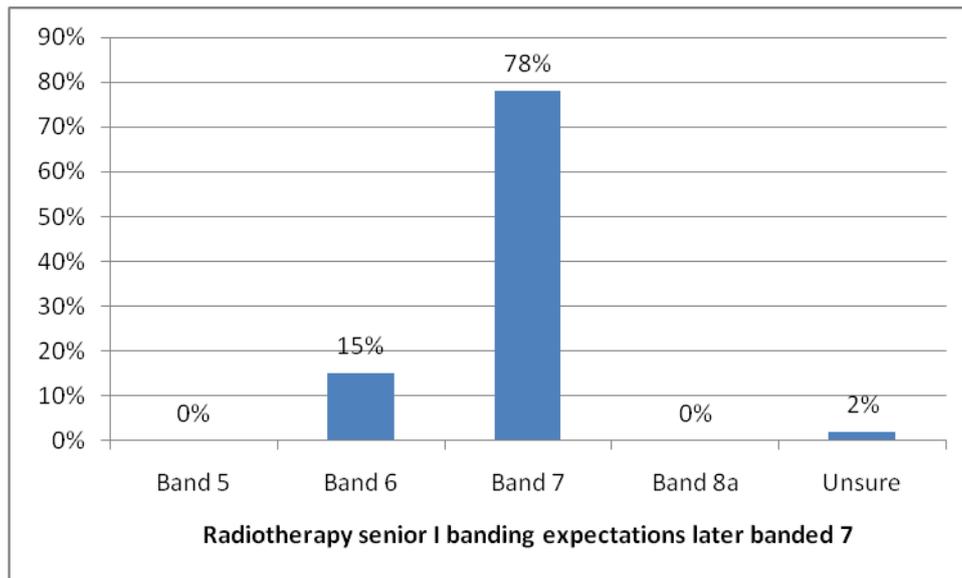
**Figure 58: Banding expectations of senior II radiographers who were later banded 6**

There were 49 senior II therapeutic radiographers who were banded 6 after AfC. The majority ( $n = 39$ , 80%) had been banded 6 in line with their expectations. Only two had been banded 7 and they had expected to be assimilated to band 6, therefore their expectations had been exceeded (Figure 58).



**Figure 59: Banding expectations of senior I radiographers who were later banded 6**

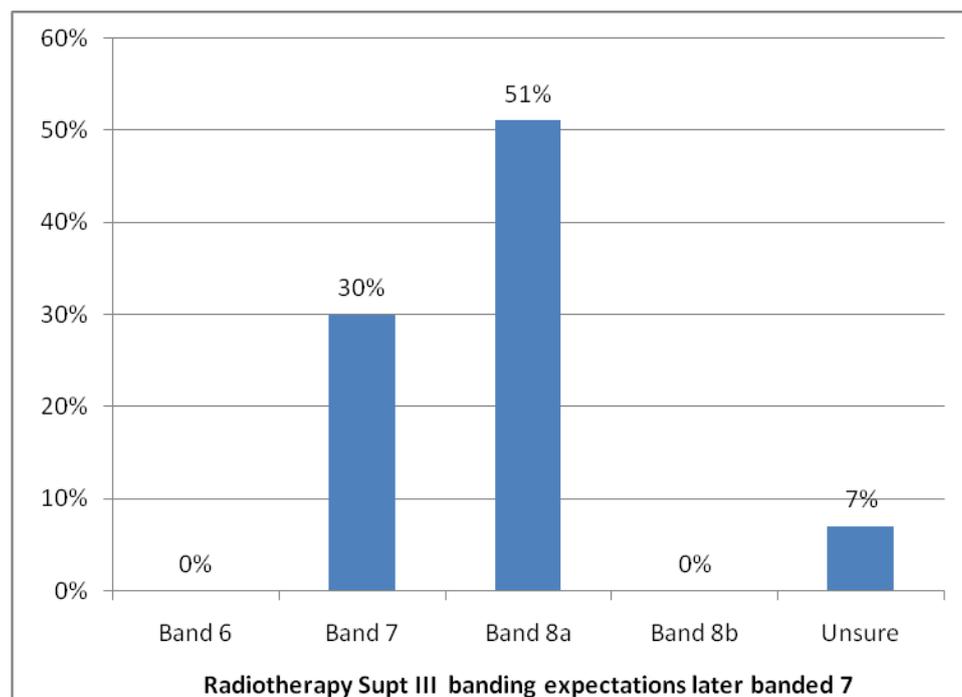
Fifty therapeutic radiographers who were senior 1 grade prior to AfC and banded 6 after AfC responded to the survey (Figure 59). All fifty answered all the questions relating to expectations. Amongst this group, the great majority ( $n = 39$ , 78%) had been banded to a lower band than anticipated. Just 16% had been banded in line with their expectations and three were unsure.



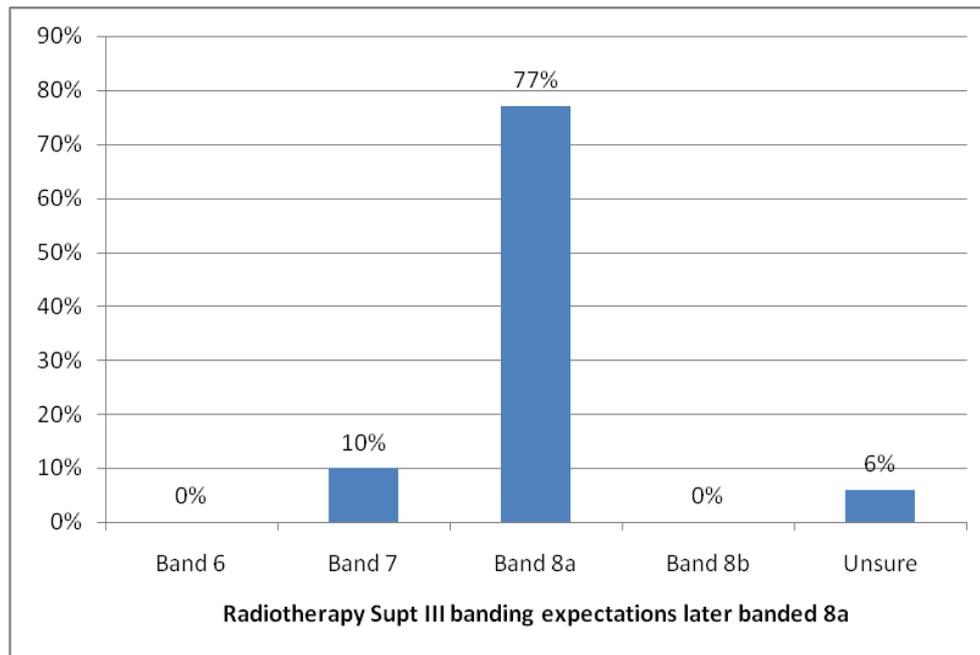
**Figure 60: Banding expectations of senior I radiographers who were later banded 7**

Forty-one senior I therapeutic radiographers later banded 7 under AfC responded to the survey (Figure 60). Amongst this group, 78% (n = 32) were banded as they had anticipated. Only six were assimilated lower at band 6. One or two were unsure or chose not to answer.

The figures obtained for superintendent III therapeutic radiographers were low but indicated strongly that, of those who were banded 7, the majority had been expecting assimilation to band 8a (Figure 61). Of those banded 8a from the start, the majority were anticipating this, with just 10% expecting only band 7 (Figure 62).



**Figure 61: Banding expectations of superintendent III radiographers who were later banded 7**



**Figure 62: Banding expectations of superintendent III radiographers who were later banded 8a**

Figures obtained for superintendent II therapeutic radiographers were too small for analysis (n = 26) but, of those who responded, banding was mainly lower than expected.

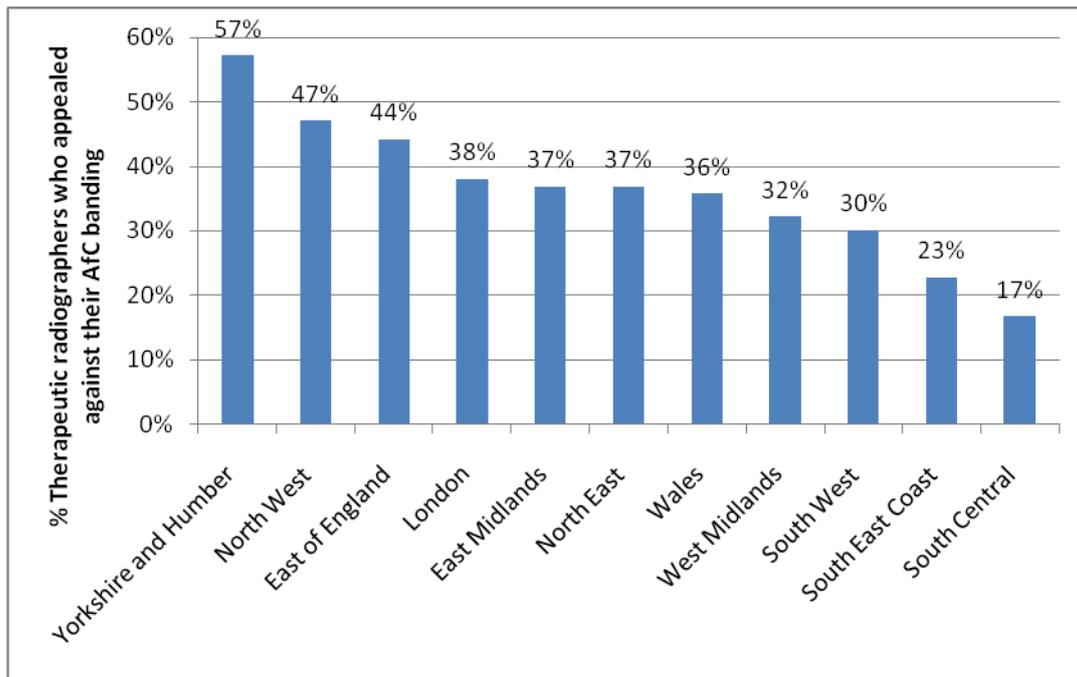
### 4.3.3 Appeals

The data from the therapeutic radiographers regarding appeals showed that 37% of the therapeutic workforce underwent appeals, which is slightly higher than the 34% of diagnostic radiographers who reported doing so.

#### *Appeals by therapeutic staff*

The data were analysed to identify any differences between regions, grades, and employment status (full time or part time).

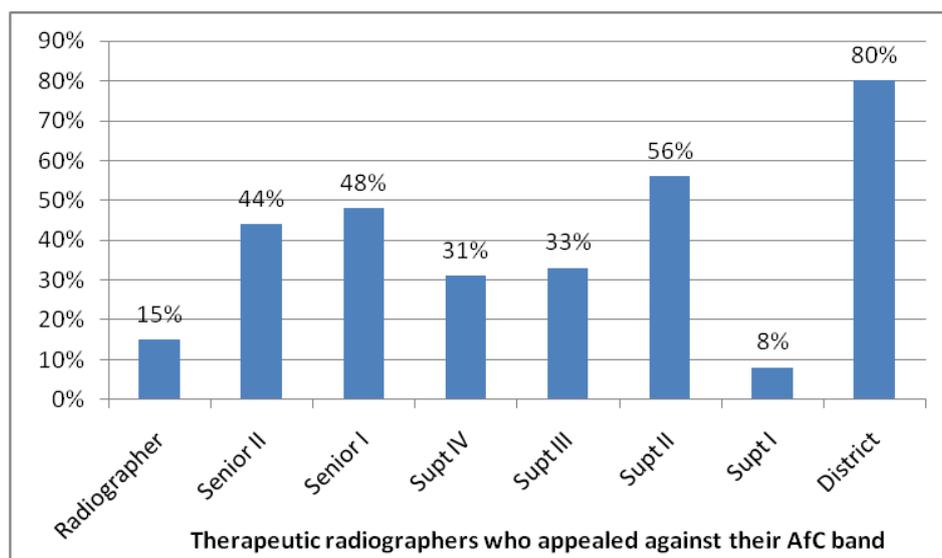
The highest numbers of appeals were reported by therapeutic radiographer respondents in the Yorkshire and Humber, North West and East of England regions. Respondents in the South Central and South East Coast areas experienced the least number of appeals (Figure 63).



**Figure 63: Strategic health authority distribution of therapeutic radiographers who underwent appeal**

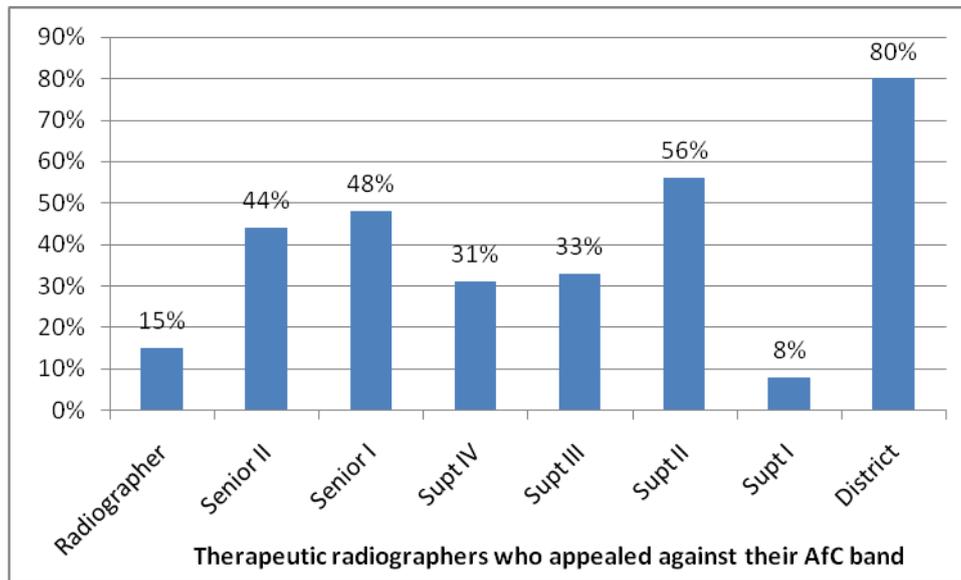
#### 4.3.3.1 Appeals in terms of staff grade

The responses of the therapeutic radiographers in terms of number of appeals differed from those of the diagnostic radiographers. It should be noted that the number of respondents at the district grade to this survey were low (n = 5), but most appealed. Around half of the senior I and superintendent II grades appealed also (Figure 64).



**Figure 64: Distribution in terms of Whitley Council grades for therapeutic radiographers who appealed against their AfC banding**

#### 4.3.3.2 Successful appeals in terms of staff grade



**Figure 65: Successful appeals against AfC banding by therapeutic radiographers in terms of their previous Whitley Council grades**

The survey analyses indicated that all radiographer and superintendent I appeals were successful, although these two groups appealed the least frequently. Most grades were successful in having the majority of their appeals upheld with the exception of senior I staff where only one in four was successful (Figure 65).

#### 4.3.3.3 Successful appeals for part time versus full time staff

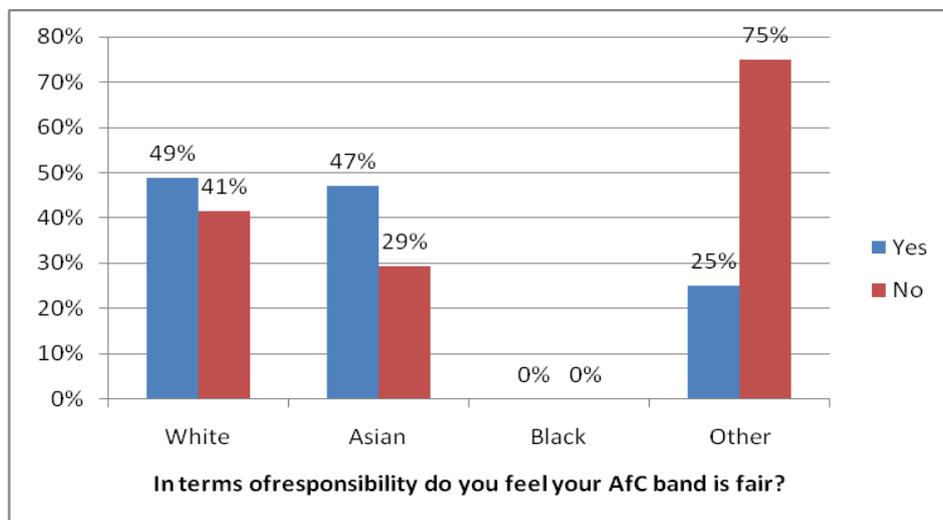
In contrast to the findings for the diagnostic respondents, there were large differences between the numbers of full time and part time staff who appealed against their AfC banding. Only one in three full time staff appealed compared to half of all part time staff. There were also considerably more examples of full time staff having their appeal supported by their managers compared to part time staff, although a few participants could not remember whether they were supported or not, hence the figures in Table 7 do not add up to 100%. A considerably higher proportion of full time staff had their appeals upheld compared to part time staff (74% full time compared to only 63% of part time) and these findings mirror the reports given by the diagnostic radiographer participants. An important point to note is that, of those who were not supported by their managers, a greater proportion of part time staff (91%) went on to lose their appeals compared to 67% of the full time staff who were not supported.

**Table 7: Appeal outcomes for full time and part time therapeutic staff**

	Full time		Part time	
	Yes	No	Yes	No
Did you appeal?	33%	67%	50%	50%
Were you supported by your manager?	Yes 77%	No 14%	Yes 57%	No 23%
And did you win?	<b>74%</b>	<b>21%</b>	<b>63%</b>	<b>37%</b>

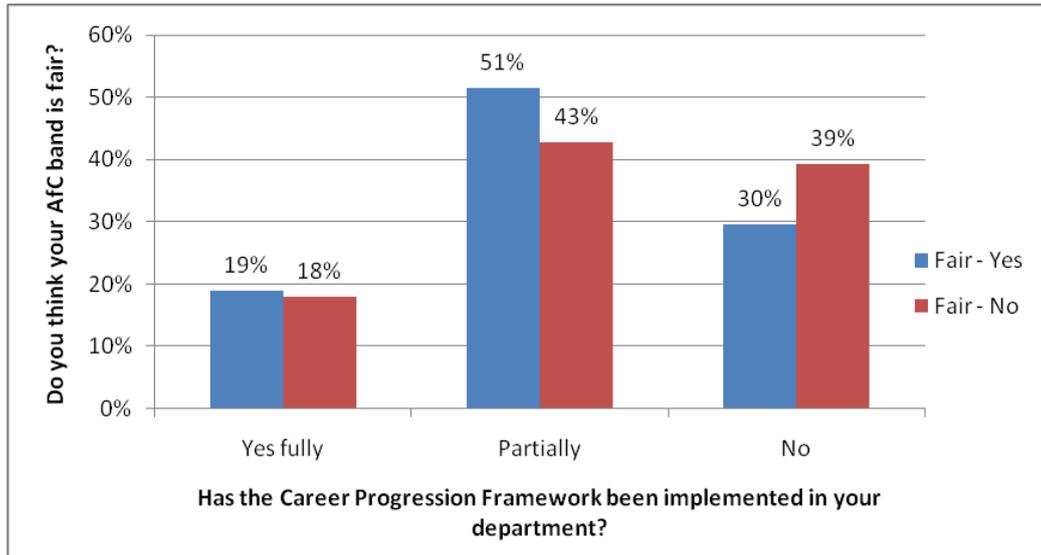
#### 4.3.4 Perceived fairness of banding

In terms of ethnicity, the majority of white and Asian therapeutic radiographers felt their band was fair (Figure 66). There were no black therapeutic radiographers who responded to the survey. Therapeutic radiographers from other ethnic backgrounds seemed less satisfied with their banding but numbers of respondents were very small and are not necessarily reflective of other members of this group (n = 25).



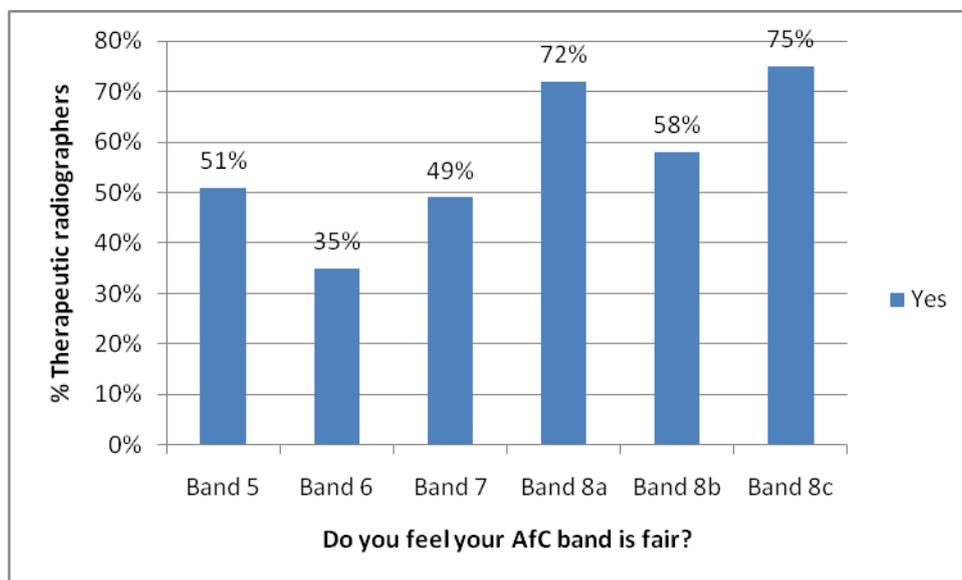
**Figure 66: Perceived fairness of AfC band in terms of the ethnicity of therapeutic radiographers**

There were also differences in perception of fairness between those in different pay bands, and between those in organisations in which the CPF was in place or not (Figure 67). Far more respondents at sites where the CPF was not used reported being dissatisfied with their banding. However, only 15% of therapeutic radiographers stated that the CPF was fully implemented where they worked, although another 38% claimed it was partially in place. These percentages were higher than those reported by diagnostic staff (§ 4.2.9).



**Figure 67: Perception of fairness in terms of the CPF**

The majority of the higher band therapeutic staff felt that the band that they had been assigned was fair. In keeping with the findings for diagnostic staff, satisfaction was highest amongst those in band 8 categories. Therapeutic staff banded 6 or 7 were least likely to feel that their band was fair in terms of responsibility (Figure 68).



**Figure 68: Fairness of their AfC band as perceived by therapeutic radiographers**

The four most common reasons identified by both diagnostic and therapeutic staff for feeling that their band did not reflect their level of responsibility included; a belief that their level of autonomy and decision-making exceeded their banding, discrepancies and inequity between trusts in job matching, and that their experience and/or qualifications were not recognised. In particular, issues relating to senior I and II staff being assigned to the same band (Band 6)

were cited frequently. Some key comments are listed below and the main themes to emerge are summarised in Table 8.

*I feel there is less recognition of achievement under AfC.* Therapeutic radiographer, band 7

*Under valued, under appreciated, you have to fight for everything.* Therapeutic radiographer, band 7

*Stuck at top of band. No incentive to progress. Experience not recognised.* Diagnostic radiographer, band 5

**Table 8:** Common reasons why diagnostic and therapeutic respondents collectively felt that their AfC pay band was unfair

Common reasons why participants felt their banding was unfair	Number of respondents
Lack of recognition of autonomy and high level decision-making	439
Inequity between roles	108
Lack of recognition of experience	67
Lack of recognition of qualifications	61
'Stuck' at top of pay band with nowhere to progress	42
Band 6 is too broad and incorporates both senior I and II grades	37
Other	23

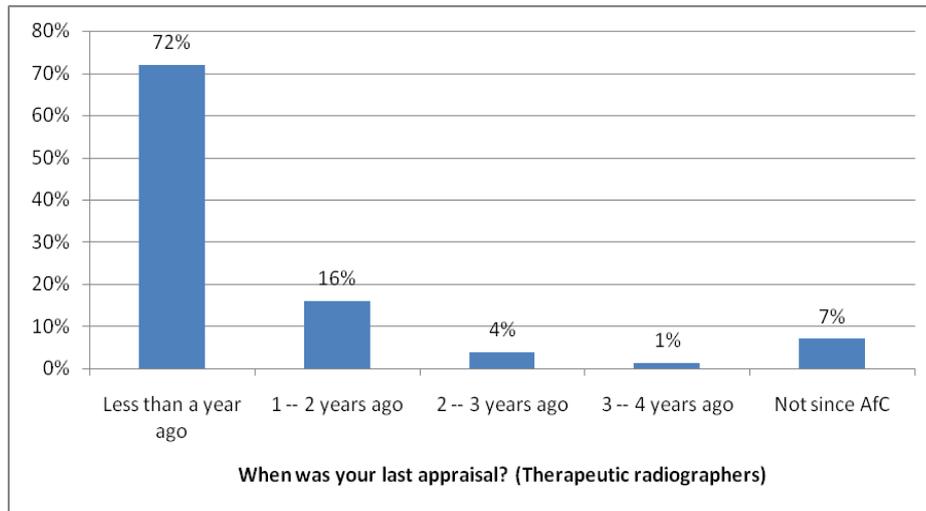
### 4.3.5 Career Development Opportunities for therapeutic radiographers

This section of the survey began by exploring therapeutic radiographers' experience of appraisals and the NHS KSF since these form a key element of AfC and are the basis for identifying career development opportunities.

#### 4.3.5.1 Appraisals

The majority of therapeutic radiographers who answered this section of the survey had had an appraisal in the last year (Figure 69). There was no difference between full time and part time staff in terms of how frequently their appraisals were carried out. Overall, a much

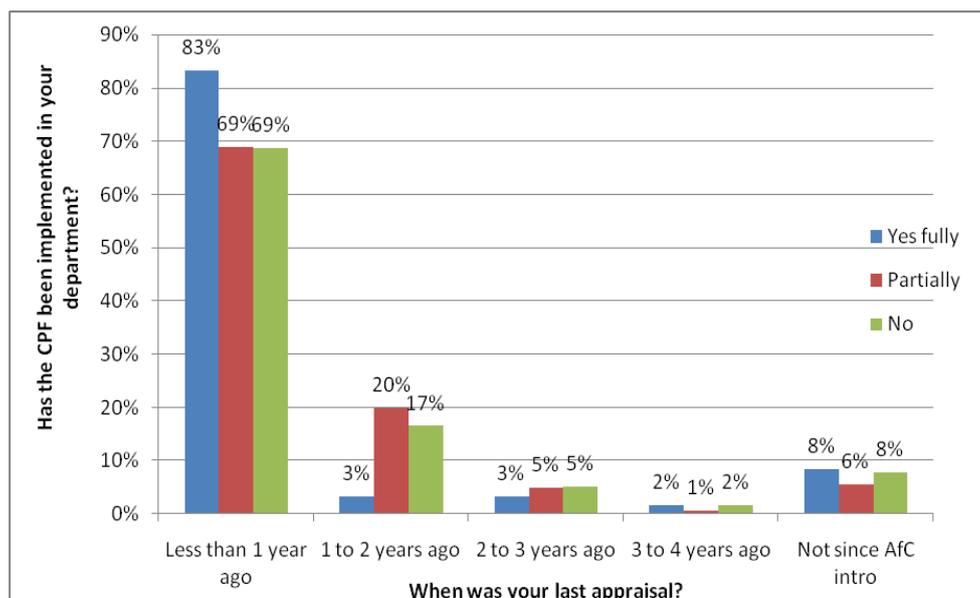
higher percentage of therapeutic radiographers (72%) had had recent appraisals compared to diagnostic staff (59%).



**Figure 69: Time elapsed since last appraisal for therapeutic radiographers**

Therapeutic radiographers were more likely to have had a recent appraisal in centres where the CPF was fully in place (83% compared to 69%), although high proportions of therapeutic radiographers in all sites reported having had an appraisal in the recent past (Figure 70).

There was no match between therapeutic radiographers who claimed not to have had an appraisal since the implementation of AfC and whether the CPF was integrated or not. One in five (20%) therapeutic radiographers did not know whether the CPF was in place at their site or not compared with one in three diagnostic radiographers.



**Figure 70: Time elapsed since last appraisal in terms of whether the CPF is in place in the therapeutic radiographers' department**

For those who had not had an appraisal since the inception of AfC a number of reasons were given, and were similar irrespective of the professional background of the radiographer (Figure 71). The most frequently cited reason was that appraisals were not taken seriously in their department and that their managers were not interested in completing them.

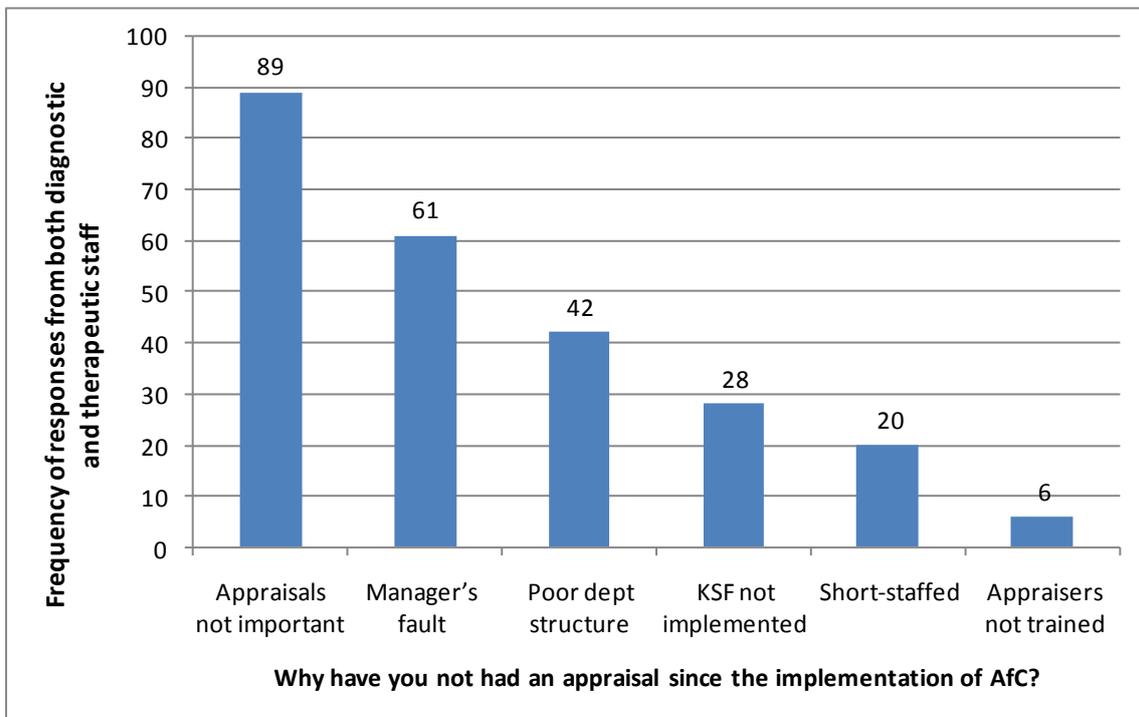


Figure 71: Common reasons for not having had an appraisal since the implementation of AfC

#### 4.3.6 The use of the NHS Knowledge and Skills Framework

The majority (76%) of therapeutic radiographers were aware of which KSF competencies were needed to carry out tasks expected in their role (Figure 72).

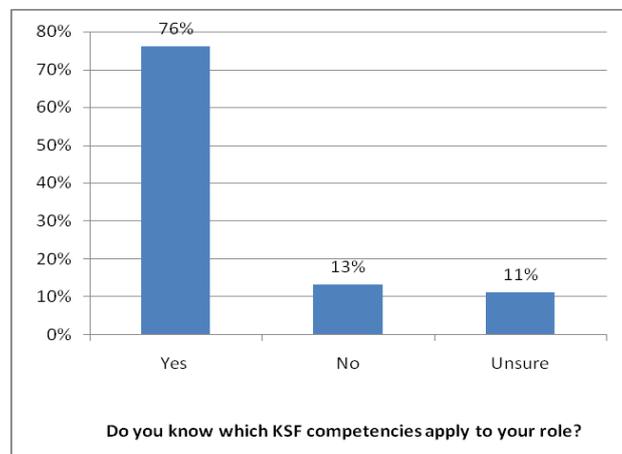
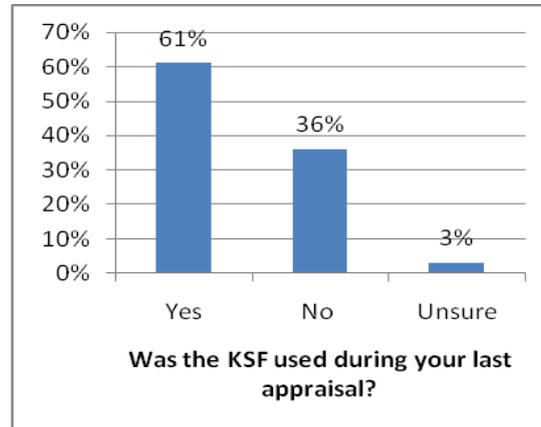


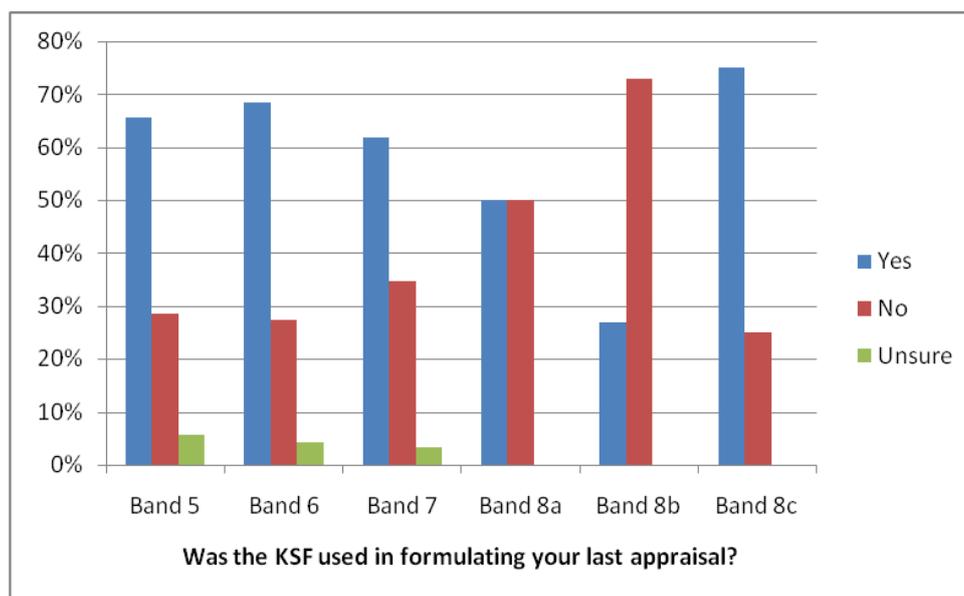
Figure 72: Therapeutic radiographers familiar with the NHS KSF competencies for their role

The majority (61%) also reported that the KSF was used during their last appraisal, although a significant proportion (36%) claimed it was not and a small proportion of participants (3%) were unsure one way or the other (Figure 73).



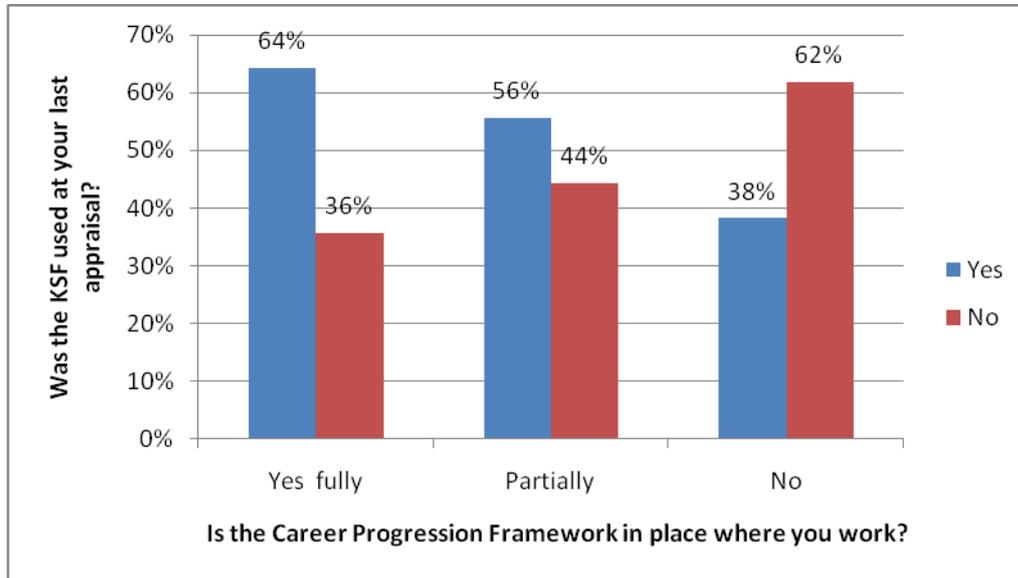
**Figure 73: Therapeutic radiographers who had had an appraisal which involved use of the KSF**

There was no difference between respondents of different ages in terms of whether the KSF had been applied in formulating their last personal development plan. There were differences, however, in the application of the KSF in relation to their AfC band. In general, the KSF was applied more frequently to appraisals of the lower bands. This pattern was reversed for band 8c respondents; although numbers were small for this group, it should be noted that the same pattern was seen amongst the higher band diagnostic respondents. Equally, and again in keeping with the patterns seen for diagnostic radiographers, as the banding increased there was less uncertainty about whether the KSF had been used or not at their appraisal (Figure 74). Lower band staff were most unsure regarding the KSF.



**Figure 74: Use of the KSF at appraisal for therapeutic radiographers in bands 5 to 8**

At institutions where the CPF is in place, either totally or partially, the KSF was more likely to be used at appraisals for formulating career development goals for therapeutic radiographers (Figure 75).

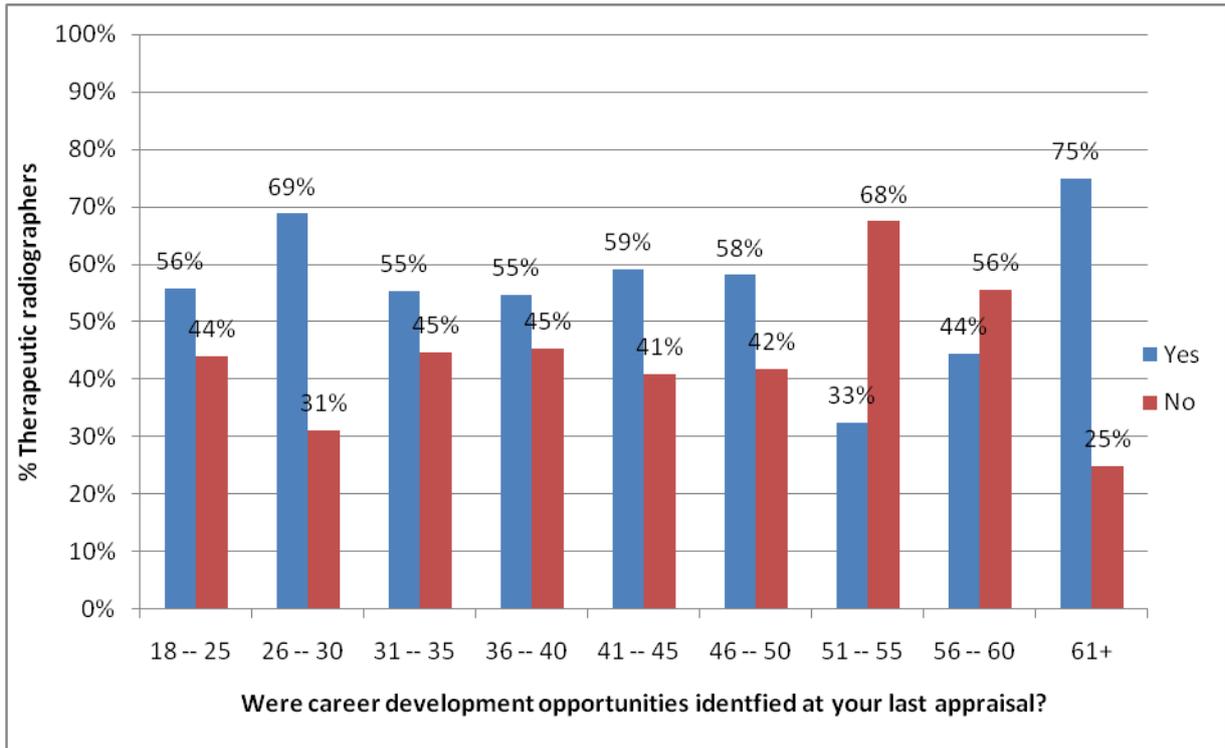


**Figure 75: Use of the KSF at appraisal in terms of whether the CPF is in place in the department**

#### 4.3.7 Opportunities identified at appraisal

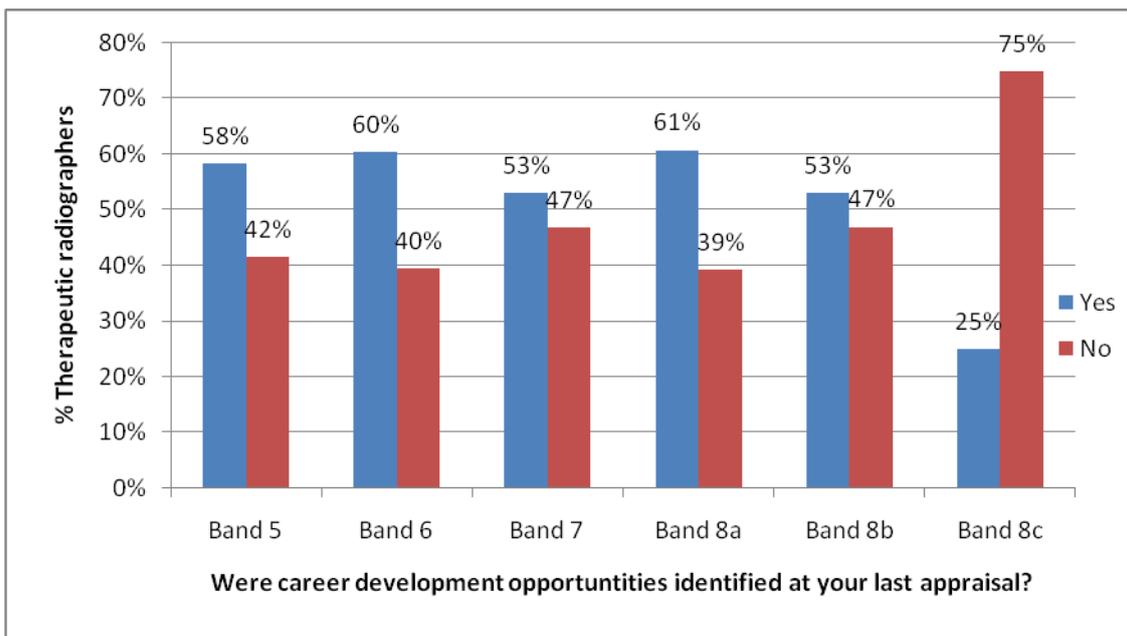
Over half (56%) of all therapeutic radiography respondents had career development opportunities identified at their last appraisal. There was no difference in the proportions of females and males reporting that career development opportunities had been identified, with some 58% of males and 56% of females indicating that career development opportunities had been identified for them at their last appraisal. There were small differences, however, between part-time and full time members of staff in that fewer (52%) part time therapeutic radiographers claimed to have had career development opportunities suggested to them compared to 59% of full time staff.

Unlike the case with diagnostic radiographers, there was no correlation between the identification of career development opportunities and age for therapeutic radiographers (Figure 76). Nor were there any differences found when assessing the type of career development opportunities, whether they were what the candidate wished for, and whether they were accessed and achieved during the ensuing year.



**Figure 76: Career development opportunities in terms of therapeutic radiographers' age**

No trends were identified when career development opportunities for therapeutic radiographers were analysed in terms of AfC pay banding (Figure 77). Amongst diagnostic radiography respondents, however, those in higher bands stated more frequently that opportunities were identified for them at appraisal.



**Figure 77: Career development opportunities in terms of therapeutic radiographers' banding**

There were some small differences depending on area of practice. Managers of therapeutic departments were less likely to have development opportunities identified at appraisal compared to average and compared to other specialist areas of practice (Table 9). Therapeutic staff in specialist areas appeared to be generally better off compared to the main survey results, since not only did they more frequently report having had career development opportunities identified at appraisal, but in addition that these were the opportunities they wanted to support their long term career plans (Table 9). For the full table see Appendix 2: Key responses from the specialties.

**Table 9: Therapeutic specialties in terms of career development opportunities and expectations**

<b>Specialty (numbers of individuals)</b>	<b>Full survey (n = 2373)</b>	<b>Pre- treatment simulation (n = 124)</b>	<b>Treatment verification (n = 156)</b>	<b>Therapeutic manager (n = 132)</b>
<b>OPPORTUNITIES</b> Career development opportunities have been identified at my last appraisal	53%	68%	59%	50%
<b>EXPECTATIONS</b> I believe these identified opportunities may aid my progression to the next band	21%	29%	32%	23%
These development opportunities are the ones I wanted and will support my long term goals	54%	66%	59%	59%

#### 4.3.8 Types of career development opportunities

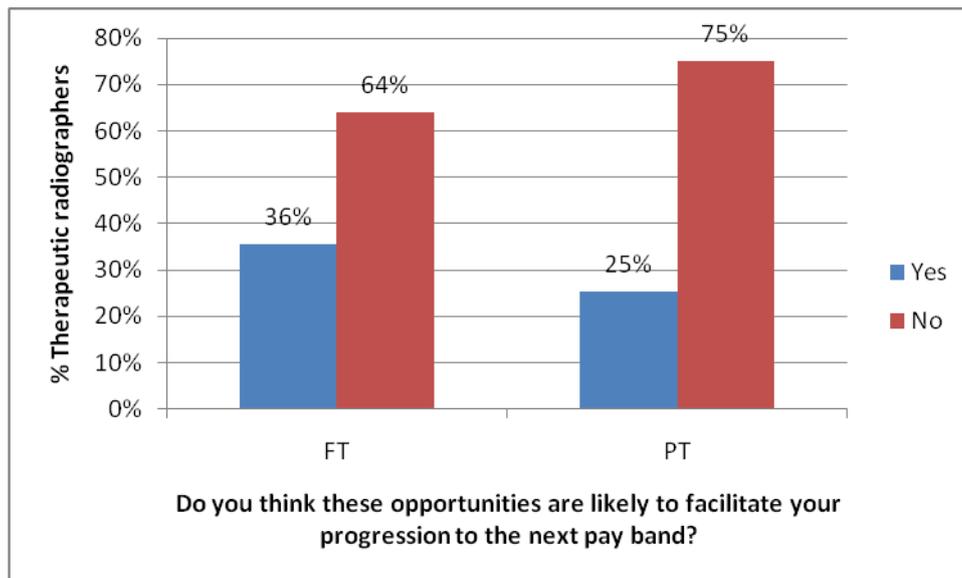
Therapeutic radiographers described a vast range of career development opportunities which were identified at their appraisal. Also, there were 37% of respondents who said that career development opportunities were identified all year round and not just at the annual appraisal. There was no difference between the types of opportunities identified either at, or outside, appraisal. These opportunities spanned the full spectrum of activities including formal academic courses, study days, counselling, and the acquisition of new clinical or managerial skills. Career development opportunities were more likely to be identified in departments which recognised the CPF (Table 10).

**Table 10: Comparison of frequency of career development opportunities offered at sites with or without the CPF**

Combined responses from the survey	Is the CPF in place where you work?	
	Yes fully	No
Career development opportunities were identified at my last appraisal	61%	47%
No career development opportunities were identified at my last appraisal	39%	53%

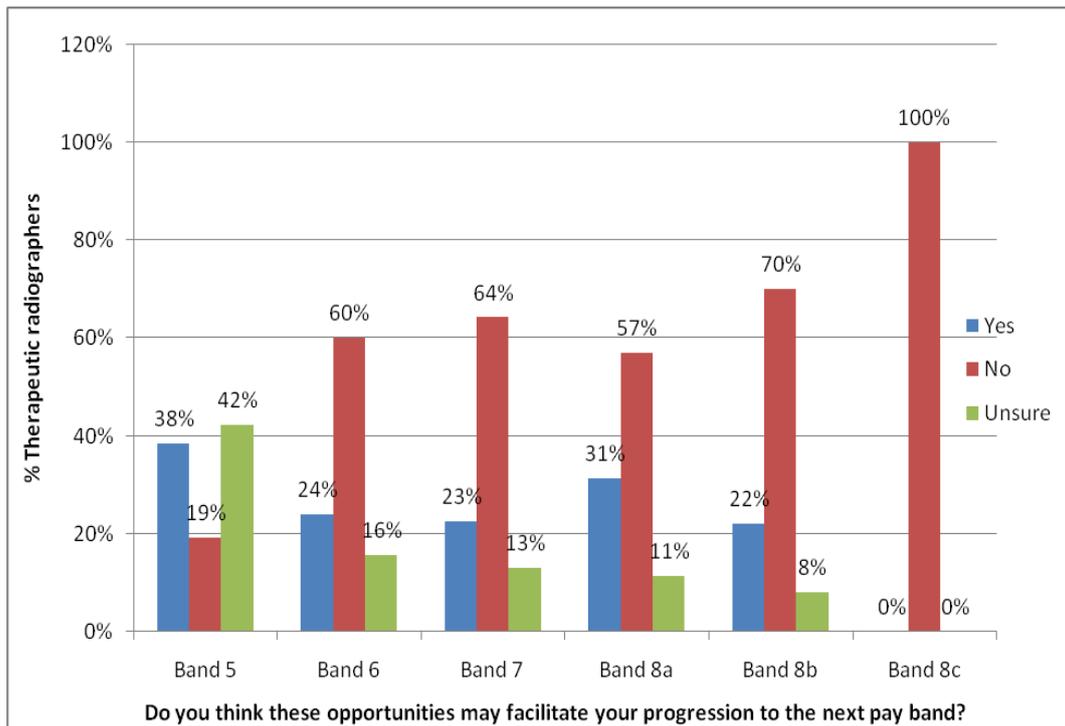
### 4.3.9 Opportunities facilitating progression

Few therapeutic radiographers thought that opportunities for developing their career would aid their progression into the next pay band. Overall, just over one in four (26%) thought they might, but 59% did not anticipate being up-graded. Full time radiographers (36%) were slightly more optimistic than part time staff (25%) (Figure 78). Those in specialist areas like pre-treatment simulation and treatment verification were also more positive (Table 9)



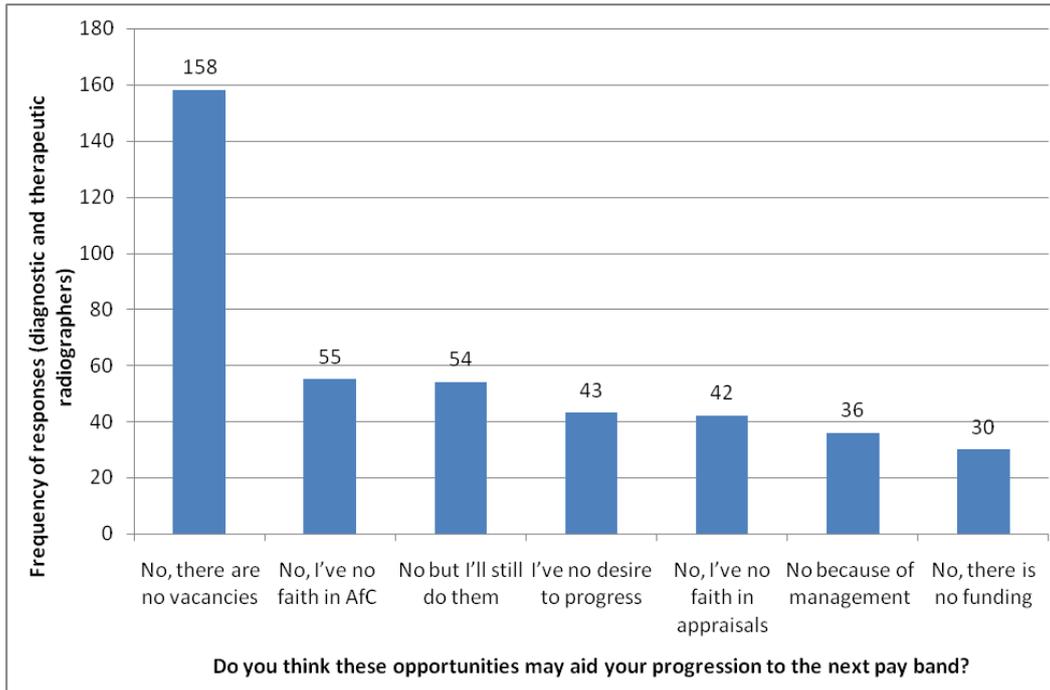
**Figure 78: Expectation of whether development opportunities might lead to pay band progression in terms of part time versus full time status for therapeutic radiographers**

In terms of banding, therapeutic radiographers in band 5 were the most optimistic that the opportunities identified may aid their progression to the next pay band. In general, staff in higher bands had lower expectations of progression and those banded 8c were unanimous in believing that they would not progress to 8d (Figure 79).



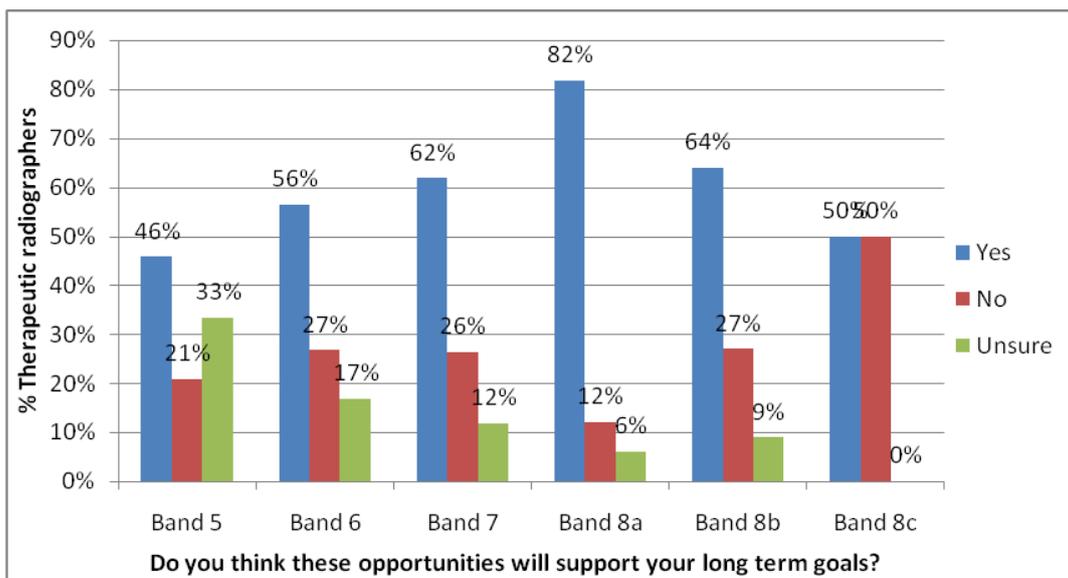
**Figure 79: Expectations of whether development opportunities for therapeutic radiographers might lead to pay band progression expressed according to their current pay band**

Common reasons why respondents thought the opportunities identified at appraisal were unlikely to facilitate progression were the same for both diagnostic and therapeutic radiographers. Most frequently they related to the fact that they would gain access to the next band only if a vacancy arose and not as a consequence of acquiring additional skills. Radiographers stated repeatedly, however, that they still wanted access to the opportunities regardless of whether they would facilitate a rise to a higher band. Responses are summarised in Figure 80.



**Figure 80: Common reasons why diagnostic and therapeutic radiographers collectively feel that development opportunities identified at appraisal are unlikely to lead to progression to the next pay band**

Satisfaction in the type of opportunities identified peaked at band 8a for therapeutic staff. As with diagnostic radiographers, those who were most unsure were in the lower bands. The percentage of radiographers who felt that the opportunities were not what they personally wanted remained fairly constant (approximately 26%) across the AfC bandings 5 to 7 and steadily increased through the band 8 divisions (Figure 81).



**Figure 81: Therapeutic radiographers' opinions on whether development opportunities available are what they wanted to support their career development**

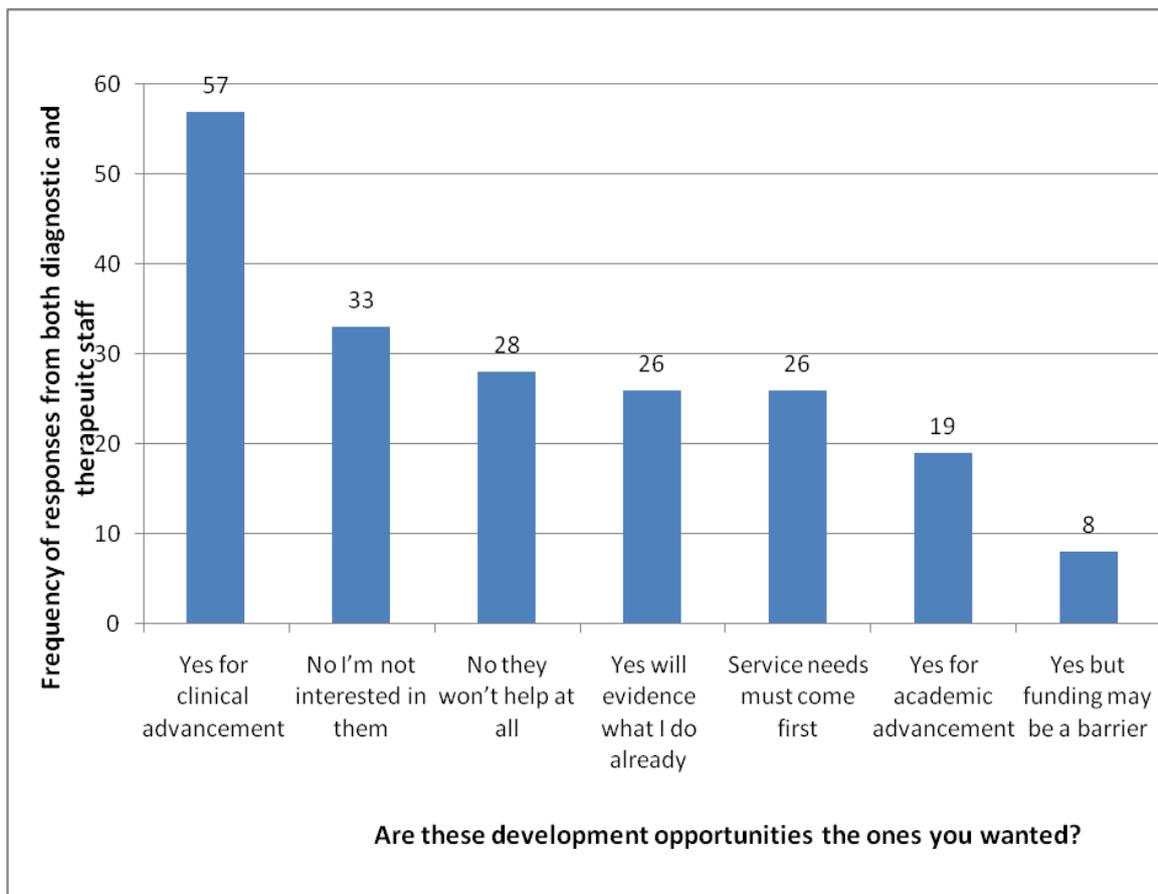
Many radiographers provided further relevant information on how they felt about the career development opportunities identified at appraisal. When explaining whether the opportunities were what they personally wanted, a number of both positive and negative common themes emerged (Figure 82). Others were pragmatic in their stance believing that patient services will drive and shape career development opportunities regardless of their own personal desires.

*People’s progression is at the mercy of the needs of the service. Therapeutic radiographer, band 6*

*They were objectives that needed to be done to benefit the department. Therapeutic radiographer, band 6*

*It involves waiting for the opportunity of a possible job to be released which I will then have to apply for. Therapeutic radiographer, band 6*

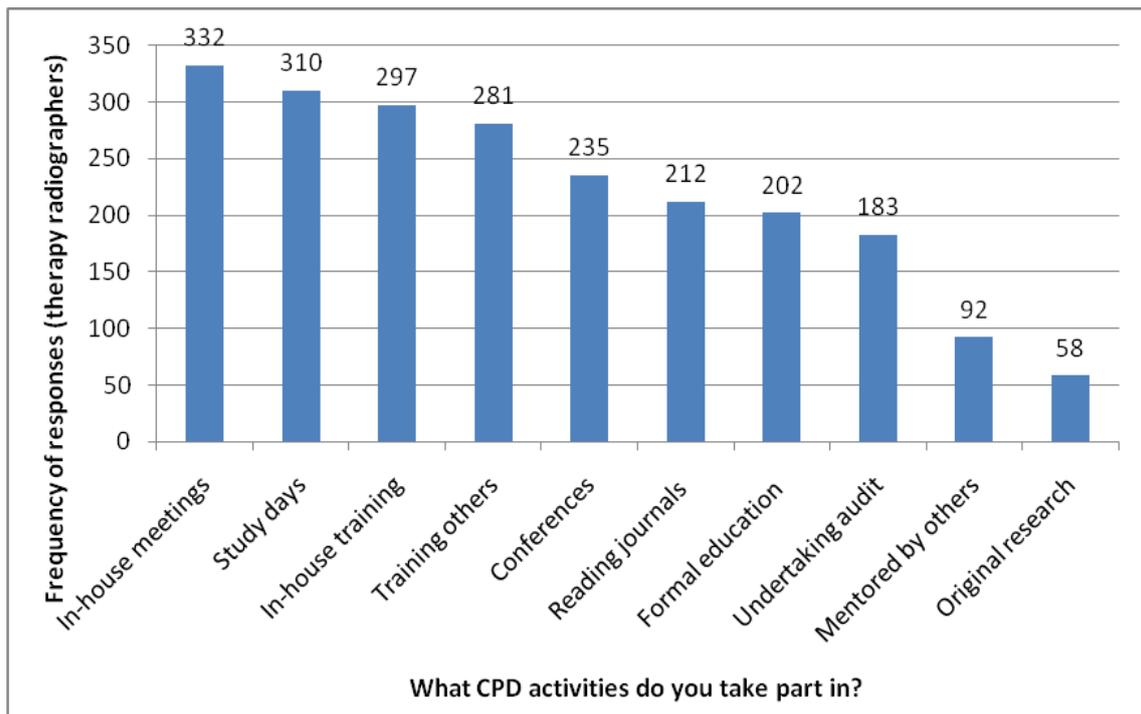
*As no money available and no movement between bands it’s difficult for anything to support long term career plans. Therapeutic radiographer, band 6*



**Figure 82: Opinions of diagnostic and therapeutic staff collectively towards the development opportunities identified at appraisal**

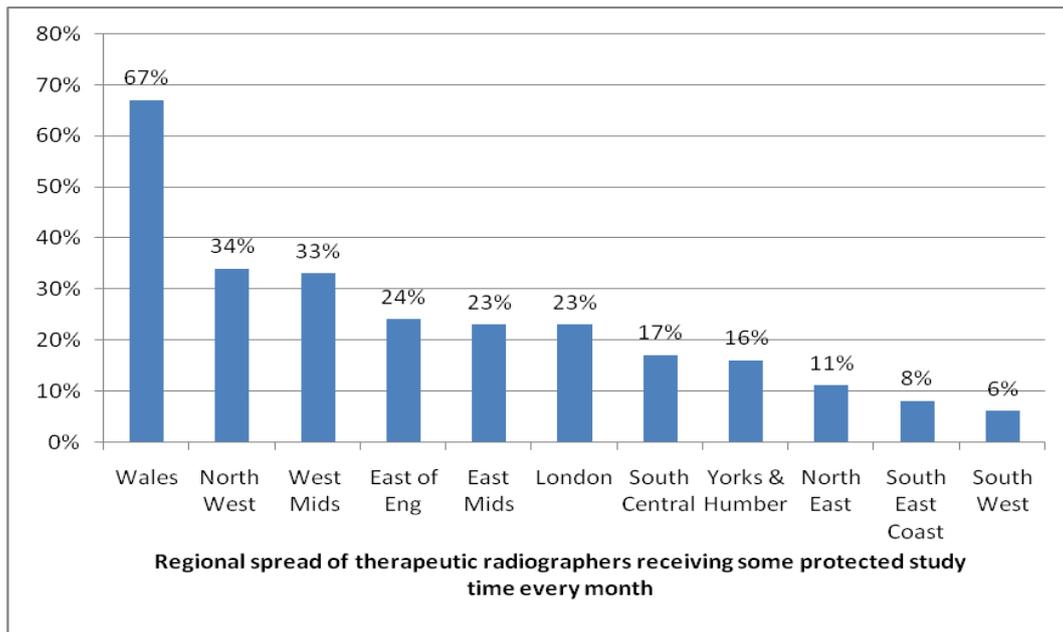
#### 4.3.10 Continuing Professional Development (CPD) activity

Almost nine out of ten (88%) of therapeutic radiographers recognised that they had CPD opportunities in the work place, and these activities were wide-ranging and varied (Figure 83). In-house meetings and study days were most frequently cited by participants, and these were identical to the diagnostic radiographers' responses. Conducting original research was, again, the least frequently cited CPD activity although proportionally more radiotherapy staff (58 = 13%) claimed to be participating in original studies compared to 109 (6%) diagnostic radiographers.



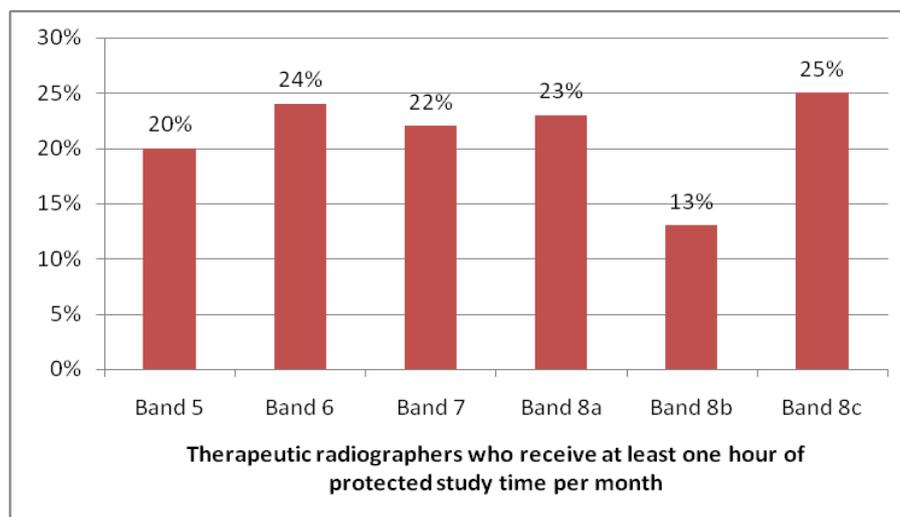
**Figure 83: CPD activities commonly cited by therapeutic radiographers**

More than one in five (22%) therapeutic radiographers claimed to receive some regular protected study time every month. The survey data suggest that departments in Wales were most likely to offer protected study time while departments in the South West and South East Coast SHAs were least likely to (Figure 84).



**Figure 84: Distribution of therapeutic radiographers' protected study time by SHA region**

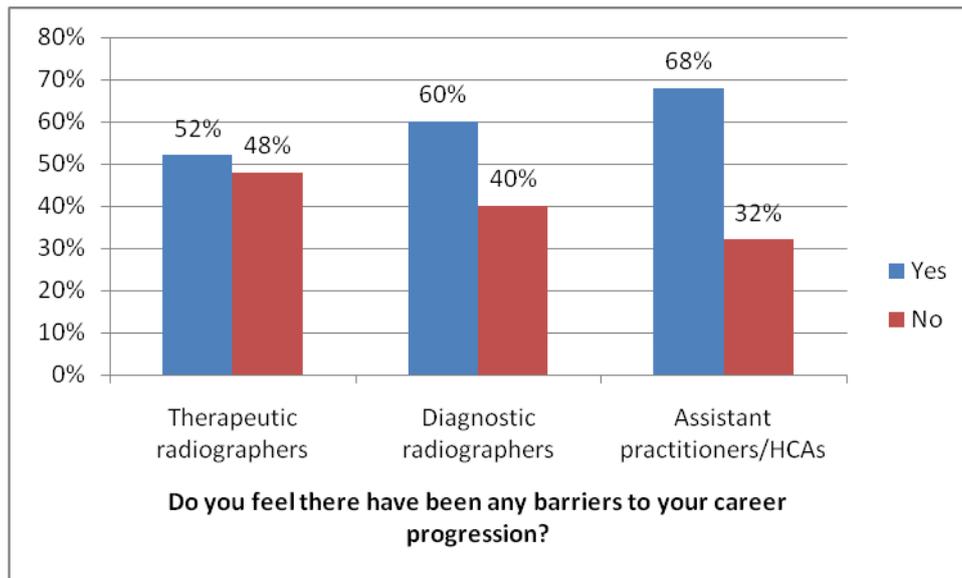
There was very little difference between allocation of protected study time and therapeutic radiographers' banding (Figure 85). Staff from all bandings reported receiving study time.



**Figure 85: Distribution of therapeutic radiographers' protected study time in terms of AfC band**

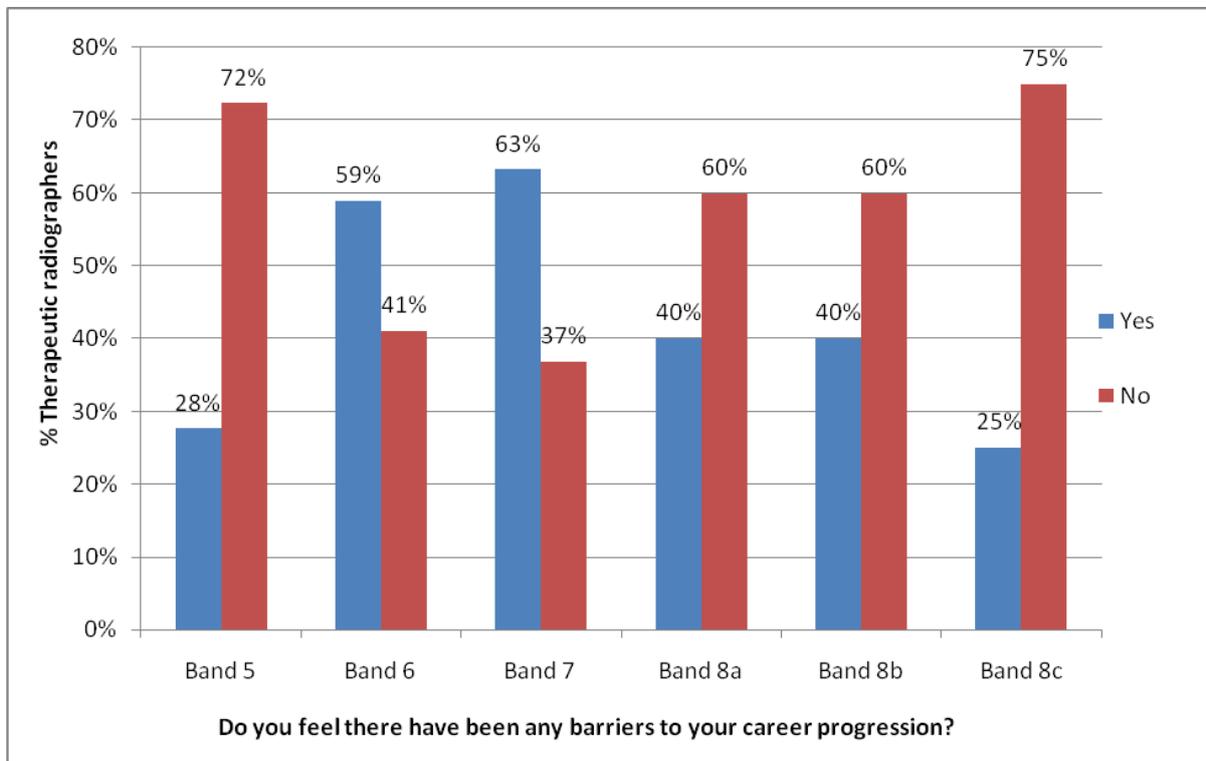
#### 4.3.11 Barriers to career development

Just over half (52%) of therapeutic radiographers felt that they had encountered barriers which hindered their career progression. Figure 86 shows the figures for therapeutic and diagnostic radiographers as well as for assistant practitioners and support workers. The percentage amongst diagnostic radiographers was higher (60%) than for therapeutic radiographers, but not as high as amongst assistant practitioners and HCAs (68%).



**Figure 86: Distribution of all staff group responses in terms of perceived barriers**

When barriers in relation to staff bands were considered, with the exception of band 5 therapeutic staff there was a clear trend indicating that those in progressively higher bands felt that they had encountered fewer barriers (Figure 87). This trend was maintained irrespective of whether the radiographer was full time or part time indicating that part time staff did not feel disadvantaged in this area when it came to career progression.



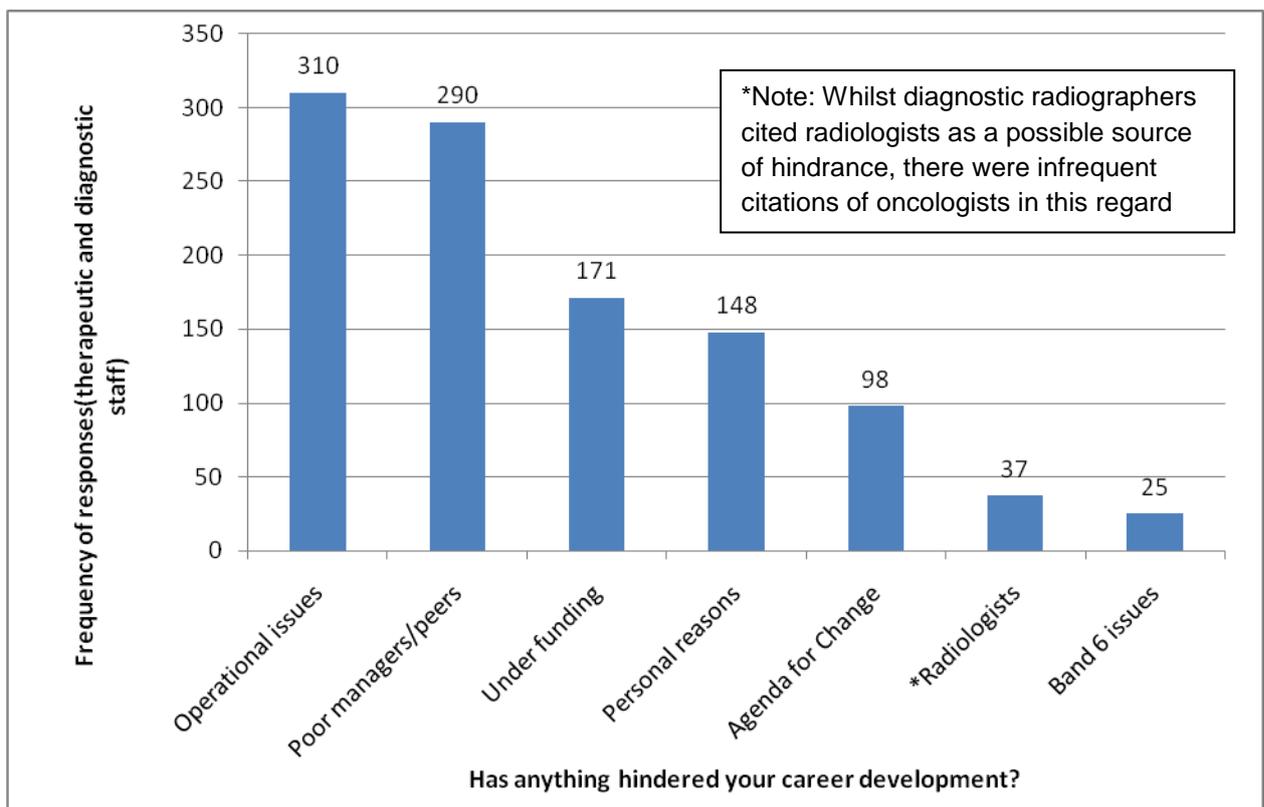
**Figure 87: Barriers perceived by therapeutic radiographers in terms of their pay banding**

The most common reasons offered by all staff when asked to explain barriers were operational issues (including under-staffing and a continuous drive to meet government targets), poor support from managers and peers, and a lack of available funding even if staffing levels are high enough to allow time off (Figure 88).

*The main barrier to my career progression has been lack of qualified and trained staff to cover my role if I am not there. Therapeutic radiographer, band 8a*

*The main barrier is the fact that I have been demoted to a Band 5 from a Senior II and don't want to take on any extra responsibility for less pay e.g cannulation. Diagnostic radiographer, band 5*

*I believe a golden opportunity to recognise and reward people properly has been missed. AFC is now a barrier that Trust boards can hide behind to stop paying fairly for the work they get out of people. Diagnostic radiographer, band 7*

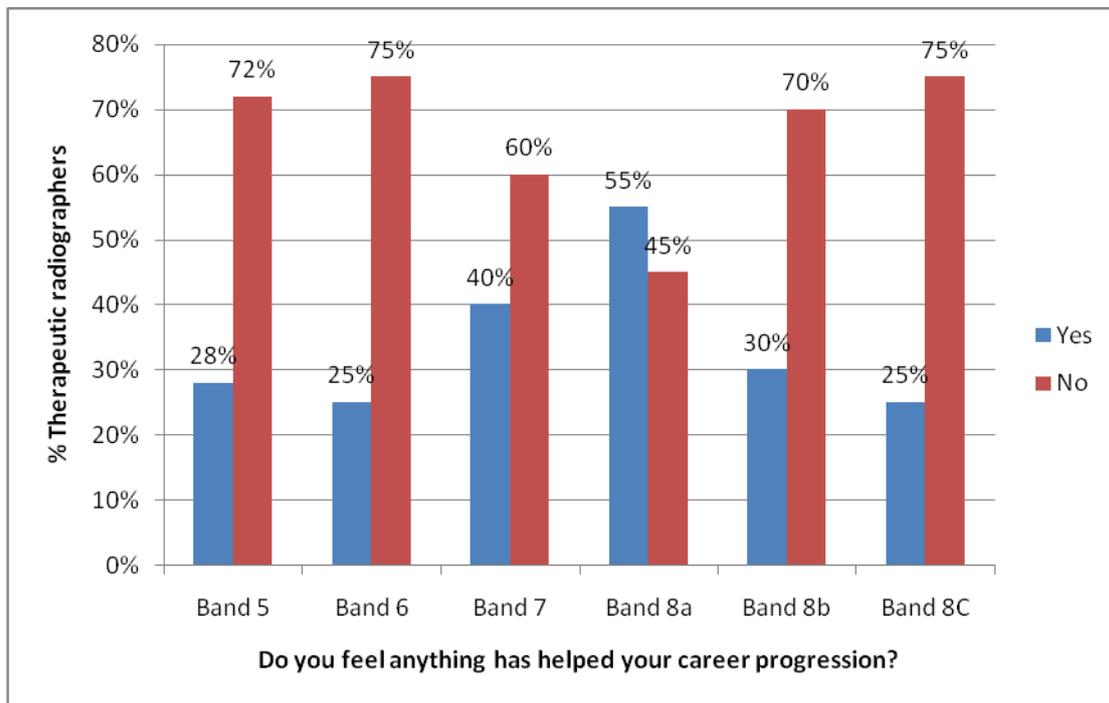


**Figure 88: Reasons given by diagnostic and therapeutic radiographers collectively as barriers to career progression**

### 4.3.12 Incentives

Approximately two thirds of all respondents, regardless of whether they were therapeutic or diagnostic radiographers, assistant practitioners or HCAs, felt that nothing had assisted their career progress. Just one third felt they had experienced support of any kind.

Looking in detail in responses across pay bands, with the exception of band 8a, the majority of therapeutic radiographers did not feel that anything had assisted their career progression (Figure 89). This differed from the responses of diagnostic radiographers, where there was a trend among the higher bands recognising more frequently factors assisting their career progression.



**Figure 89: Assistance with therapeutic radiographers' career progression in terms of their pay banding**

The most frequently-cited responses from all staff grades when describing factors which they believed had helped them included good support from managers and colleagues, self determination and self motivation, and changes in trust or department structures which had enabled promotion or progression (Figure 90). Oncologists were cited infrequently in terms of either helping or hindering career progression.

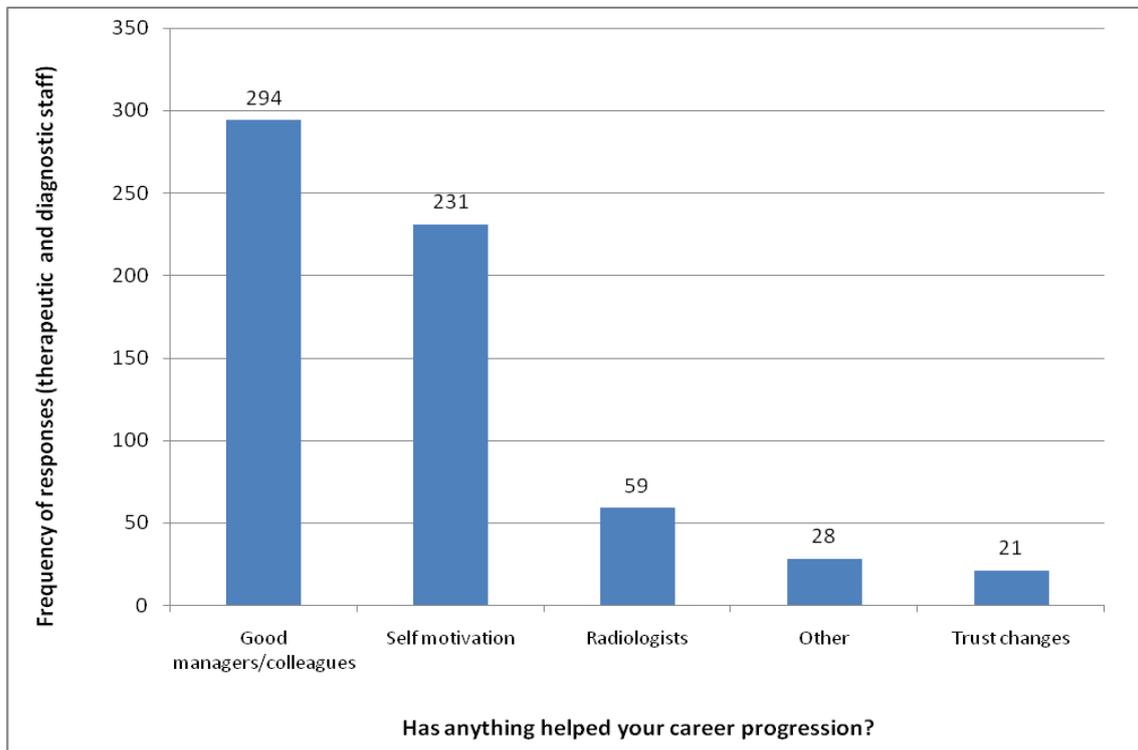
*Being motivated and keen to progress in my career myself.* Therapeutic radiographer, band 6

*Inspirational line manager in previous workplace who encouraged my development towards service management.* Therapeutic radiographer, band 8b

*The implementation of the 4 tier structure, and support of clinical and surgical colleagues in supporting service redesign. Therapeutic radiographer, band 8b*

*The opportunity to set up a part time lymphoedema service supported and part funded by my line manager. Therapeutic radiographer, band 7*

*High level of support from the oncologists. Therapeutic radiographer, band 8b*

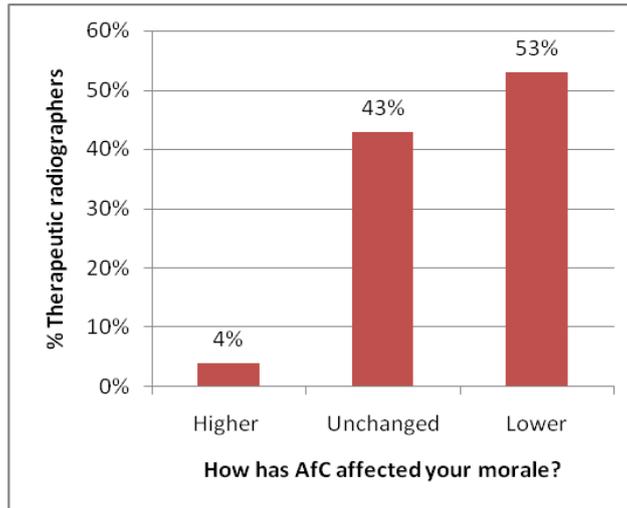


**Figure 90: Reasons cited by diagnostic and therapeutic staff collectively which are perceived to have assisted career progression**

#### 4.3.13 Morale

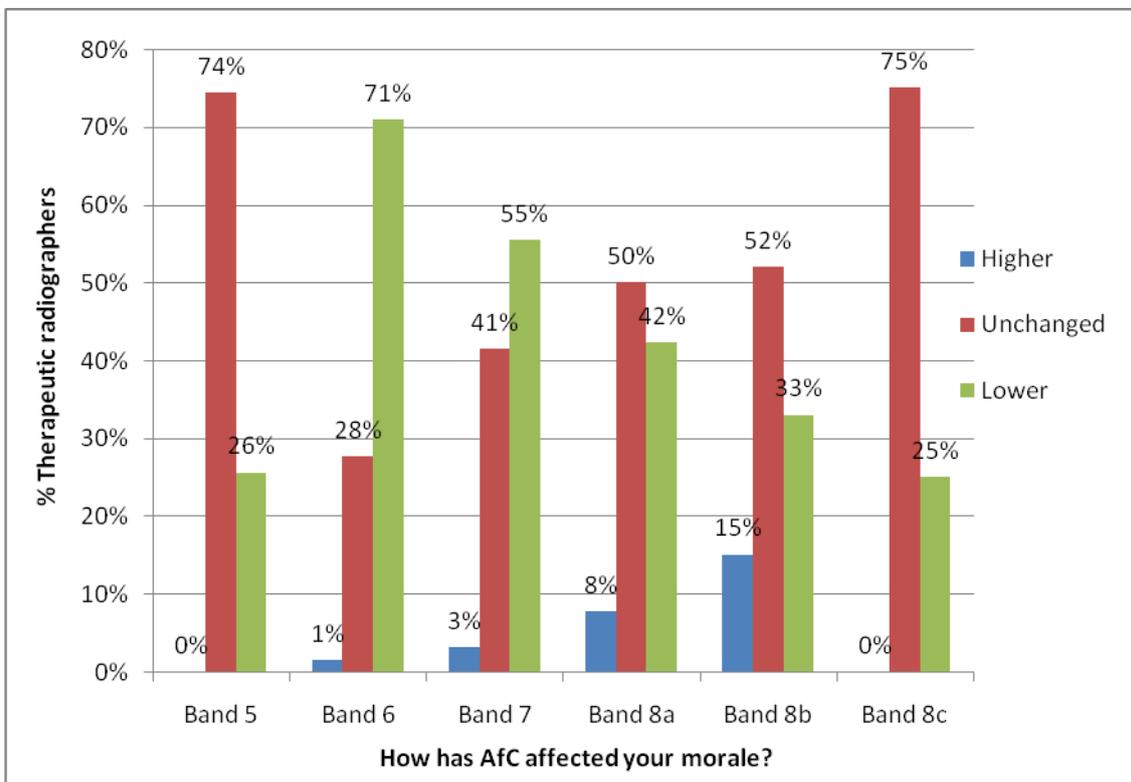
To gain a holistic view of therapeutic radiographers' attitudes towards AfC and their career progression, participants were asked if their morale had changed since the implementation of AfC. The majority of therapeutic radiographers said that it was lower (Figure 91).

Amongst the specialties, those in pre-treatment simulation were most negative with 62% claiming a reduction in morale and only 1% felt it had increased. Managers of therapeutic radiographers most frequently reported an increase in morale but at just 7% this still accounts only for a minority of the therapeutic workforce.



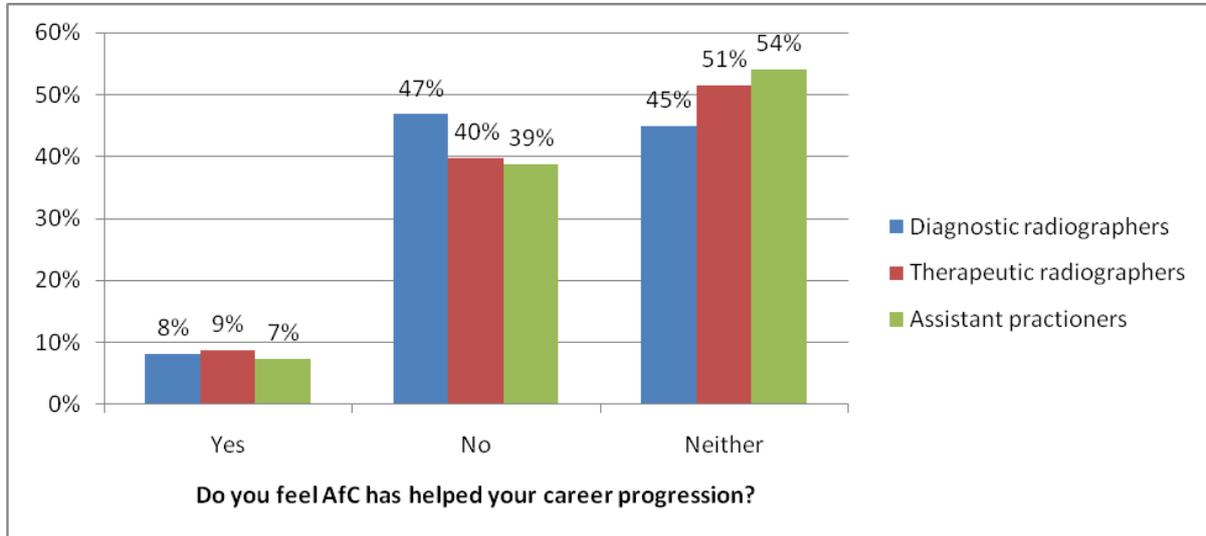
**Figure 91: Therapeutic radiographers' change in morale since AfC**

Just under half (43%) of respondents felt that their morale had been unaffected by AfC, and among the remaining respondents there was a general trend towards those in higher bands believing their morale had increased under AfC. Equally, and in support of this finding, the higher the band the less negative many felt towards AfC. Noticeably, those in bands 6 and 7 felt most frequently that their morale had been lowered by AfC (Figure 92). The result for band 8c staff should be treated with caution, due to a small sample size of four respondents.



**Figure 92: Effect of AfC on therapeutic radiographers' morale in terms of their pay bands**

When participants were asked if they felt AfC had assisted with their career progression, very few staff from any sectors felt it had. However, large numbers felt it had had no influence either way. Almost equal numbers felt it had had a negative impact on their career development (Figure 93).



**Figure 93: Distribution of responses in terms of assistance with career progression for all staff groups**

Common reasons cited by staff when justifying their opinion on AfC included poor implementation, issues related to band 6 being too broad and the view that it should not contain senior I and II staff, and a belief that AfC was designed to save money and not facilitate career progression (Figure 94).

*Trusts should be named and shamed for the disgusting manner in which they have treated staff and their on going lack of commitment to KSF. Diagnostic radiographer, band 5*

*I am getting paid less to do the same job as a lead radiographer in another hospital just because we were banded badly. Therapeutic radiographer, band 6*

*I don't think that a career structure exists within radiotherapy anymore.*

*Radiographers are applying for band 6 post 18 months after graduation and then potentially they will remain there until ready for advanced practice or managerial posts (the senior 2 and senior 1 posts are both banded at 6 in our Trust). Therapeutic radiographer, band 7*

Examples from participants who feel AfC had assisted their progression are as follows:

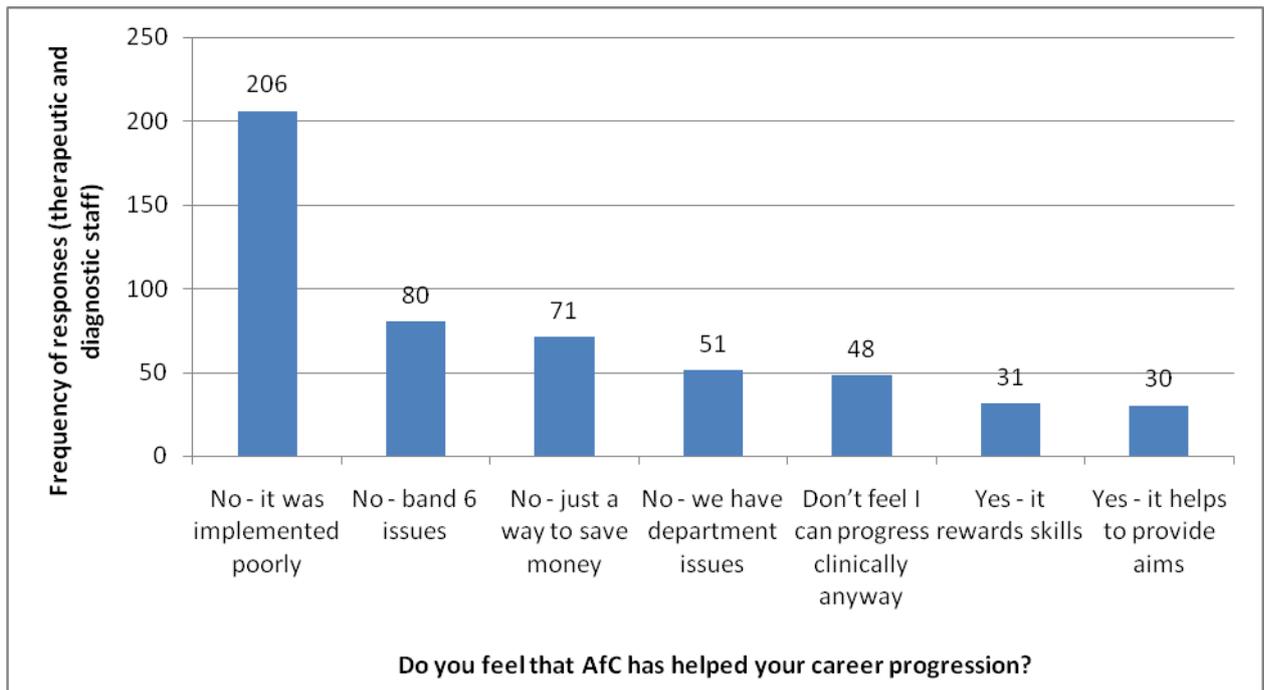
*Yes [it has helped] because it provides an opportunity to develop clinically and get some recognition and reward for it. The problem is that there is inconsistency between Trusts and it has failed to deliver some of the things it was supposed to.*

Therapeutic radiographer, band 7

*Gave me the initial idea of further advancement through academic and clinical*

Therapeutic radiographer, band 7

*KSF does help to develop future plans.* Therapeutic radiographer, band 8c



**Figure 94: Reasons cited by diagnostic and therapeutic staff collectively as to whether AfC assists with career progression**

#### 4.3.14 Voting intentions

The majority (62%) of therapeutic radiographers would vote against AfC if given the chance to vote today (Figure 95). However, when responses were analysed in terms of staff bands it was clear that therapeutic radiographers in higher bands were less negative towards the AfC initiative. They were more likely to vote in favour of AfC or were undecided. This trend also was apparent among diagnostic radiographers. Those most frequently against AfC were radiographers involved in pre-treatment simulation and those banded 6 and 7 (Figure 96). Perceptions of morale appeared to correlate with AfC voting intentions.

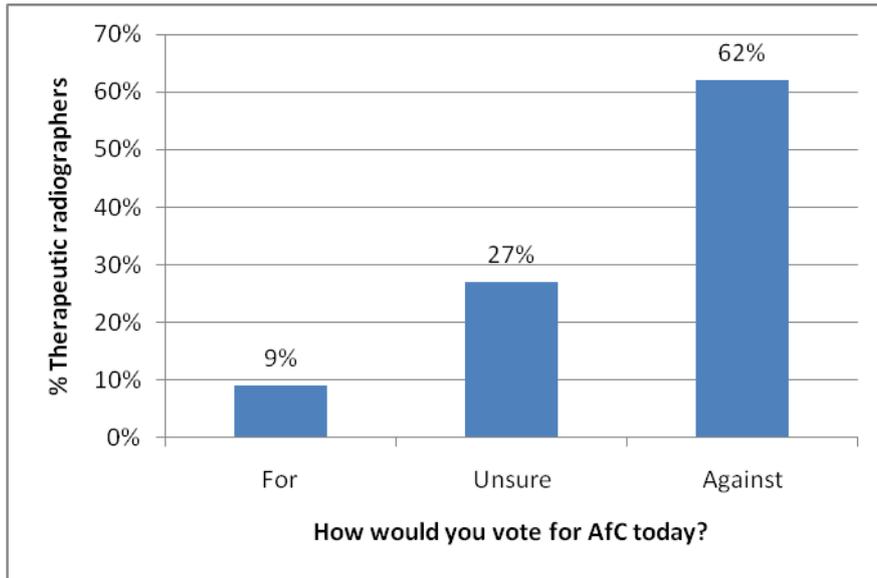


Figure 95: Present-day AfC voting intentions of therapeutic radiographers

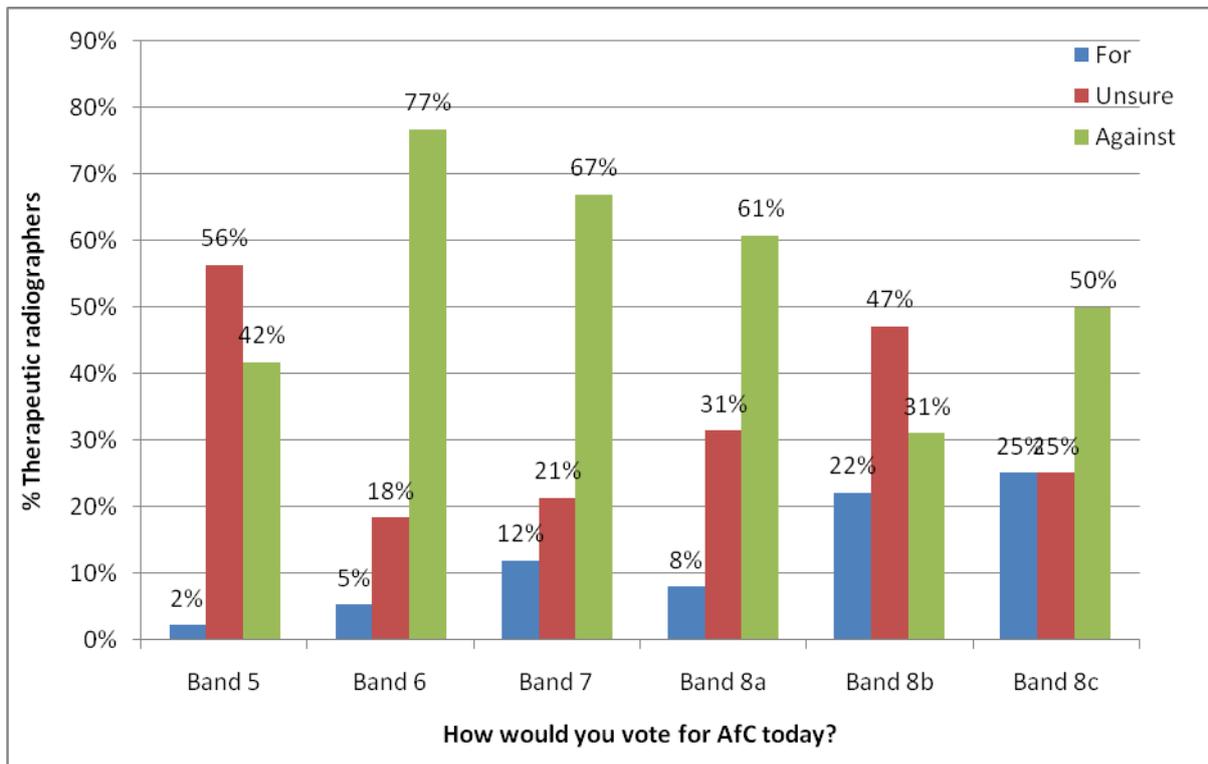


Figure 96: Present-day AfC voting intentions of therapeutic radiographers in terms of pay band

#### 4.3.15 Summary of attitudes and experiences of therapeutic radiographers in terms of sub-specialties

Therapeutic radiographers’ responses were analysed in terms of whether their specialist area of practice had influenced their experience of AfC, similarly to the analyses of

responses from diagnostic radiographers and from the main survey results. The sub-groups identified for further examination were staff in pre-treatment simulation, treatment verification, and managers. Staff from therapeutic sub-groups were more optimistic regarding their progression and there were fewer individuals in these groups (compared to the therapeutic group overall) who would vote against AfC given the chance. There were no large differences between the groups when it came to deciding if the opportunities identified at appraisal were the ones wanted by the appraisees. The majority of each of these groups said that these opportunities were wanted and would be taken to support long term goals even if they were unlikely to facilitate progression to the next pay band (Appendix 2: Key responses from the specialties).

#### 4.4 Assistant practitioners and healthcare assistants (HCAs)

Fifty-two assistant practitioners and twenty-two healthcare assistants responded to the survey. This comprised 3% of the total responses. The majority of assistant practitioners and HCAs worked in teaching hospitals or foundation trusts (Figure 97). Small numbers were located in PCTs and cancer centres. Females accounted for 86% of these staff, with only 14% being male.

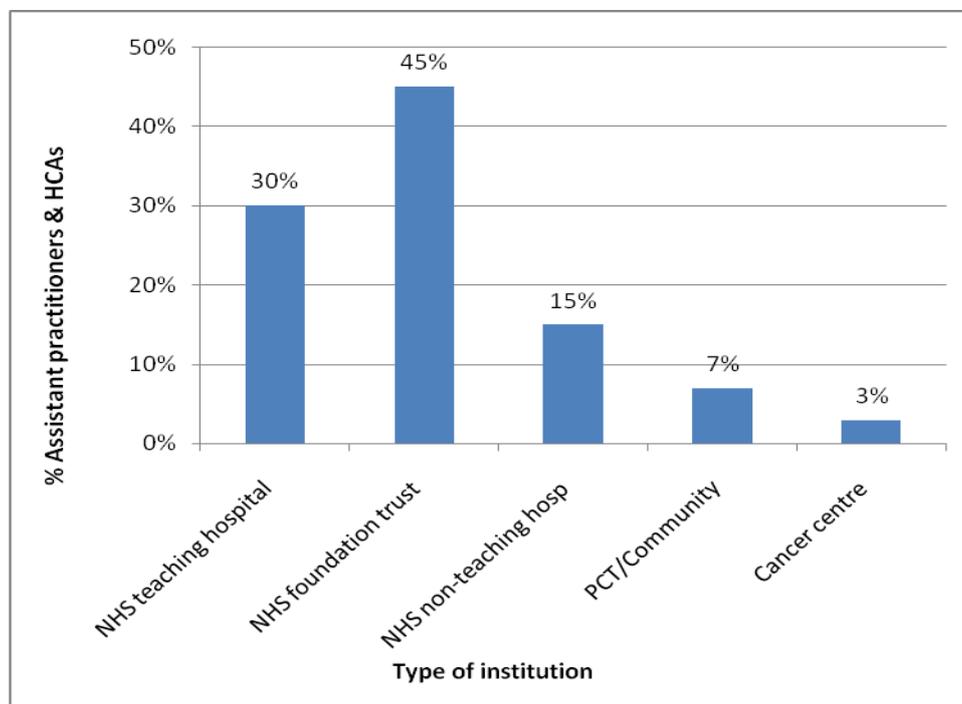


Figure 97: Distribution of assistant practitioners and HCAs in terms of place of work

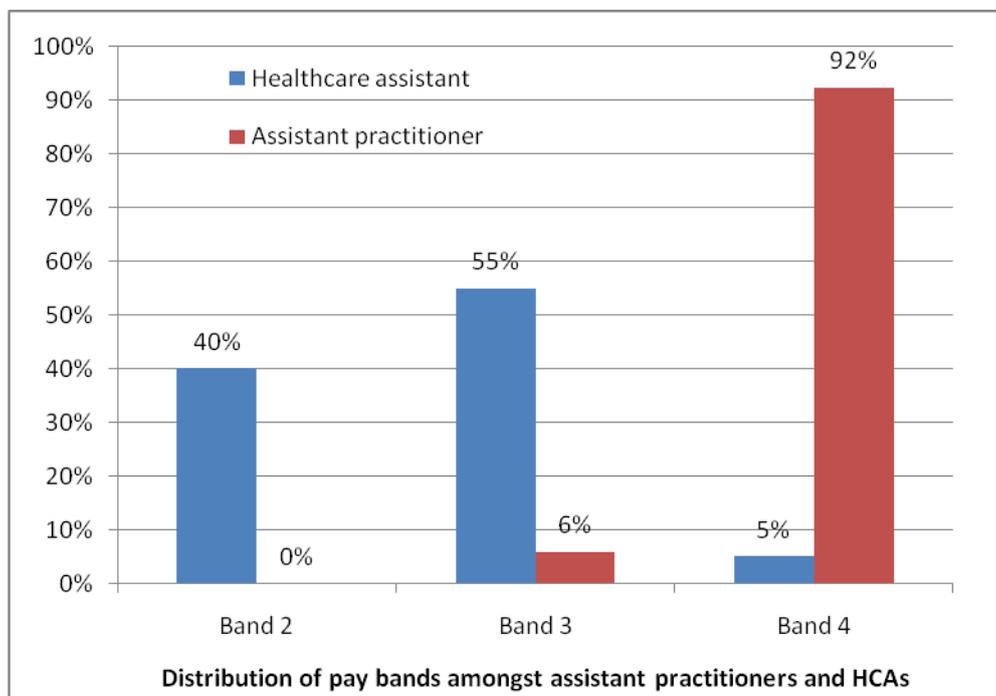
The majority (91%) were white British and there were peaks in age groups for those in their late twenties and late forties. With the exception of just three, all had gained their qualifications since 2000.

#### 4.4.1 Areas of practice

As with radiographers, assistant practitioners and HCAs were active in most types of services including breast imaging, MRI, ultrasound and brachytherapy. Areas of work in which assistant practitioners and HCAs were not involved included research, radiotherapy isotopes and counselling.

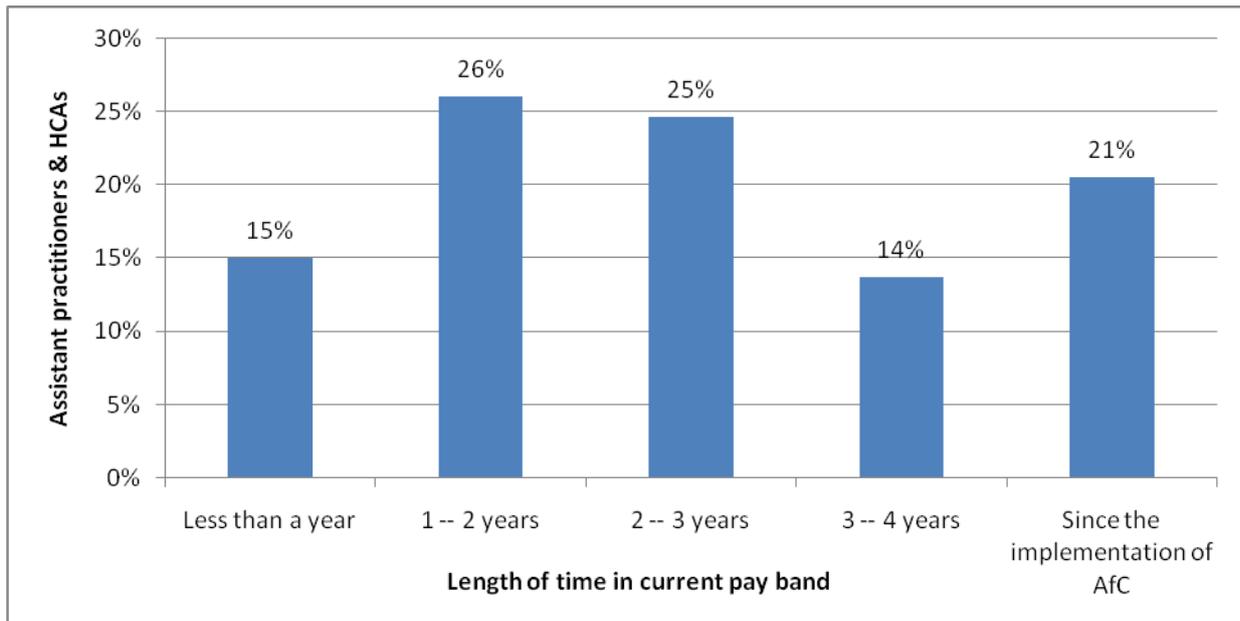
#### 4.4.2 Agenda for Change current pay banding

The majority (92%) of assistant practitioners were banded 4 and just over half (55%) of HCAs who responded to this survey were in band 3 (Figure 98).



**Figure 98: Distribution of pay bands for assistant practitioners and HCAs**

Only one in five (21%) had been in their current pay band since the implementation of AfC terms and conditions but there was no obvious difference identified between males and females or Strategic Health Authority regions in relation to AfC banding (Figure 99). The distribution was similar throughout England and Wales. Proportionally greater numbers of assistant practitioners were located in the North West, Yorkshire and Humber, and East of England SHAs.



**Figure 99: Length of time in current pay band for assistant practitioners and HCAs**

#### 4.4.3 Expectations of assistant practitioners and HCAs in terms of career progression under AfC

Assistant practitioners and HCAs who were employed prior to AfC were asked about their former Whitley Council grading and to what band they expected to be assimilated under AfC terms and conditions. This information was then compared with where they were actually placed after implementation of AfC.

About two thirds of assistant practitioners (n = 32, 62%) had expected to be placed on band 4 prior to AfC. Ten (19%) were unsure, six (12%) had expected to be banded 3 and two to band 5. Since 48 (92%) were assimilated to band 4 most assistant practitioners' expectations were met or exceeded.

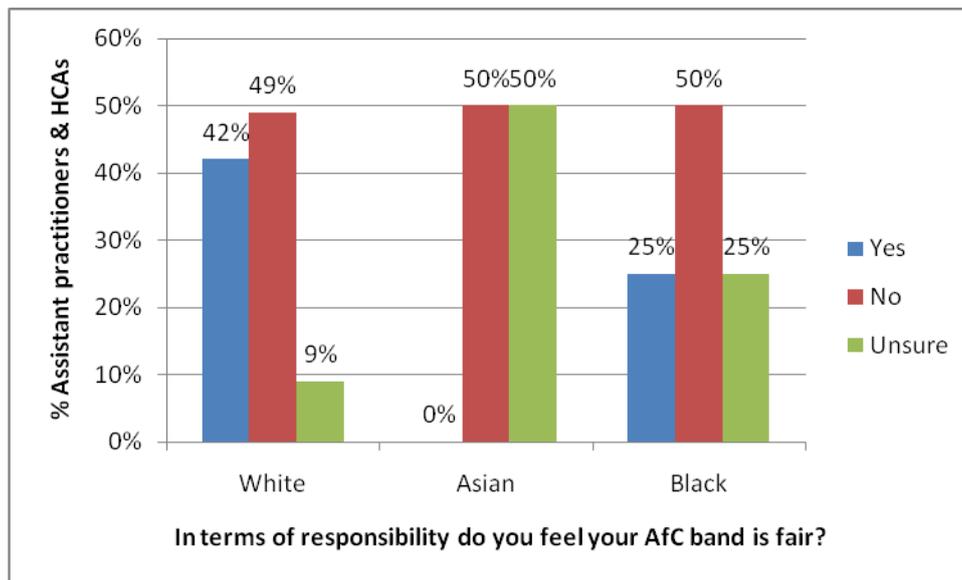
Twelve out of twenty-two (56%) HCAs expected to be banded 3 but eight (36%) were actually banded 2 after implementation. Similarly, four anticipated band 4 but after implementation only one was actually assimilated to this band.

#### 4.4.4 Appeals

From this survey small but equal numbers of assistant practitioners and HCAs underwent a formal appeal to contest their banding. Seven out of eight assistant practitioners had their appeals upheld compared to only three out of eight HCAs. There was a strong relationship between successful appeals and those staff supported by their managers.

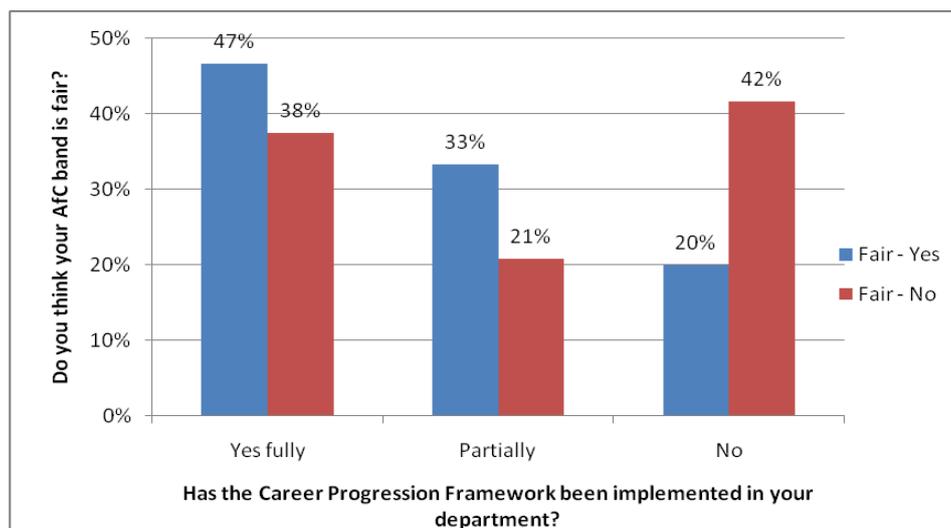
#### 4.4.5 Perceived fairness of banding

In terms of responsibility in relation to the perceived fairness of AfC banding, there were differences in the opinion of the support workforce. Half the workforce, irrespective of ethnic background felt their banding did not reflect fairly their responsibility. White staff felt most often (42%) that their band was fair. In contrast, only 25% of black assistant practitioners or HCAs and none from Asian backgrounds felt their band was fair (Figure 100).



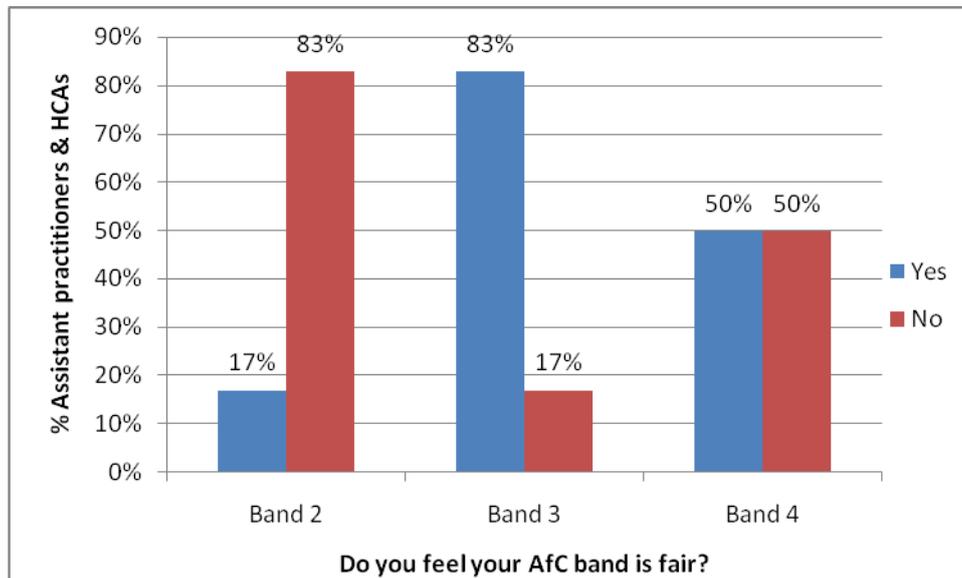
**Figure 100: Perceived fairness of AfC band in terms of the ethnicity of assistant practitioners and HCAs**

In keeping with the findings for the other staff groups there was a strong trend indicating that assistant practitioners and HCAs were more likely to feel their banding was fair in centres where the CPF was either fully or partially implemented (Figure 101).



**Figure 101: Fairness of AfC band in terms of the CPF, as perceived by assistant practitioners and HCAs**

The majority (83%) of band 2 HCAs thought their pay banding was unfair (Figure 102). No assistant practitioners were banded at 2.



**Figure 102: Fairness of their AfC band as perceived by assistant practitioners and HCAs**

Reasons given for feeling their banding was unfair were very similar to those provided by therapeutic and diagnostic radiographers. Commonly, assistant practitioners and HCAs felt that they worked above the responsibilities associated with their band. Assistant practitioners in particular frequently commented that they believed they did the work of a junior radiographer:

*I feel the banding should be higher, as APs do the same as a junior radiographer.*

Diagnostic assistant practitioner, band 4

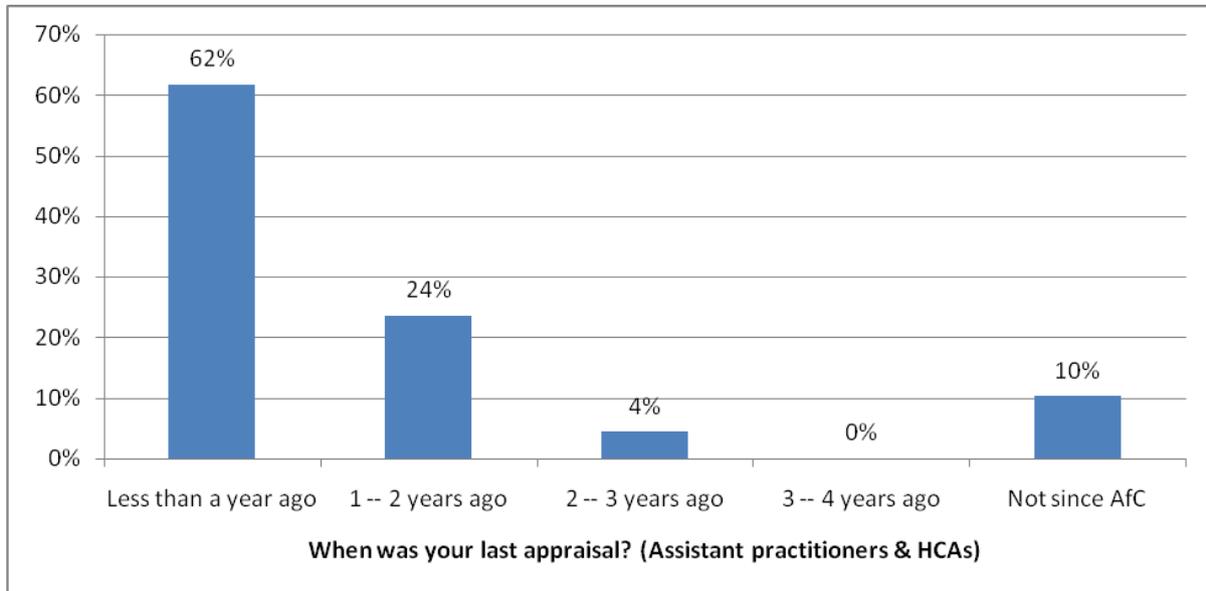
*We assist with injections, drainages and biopsies and other interventional techniques on a one to one basis with the consultant radiologists without support from qualified staff. We are constantly taking on more responsibility for no more pay. Other trusts with job descriptions the same or less intensive than ours are known to be band 3. In this trust we are paid the same as a domestic. Diagnostic HCA, band 2*

#### **4.4.6 Career Development Opportunities for assistant practitioners and HCAs**

This section of the survey began by exploring assistant practitioners' and HCAs' experiences of appraisals and the NHS KSF since these form a key element of AfC and are the basis for identifying career development opportunities.

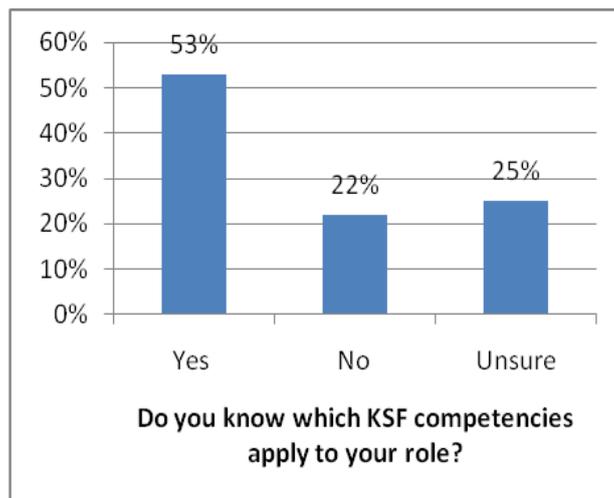
#### 4.4.7 Appraisals

The majority of assistant practitioners and HCAs who answered this section of the survey had received an appraisal in the last year. The percentage was very similar to figures obtained for diagnostic radiographers. There was no difference between full-time and part-time staff and how frequently their appraisals were carried out.

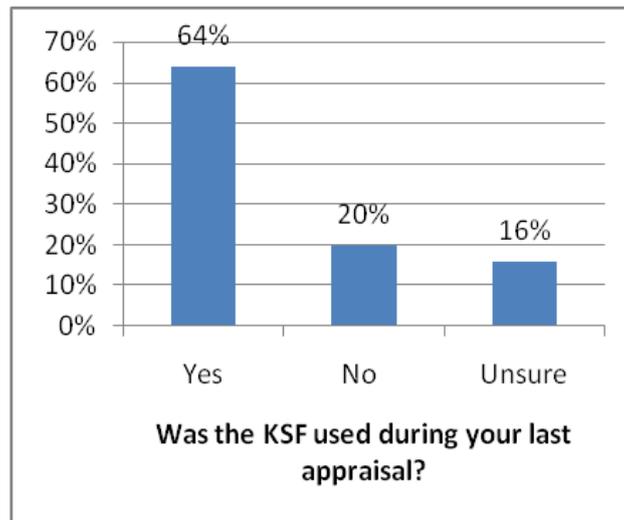


**Figure 103 Time elapsed since last appraisal for assistant practitioners and HCAs**

Just over half (53%) were aware of which NHS KSF competencies related to their current role, 25% did not know and 22% were unsure (Figure 104). Almost two thirds (64%) reported that the KSF has been used at their last appraisal (Figure 105).



**Figure 104: Assistant practitioners' and HCAs' familiarity with the KSF competencies for their role**



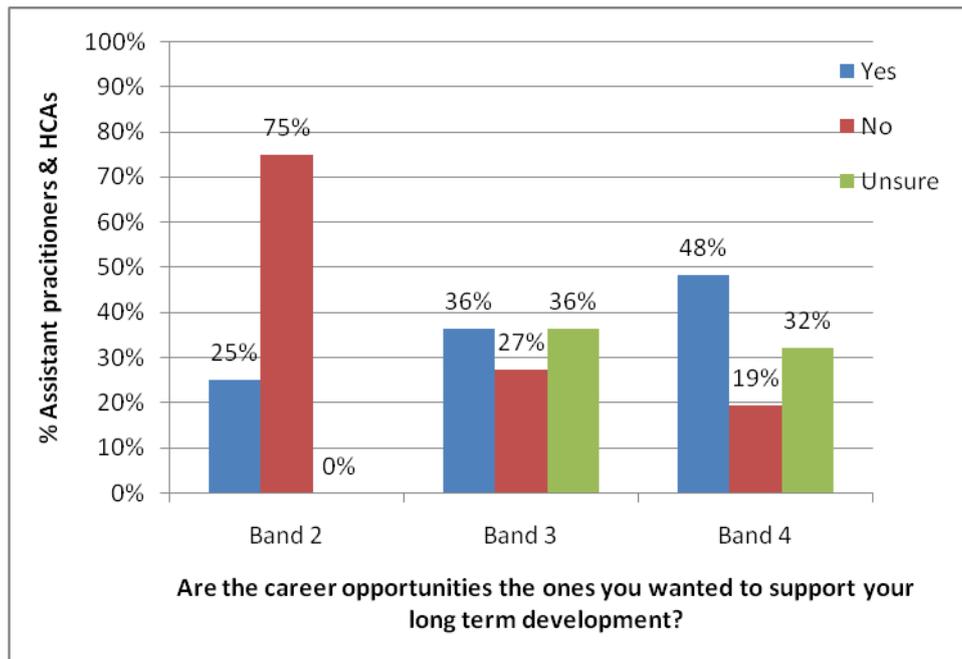
**Figure 105: Assistant practitioners and HCAs who had received an appraisal which involved use of the KSF**

Unlike with therapeutic and diagnostic radiographers, there was no obvious trend between use of the KSF at appraisal and whether the CPF was in place. Over a third (36%) of assistant practitioners and HCAs did not know whether the CPF was in place at their site or not. However, the numbers who responded to our survey were small.

#### **4.4.8 Opportunities identified at appraisal**

Just under half (46%) of assistant practitioners and HCAs claimed to have had career development opportunities identified at their last appraisal. There was no relationship between the pay band of the participant and how frequently career development opportunities were identified at appraisal. Approximately half of all assistant practitioners and HCAs reported that opportunities were identified irrespective of whether they were banded 2, 3 or 4.

Of those who had had development opportunities suggested, just 28% were optimistic that these opportunities may aid their progression into the next pay band. Over half (55%) thought that they would not and 17% were unsure. As with the postgraduate workforce, there was a clear trend that the higher the band the more welcome the opportunities were, regardless of whether they would aid progression into the next band or not (Figure 106). Nearly half (48%) of all assistant practitioners and over one third (36%) of HCAs still wished to access these opportunities. Band 2 staff were the most negative towards the activities identified at appraisal.



**Figure 106: Assistant practitioners' and HCAs' opinions of whether available development opportunities are what they wanted to support their careers**

Career development opportunities identified included access to foundation degree courses, access to assistant practitioner courses, further NVQ study, and in-house training for cannulation.

The reasons given for why respondents thought the opportunities identified at appraisal were unlikely to facilitate progression most frequently related to a lack of funding within their department, and a barrier to progressing beyond band 4. Typical comments are shown below:

*Restricted because development of role prevented by pay banding.* Diagnostic assistant practitioner, band 4

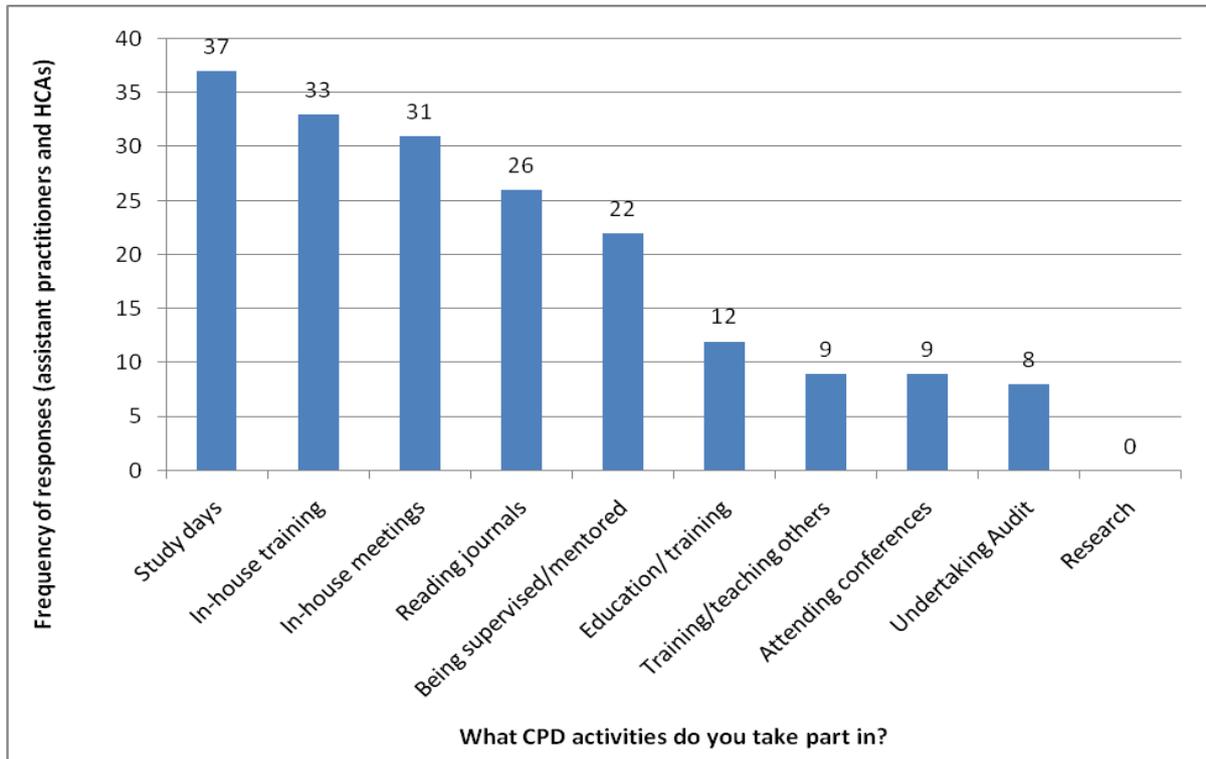
*As an assistant practitioner, on this qualification, I have been told that we will never leave pay band 4.* Diagnostic assistant practitioner, band 4

*I feel that gaining a BSc will be hard due to funding issues.* Therapeutic assistant practitioner in training, band 3

*Lack of funding and no time available.* Diagnostic assistant practitioner, band 4

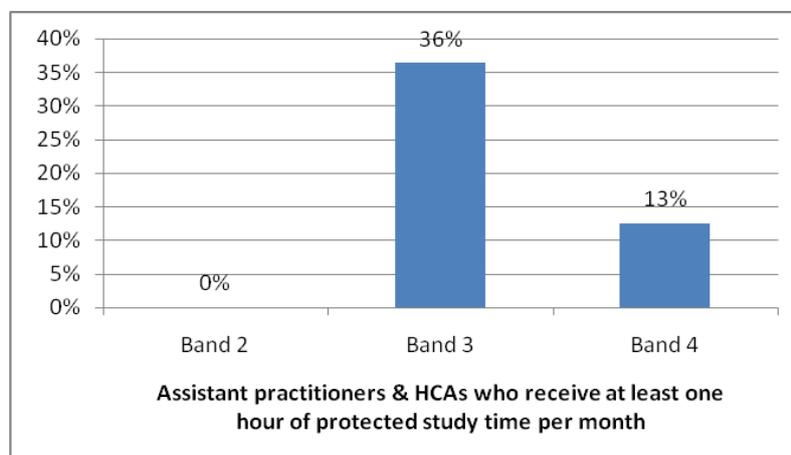
#### 4.4.9 Continuing Professional Development (CPD) activity

Almost three quarters (72%) of assistant practitioners and HCAs recognised that they had CPD opportunities in the work place, and these activities were wide-ranging and varied. Study days and in-house activities were most frequently cited by respondents (Figure 107). No assistant practitioners or HCAs were involved in research projects.



**Figure 107: CPD activities commonly cited by assistant practitioners and HCAs**

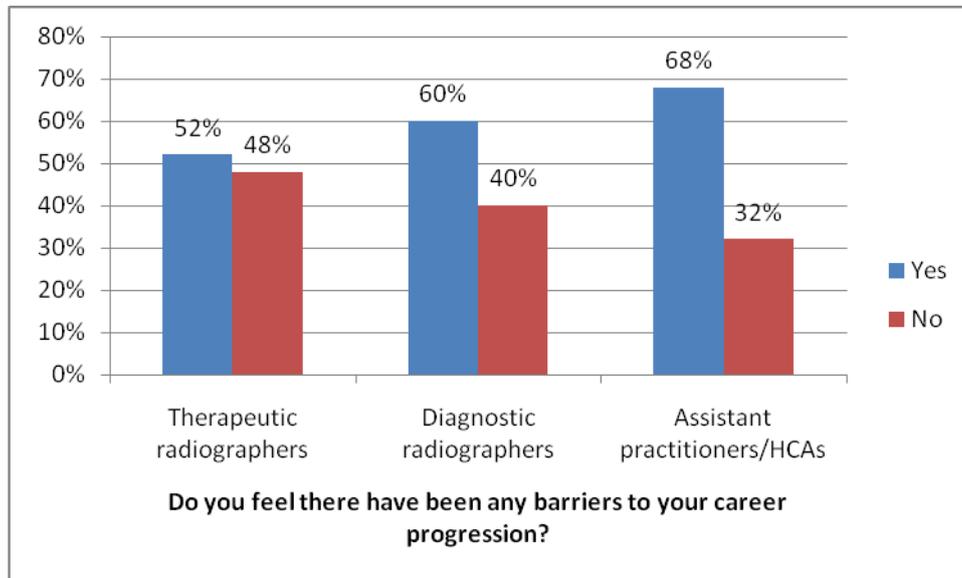
The majority (85%) received no protected study time per month, but of the small proportion who did, most were banded 3. There were no examples of band 2 HCAs being provided with any regular development time (Figure 108).



**Figure 108: Distribution of protected study time for assistant practitioners and HCAs**

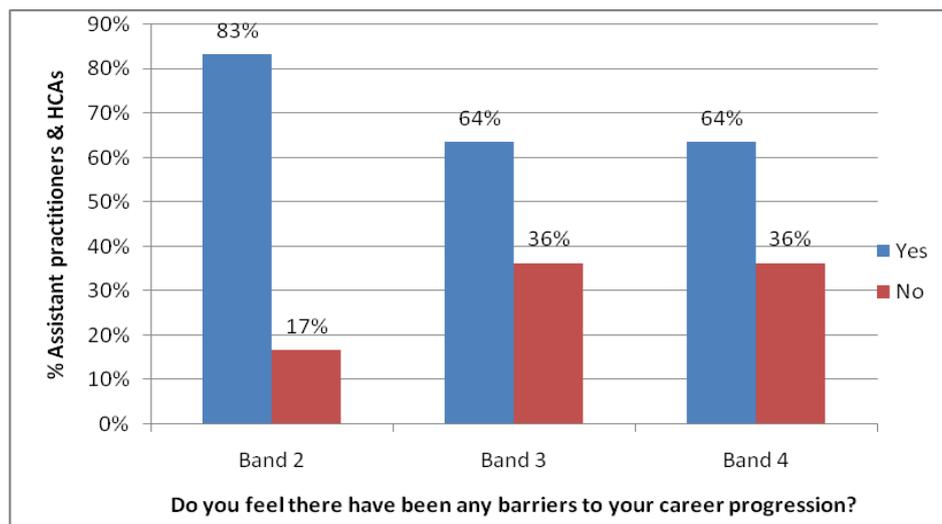
#### 4.4.10 Barriers to career development

The majority (68%) of assistant practitioners and HCAs felt that they had encountered barriers which hindered their career progression. Of all the staff groups contained within the survey, they reported experiencing barriers the most often (Figure 109).



**Figure 109: Distribution of all staff group responses in terms of perceived barriers**

In terms of pay banding, there was a clear distinction between the experiences of band 2 staff and those in the higher bands who felt that they had encountered fewer barriers (Figure 110). Nevertheless, almost two thirds of those in bands 3 and 4 still felt there were obstacles to their career progression.



**Figure 110: Perceived barriers to career progression for assistant practitioners and HCAs in terms of their pay banding**

The most common barriers cited by assistant practitioners and HCAs involved funding, the feeling of not being valued, and a belief that radiographers' development is put first:

*AfC does not help assistant practioners develop their career, no substantial courses are available to move up a band, and most radiographers are against AP's progression anyway.* Diagnostic assistant practitioner, band 4

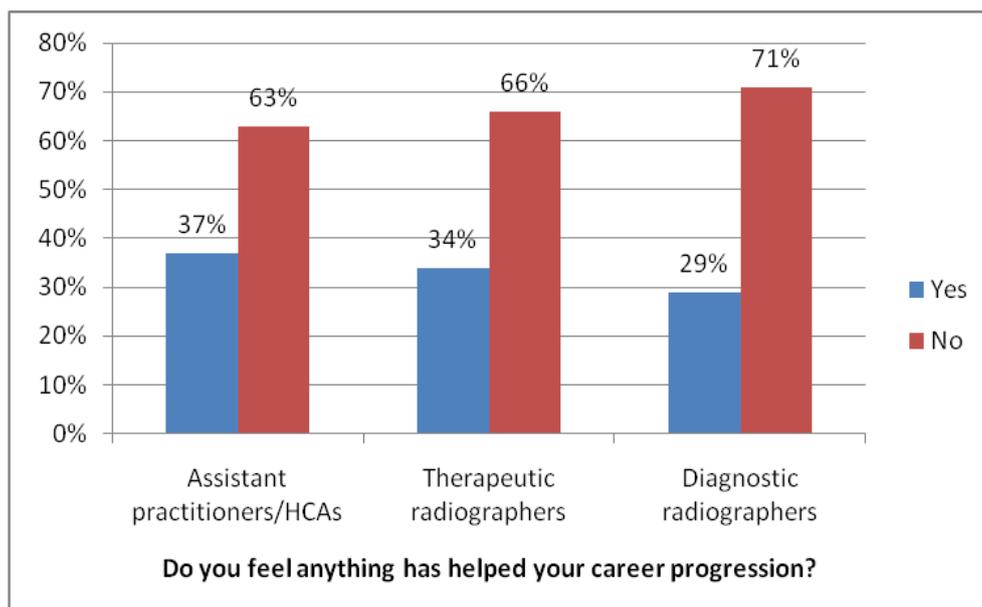
*Our profile needs lifting and feel the SoR should be supporting our role more.* Diagnostic assistant practitioner, band 3

*APs have to prove all the time that they are capable of working alongside the radiographers - some radiographers feels threatened that we are here to take their jobs - hence the animosity.* Diagnostic assistant practitioner, band 4

*Lack of funding and no support from senior staff. 'It won't affect your banding' is a comment I get.* Diagnostic assistant practitioner, band 4

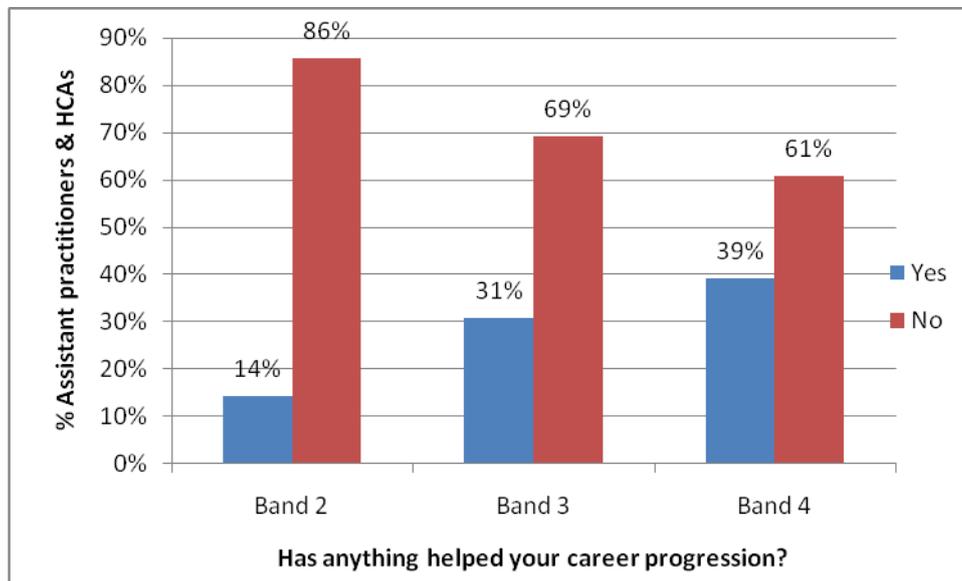
#### 4.4.11 Incentives

Across all respondents to the survey, approximately two thirds of respondents, regardless of whether they were therapeutic or diagnostic radiographers, assistant practitioners or HCAs, felt that nothing had assisted them in their career progression, with just one third believing they had experienced support. Of the staff groups, the assistant practitioners and HCAs were the most likely (37%) to say that they had found something or someone helpful during their career progression (Figure 111).



**Figure 111: Distribution of responses for all staff groups in terms of assistance with career progression**

Once again, in terms of banding, and in support of the evidence gained from exploring barriers, those in higher bands reported more frequently that they recognised that some factor during their career had assisted their progression (Figure 112).



**Figure 112: Assistance with career progression in terms of assistant practitioners' and HCAs' pay banding**

The most frequently cited responses from assistant practitioners and HCAs when describing factors which they believed had helped them included good support from managers and colleagues:

*Colleagues within department very supportive.* Diagnostic assistant practitioner, band 4

*I was lucky enough to have an excellent NVQ assessor who helped me obtain my NVQ level 2.* Diagnostic HCA, band 3

*My line manager encouraged me to apply for the assistant practitioner role.* Therapeutic HCA, band 3

*My brachytherapy team leader has given me opportunities to enhance my skills.* Therapeutic assistant practitioner, band 4

#### 4.4.12 Morale

To gain a holistic view of assistant practitioners' and HCAs' attitudes towards AfC and their career progression, participants were asked if their morale had changed since the implementation of AfC. The majority said it was lower (Figure 113). No staff in bands 2 or 3 reported that their morale was higher as a consequence of AfC and only 2% of band 4 staff

felt their morale had increased. A large proportion of those in bands 3 and 4 felt AfC had not affected their morale in any way.

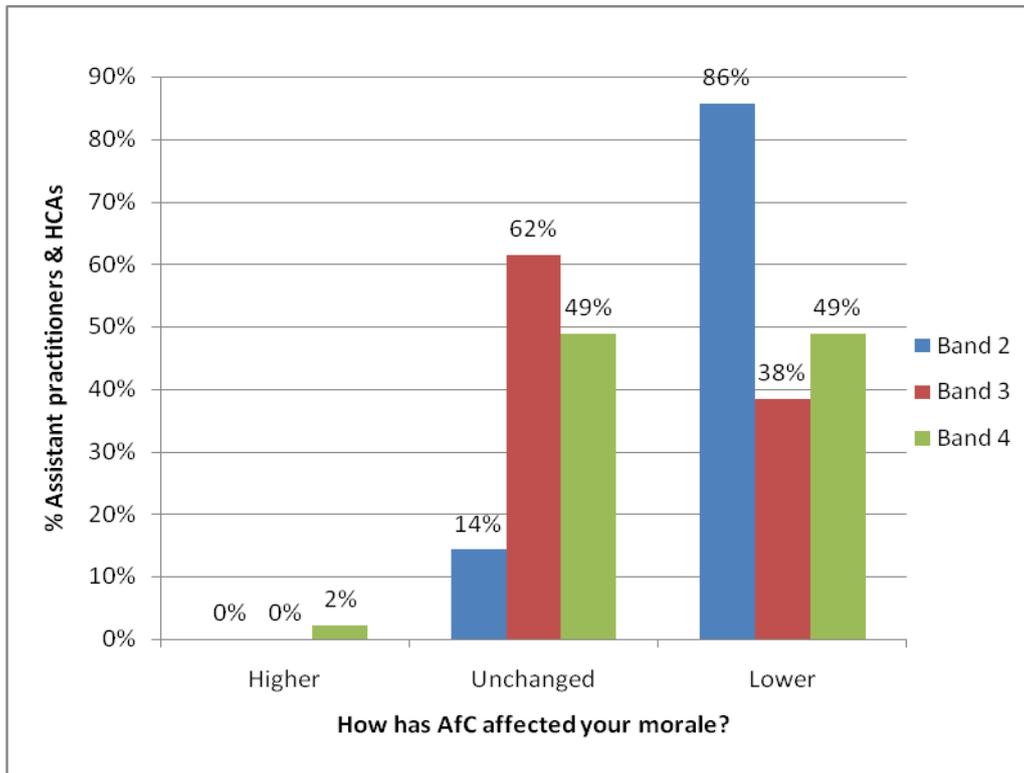


Figure 113: Assistant practitioners' and HCAs' change in morale since AfC

When the responses of assistant practitioners and HCAs were compared with radiographers' there is very little overall difference in attitude (Figure 114).

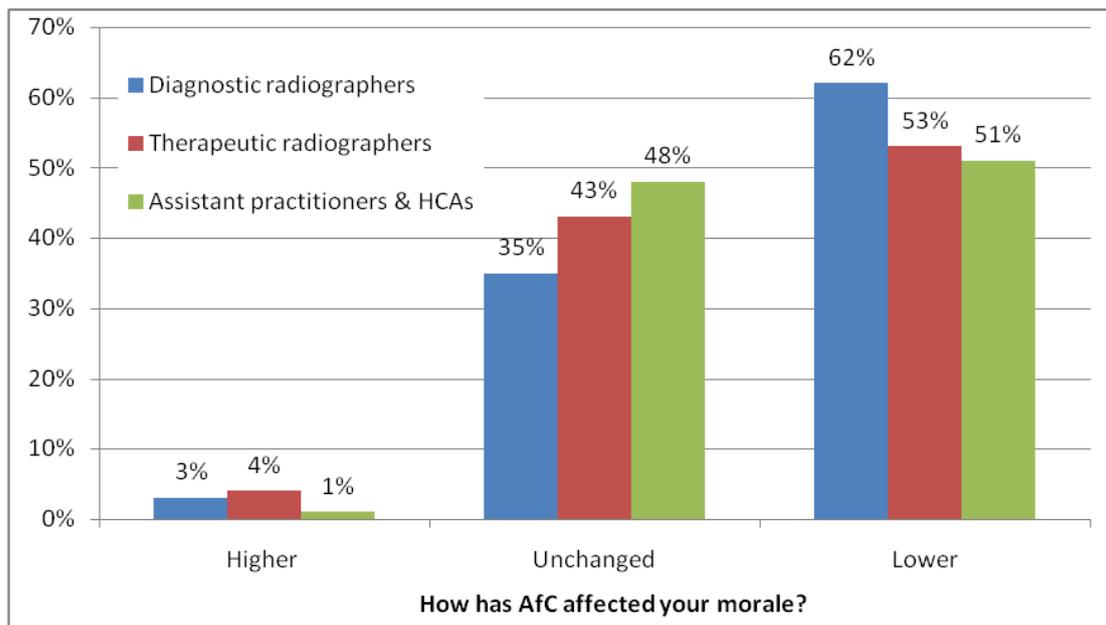
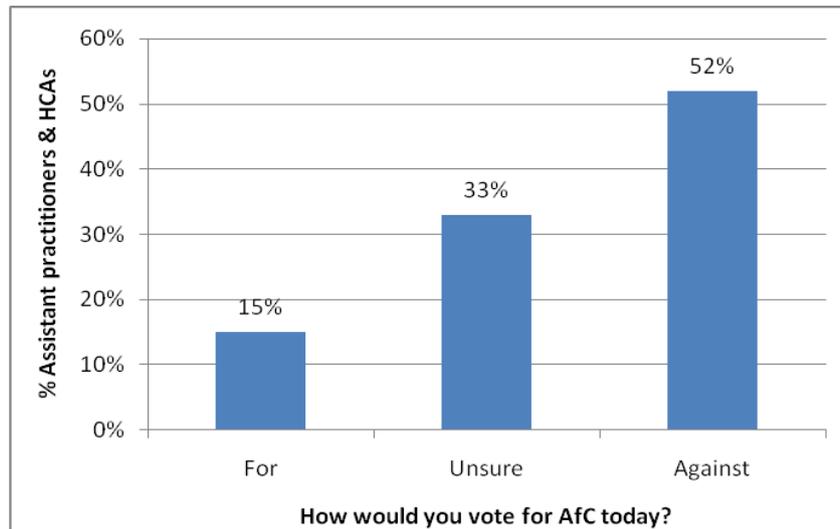


Figure 114: Effects of AfC on morale for all staff groups

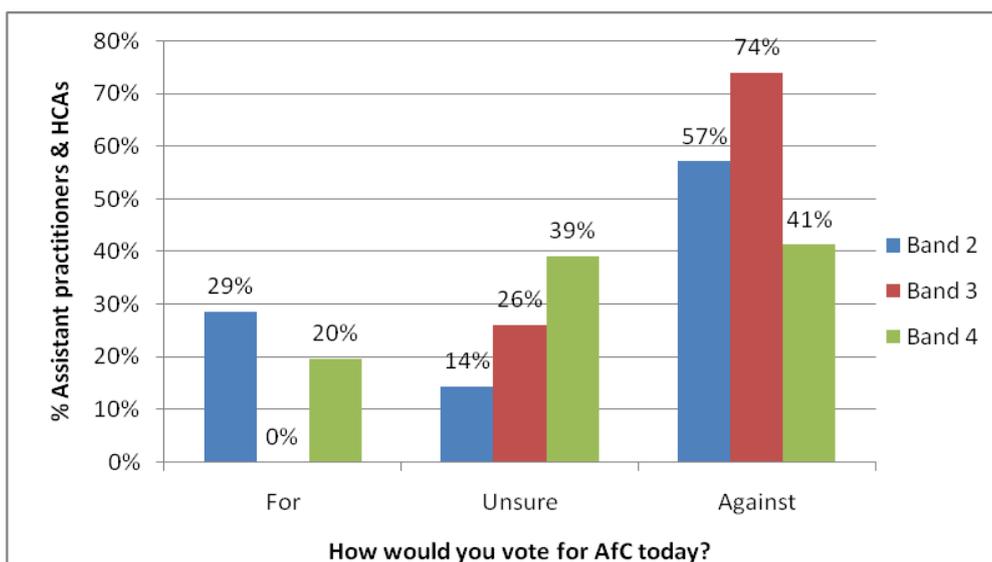
#### 4.4.13 Voting intentions

Just over half (52%) of assistant practitioners and HCAs who responded to this survey would vote against AfC if given the chance to vote today (Figure 115). A third (33%) was unsure and 15% would vote in favour.



**Figure 115: Present-day AfC voting intentions of assistant practitioners and HCAs**

There was no clear trend when bands 2, 3 and 4 are analysed separately. In fact, it was confounding that those in band 2 were most in favour of retaining AfC in spite of claiming most frequently that their morale was lower. Voting intentions of band 3 and 4 staff appeared to be more consistent in view of earlier responses (Figure 116).



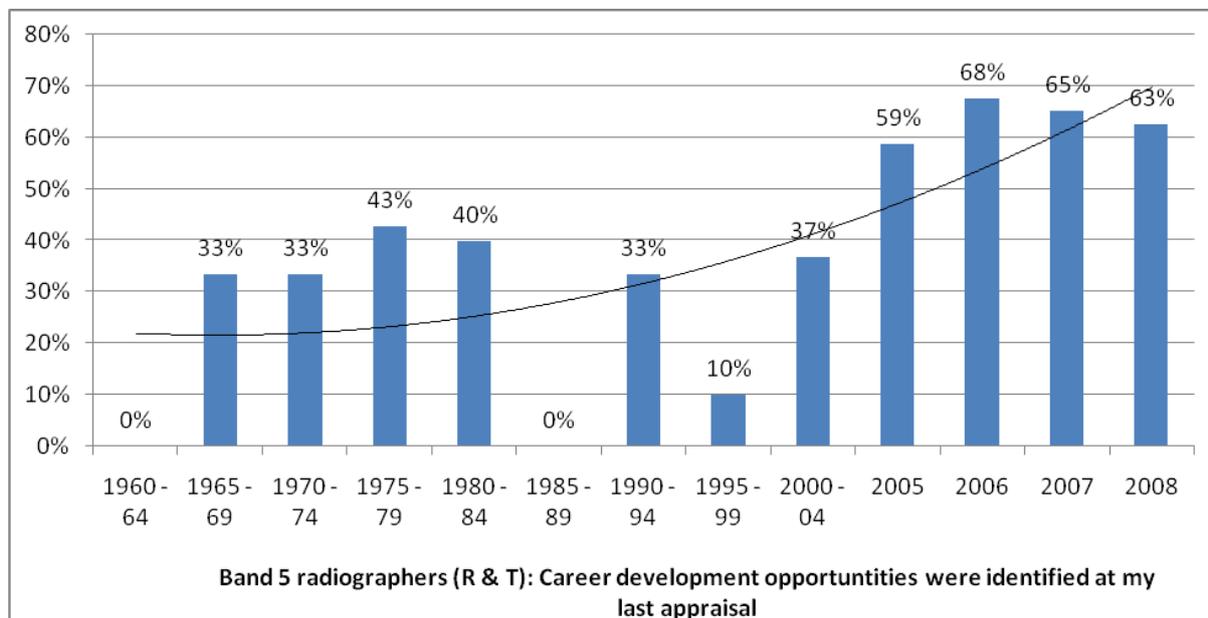
**Figure 116: Present-day AfC voting intentions of assistant practitioners and HCAs in terms of pay band**

#### 4.5 Section 5: Experiences and attitudes of therapeutic and diagnostic radiographers in terms of length of time since qualification

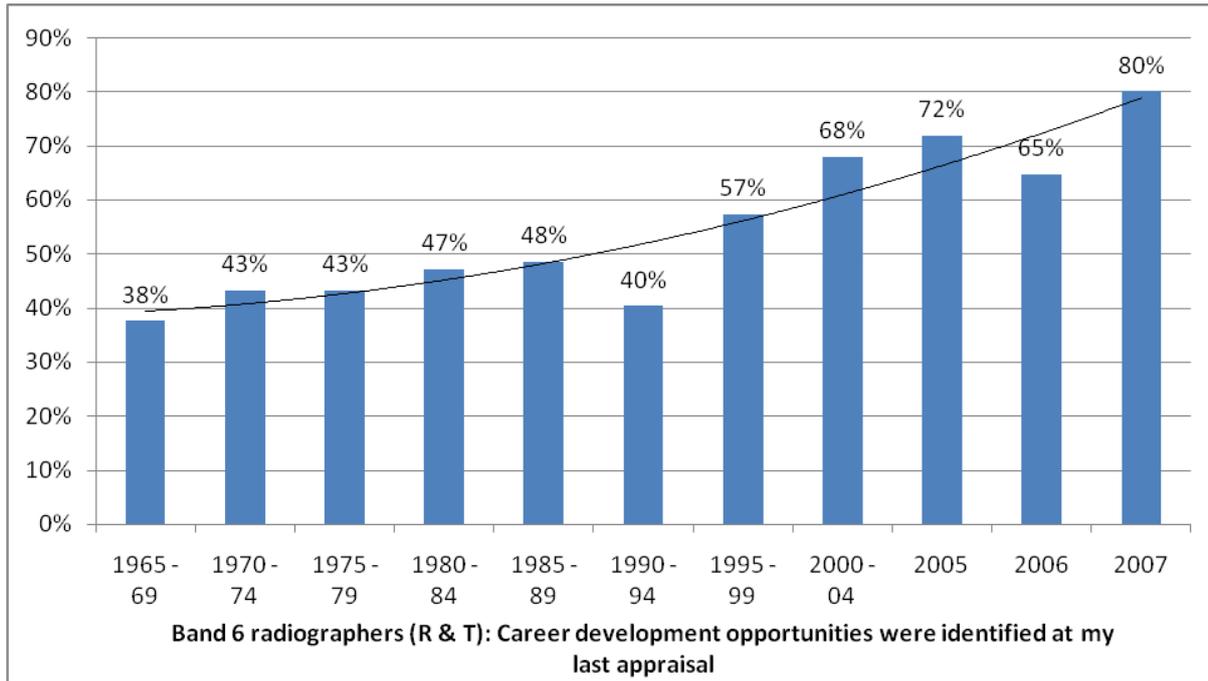
Since it was possible that radiographers may have different perceptions of their career depending on how long they have been in the profession, key responses on expectations, opportunities and barriers were analysed with respondents grouped according to when the individual had gained their entry qualification.

Those who gained entry to the profession after implementation of AfC claimed more frequently to have career development opportunities identified for them than did those who had qualified prior to AfC. Similarly, the longer a radiographer had been qualified, the less frequently they stated that development opportunities were offered. This clear trend was visible throughout the bandings for 5, 6, 7, 8a, and 8b (see Figure 117, Figure 118, Figure 119, Figure 120, Figure 121). There were too few band 8c, 8d and 9 respondents to subdivide by year of qualification.

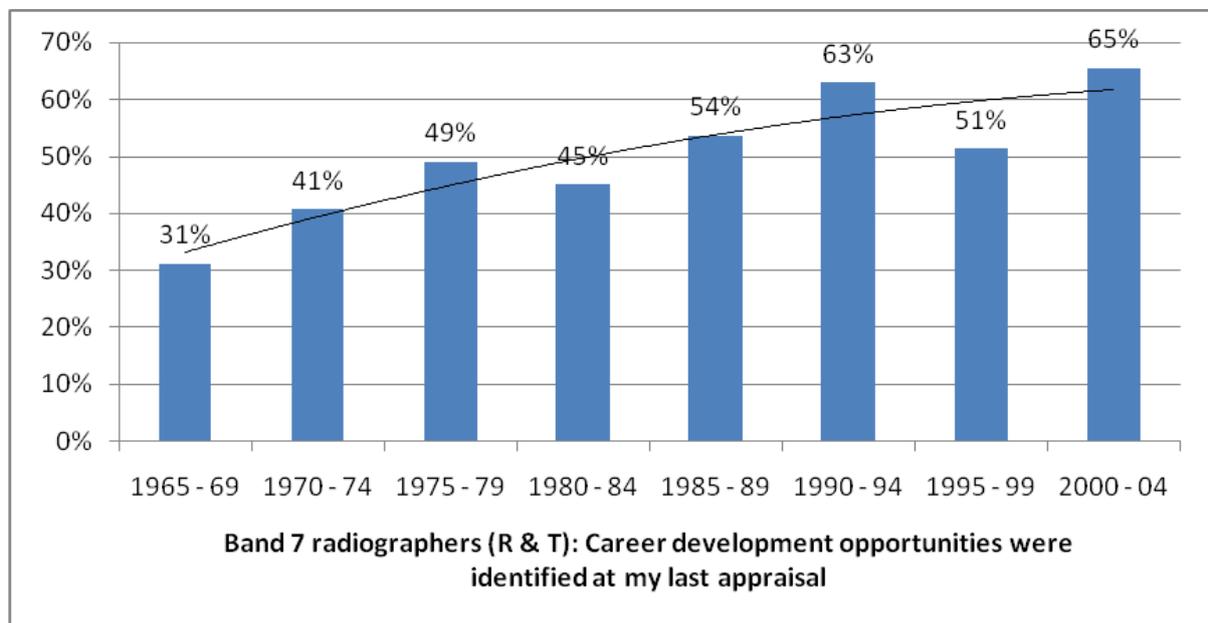
Within the common bands where samples were very small with just a few respondents, the percentages have been removed since they may not be representative. For example, there were very few band 5 radiographers in the survey who had qualified in the early 1960s or late 1980s. Similarly, there were very few band 7 respondents who qualified in 2005 or later and very few band 8 respondents who qualified more recently than 1999.



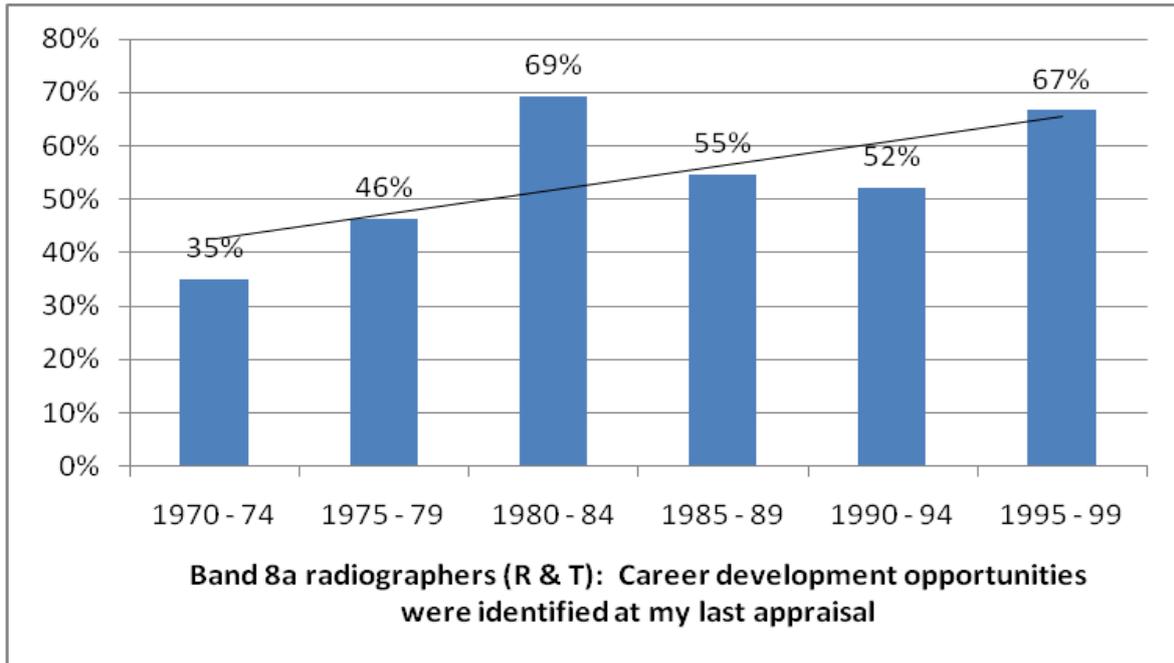
**Figure 117: Career development opportunities identified for band 5 diagnostic and therapeutic radiographers collectively, compared with length of time qualified**



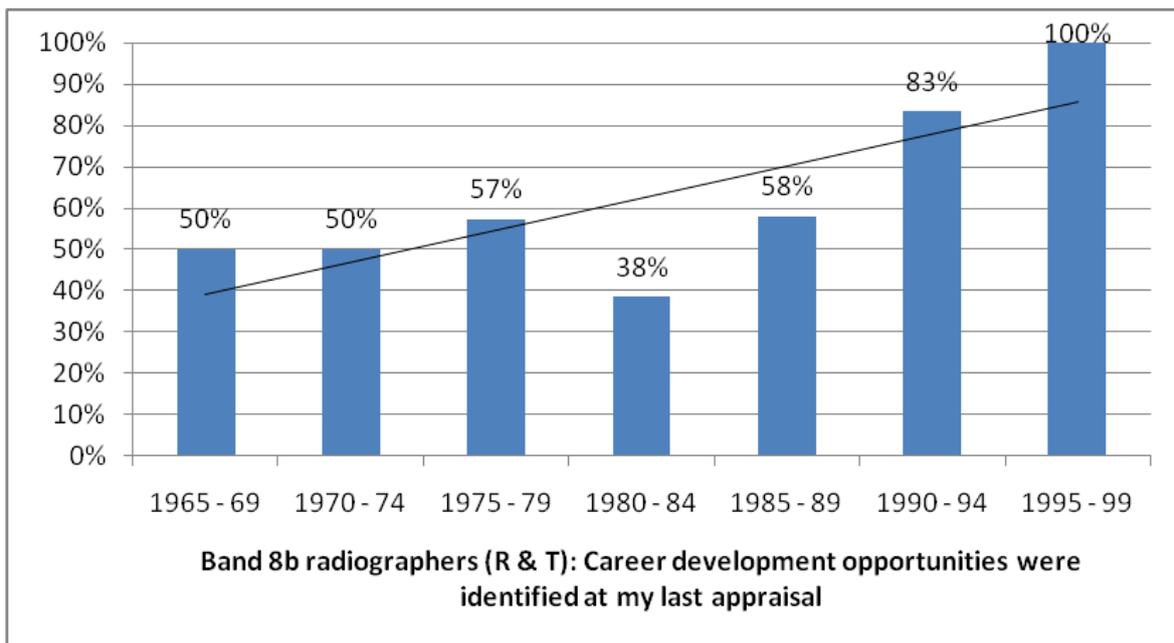
**Figure 118: Career development opportunities identified for band 6 diagnostic and therapeutic radiographers collectively, compared with length of time qualified**



**Figure 119: Career development opportunities identified for band 7 diagnostic and therapeutic radiographers collectively, compared with length of time qualified**

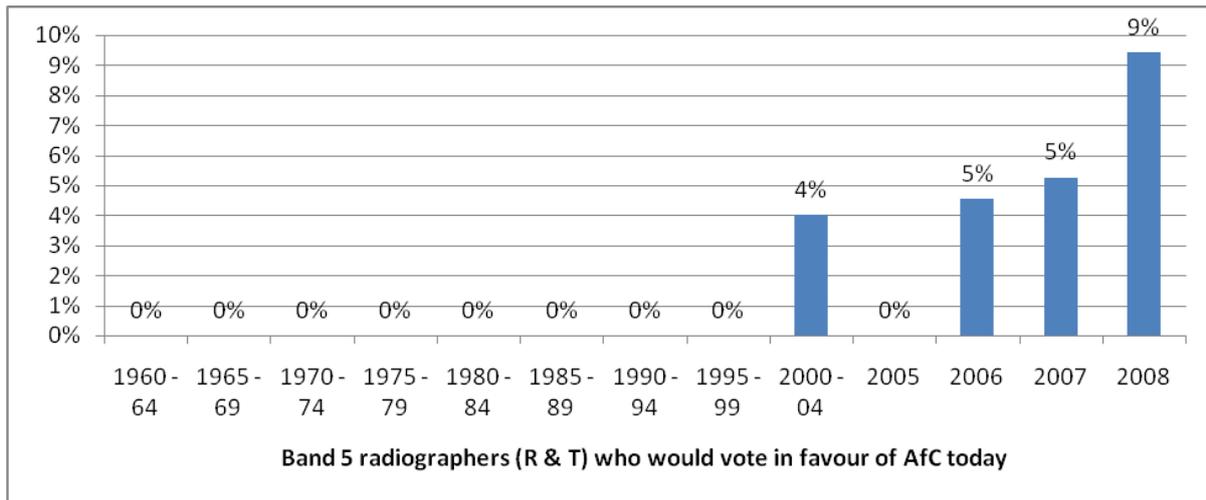


**Figure 120: Career development opportunities identified for band 8a diagnostic and therapeutic radiographers collectively, compared with length of time qualified**



**Figure 121: Career development opportunities identified for band 8b diagnostic and therapeutic radiographers collectively, compared with length of time qualified**

Analyses were conducted to determine whether these findings correlated with how they would vote in relation to AfC if given the chance today. In spite of adequate response rates, no band 5 radiographers who qualified before 2000 said they would vote in favour of AfC, and only small percentages of more recently qualified band 5 staff would cast their vote in favour of AfC (Figure 122).



**Figure 122: AfC voting intentions of band 5 diagnostic and therapeutic radiographers collectively, compared with length of time qualified**

However, similar trends among other bands were not identified. In bands 6, 7 and 8 the proportion of individuals voting in favour of AfC remained low but fairly constant regardless of how long the individual had been qualified.

#### **4.5.1 Further attitudes and experiences of radiographers pre- and post-implementation of AfC**

Radiographers' responses were analysed in terms of whether they had practised only under AfC terms and conditions or whether they had practised before 2004 and experienced Whitley Council arrangements. Significant differences in career development opportunities, expectations and attitudes towards AfC were identified. The majority (85%) of the respondents obtained their entry qualifications in 2003 or earlier. Those who had qualified in 2004 or later (15%) and who had therefore known only AfC conditions gave more positive responses; they more frequently said that they had had development opportunities offered at appraisal, and almost half (43%) felt optimistic that these could facilitate progression into the next pay band.

Nonetheless, over half (57%) of those who had qualified more recently would vote against AfC given the chance today; however, this is a smaller proportion compared to staff who had practised pre-AfC (73%). A further third (33%) of recent graduates were unsure as to how they might vote. These findings are significantly different from answers given by respondents who qualified in 2003 or earlier (Table 11). However, when asked directly about barriers to career development or whether they felt AfC had helped their careers there were no significant differences between the two groups or with the main survey responses.

Table 11: Key responses in terms of length of time qualified

<b>Key responses from individuals:</b> comparing those who have practised since 2004 (under AfC terms only) with those who practised before (under both Whitley Council and AfC terms)	<b>Full survey</b>	<b>Qualified in 2003 or earlier</b>	<b>Qualified in 2004 or later</b>	<b>Chi-square &amp; P value</b>
	<b>N = 2373</b>	<b>N = 2025 85%</b>	<b>N = 348 15%</b>	
<b>OPPORTUNITIES</b> Career development opportunities have been identified at my last appraisal	N = 1032 (53%)	N = 858 (51%)	N = 174 (66%)	22.0 P = <0.0001
<b>EXPECTATIONS</b> I believe these identified opportunities may aid my progression to the next band	N = 309 (21%)	N = 214 (17%)	N = 95 (43%)	73.7 P = <0.0001
These development opportunities are the ones I wanted and will support my long term goals	N = 748 (54%)	N = 620 (53%)	N = 128 (59%)	5.0 P = 0.025
<b>BARRIERS</b> I feel I've been prevented from accessing some career development opportunities	N = 540 (37%)	N = 444 (36%)	N = 96 (42%)	2.45 P = 0.118 (Not significant)
AfC has helped my career	N = 190 (8%)	N = 160 (8%)	N = 30 (9%)	1.11 P = 0.29 (Not significant)
My morale is higher since AfC	N = 71 (3%)	N = 68 (4%)	N = 3 (1%)	
My morale is unchanged since AfC	N = 826 (37%)	N = 657 (34%)	N = 169 (53%)	44.5 P = <0.0001
My morale is lower since AfC	N = 1350 (60%)	N = 1203 (62%)	N = 147 (46%)	
Today I would vote for AfC	N = 175 (8%)	N = 147 (8%)	N = 28 (8%)	
I'm not sure how I would vote	N = 454 (20%)	N = 343 (18%)	N = 111 (33%)	44.5 P = <0.001
Today I would vote against AfC	N = 1613 (71%)	N = 1421 (73%)	N = 192 (57%)	

### **4.5.2 Voting intentions of therapeutic and diagnostic staff in relation to length of time qualified**

To identify any differences between diagnostic and therapeutic radiographers, responses were subdivided into these two groups and then further filtered in terms of whether the participant had been eligible to vote in the Society of Radiographers' ballot in 2003. Again, the assumption made was that the majority of those ineligible to vote would have been more positive because they had qualified since the introduction of AfC and had not experienced working under any other conditions. Experiences and attitudes were very similar between diagnostic and therapeutic radiographers for most of the questions including career expectations and barriers. There were differences, however, in terms of morale and perception of AfC. While diagnostic radiographers who were eligible to vote in 2003 are significantly more likely to report lower morale under AfC compared to those who were ineligible to vote (chi-square = 20, p value <0.001), among the therapeutic workforce there was no significant difference in their morale (chi-square = 1.63, p = not significant). Similarly, intentions to vote in favour or against AfC if a ballot were held today were in line with this finding.

In summary, while diagnostic radiographers who qualified prior to 2004 were more likely to say their morale had been affected and they would not vote for AfC than those who qualified after that time, this difference was not seen amongst therapeutic radiographers.

## **4.6 Annex T, on-call arrangements and split contracts**

### **4.6.1 Annex T**

Annex T is intended to provide an accelerated progression for newly qualified staff at band 5 under AfC. Sixty-one staff who had first registered in 2008 were represented in the survey. Sixty were working at band 5 and one at band 4. Most of these (87%) were female and 95% were working full-time. Two thirds of the sample (67%) were working in diagnostic imaging. One third (33%) were therapeutic radiographers. Interestingly, the majority (59%) of these new graduates did not know whether annex T was recognised by their employer or not.

The majority (58%) expected to progress to band 6 in 1 – 2 years and the same percentage was prepared to move and change employers if they did not. Almost a quarter (22%) said other reasons would keep them in their current location regardless of whether they secured a band 6 position or not. A small percentage (10%) felt they might move, and another 10% was unsure (fig 125).

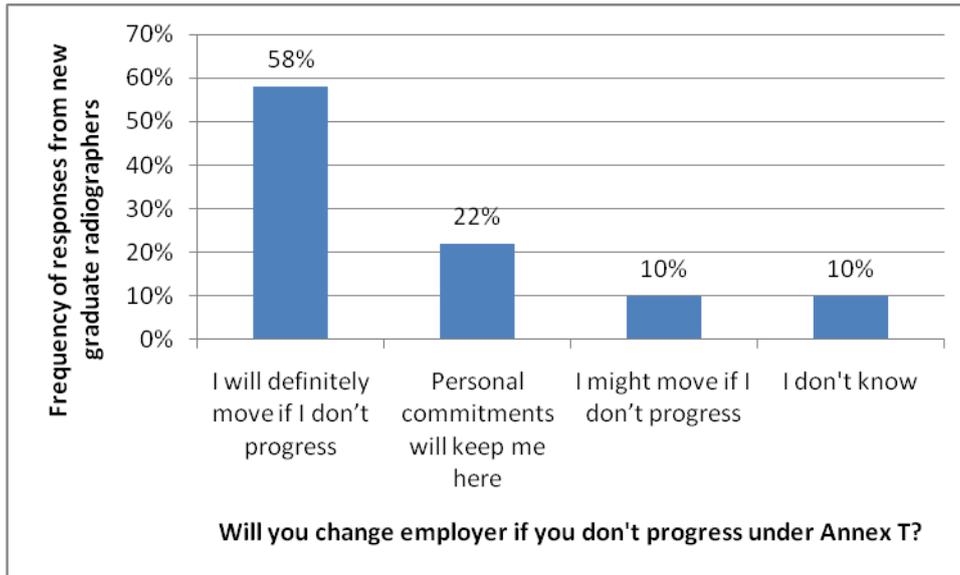


Figure 123: New graduate radiographer responses to career progression under Annex T

#### 4.6.2 On call arrangements

The survey asked band 5 and 6 radiographers to specify how they were paid when practising out-of-hours as a lone worker. Out of those who answered this question, most band 5 radiographers receiving AfC rates when on-call were paid at band 5 when acting as lone workers. A small number (9) received band 6 payment. All band 6 radiographers receiving AfC rates when on-call were paid at band 6. None reported receiving a lower amount (Figure 124).

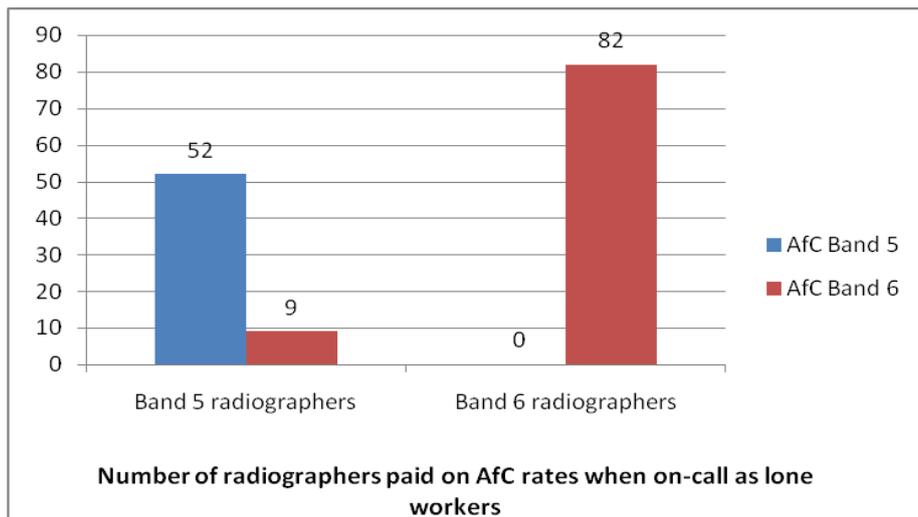
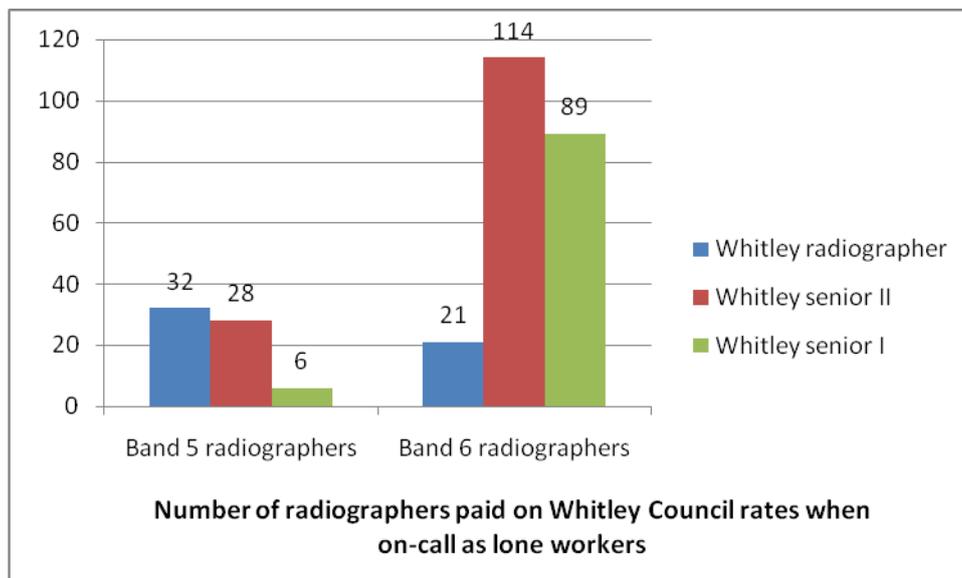


Figure 124: Radiographers receiving on call payments at AfC rates

However, most radiographers in the survey reported that they still received on-call payments under the old Whitley Council system. Under these terms most band 5 radiographers were paid at radiographer grade or senior II grade. The majority of band 6 radiographers were paid at senior II or senior I grade when on-call, although small numbers (21) reported receiving a lower payment when on-call compared to within their normal working hours (Figure 125).



**Figure 125: Radiographers receiving on call payments at Whitley Council rates**

### 4.6.3 Split contracts

Since the implementation of AfC, there have been anecdotal reports of staff holding split contracts where, for part of their working week they were paid at one band, but for the remaining hours, or when performing other duties, they were paid at a different band. This study uncovered 25 examples of split contracts, seven of which involved staff being paid at a higher rate for clinical/educational responsibilities compared to their other duties, five involved mammographers, four sonographers and the remaining examples included responsibilities regarding reporting, MRI, CT, nuclear medicine, DEXA scanning, pain management and just two therapeutic roles.

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## 5. Issues arising from the report

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The results from this survey provide a comprehensive picture of the radiographic workforce in the NHS in England and Wales five years after the start of the AfC roll-out. Overall, results indicate that AfC has not been well received. Before its inception the majority of the workforce voted to oppose it (SoR 2004). Despite promises of pay increases for many, large numbers of radiographers were against AfC due to the proposed increase of 2 ½ hours to the working week (SoR 2003). This was viewed as unacceptable five years ago and was still cited by many of the survey participants as their greatest reason for feeling dissatisfied with AfC.

However, this study was concerned with investigating the impact of AfC on the career progression of the radiographic workforce rather than on pay or length of the working week. Nevertheless, it is acknowledged that basic terms and conditions affect greatly workers' morale, goodwill and their perceived ability to progress. Therefore, it is impossible to consider issues affecting career progression whilst ignoring responses relating to hours and salary.

### 5.1 Expectations for career development and progression

This study has demonstrated that certain sections of the radiographic workforce felt that their expectations and career progression were adversely affected from the start of AfC implementation. During the assimilation process, although large numbers of staff were banded as they had anticipated, many were assimilated to lower pay bands whilst colleagues performing similar duties in the same department or at other sites were banded higher. Managers receiving inadequate training to handle the roll-out of AfC was cited frequently by key stakeholders and survey participants as the main reason for the inequitable nature of the assimilation process.

Our results suggest that, in general, radiographers and senior II radiographers who were banded 5 and 6 were satisfied, as were senior I radiographers who were assimilated to band 7. Those who were most frequently disappointed were senior I radiographers who were banded 6, and superintendent III radiographers who were banded 7. Discrepancies were apparent amongst both therapeutic and diagnostic staff. Of the large numbers of senior I staff who appealed, only half of diagnostic and one quarter of therapeutic staff were successful, thus leaving a significant proportion disappointed and demoralised. AfC's pledge to harmonise working arrangements and deliver equal pay for equal work does not appear to have materialised in all sections of the radiography workforce.

The perception of incorrect assimilation from the start has far-reaching consequences on career development for these staff. Many have no expectations of being able to go forward in their careers, while others claim to have lost the desire to progress since they feel they are defined only by their salary band rather than by their experience and skills. Another important factor is the loss of good will which was highlighted as a potential issue by some of the interviewees prior to the development of the questionnaire. Repeatedly during the survey staff who were dissatisfied in relation to their own banding and/or the increase in hours described a lack of incentive to do anything more than the minimum required. This was most apparent among band 6 staff who felt they should have been assimilated to band 7.

Arguably, one of the strongest themes emerging from this study is that band 6 is too broad and should not accommodate staff who were graded senior I and II under Whitley Council terms. There is no way of differentiating between experienced and inexperienced band 6 staff. Those who were previously graded senior I and have much more responsibility and many years' experience have been placed on the same band as colleagues with far less experience and responsibility. In some cases, they had found themselves being paid the same rate as these less experienced colleagues who had progressed up the band while they had remained fixed at the top. A similar situation has emerged amongst the ultrasound workforce where many experienced sonographers reported being 'stuck' at the top of band 7, working alongside more junior sonographers for the same pay and with nowhere to progress. These issues have caused not just a loss of goodwill and reduction in morale but there are also reports of a loss of clear lines of authority and management in some departments.

The fundamental problem is that under AfC the radiographic workforce is defined by salary range rather than status. Gone are the old Whitley titles of senior and superintendent and in their wake are many reports of confusion and disappointment. Both participants and key

stakeholders indicate that the workforce needs to be defined by their role and practice, and this notion is supported further by our findings at sites where the CPF is recognised. In addition, there is evidence of better career development opportunities for the radiography workforce at sites using the CPF, therefore it is disappointing that its implementation continues to be patchy (Woodford, 2006).

## **5.2 Opportunities for career development and progression**

Regular appraisal is a fundamental element for staff development and forms a key part of AfC. Career development opportunities are likely to be highlighted at appraisal so it was interesting to find that radiographers' responses indicated that appraisals take place more frequently in departments where the CPF is in place. It is reassuring to find that the majority of all respondents have had an appraisal within the last 12 months, but nevertheless a considerable number claim to have had no appraisal for several years. Common reasons for this absence related not to a fault of AfC but to a culture in their departments that viewed appraisals as having no value and importance. This perception has to change if career development opportunities are to be increased and if morale is to be lifted.

Evidence indicates that in centres which have integrated the CPF, career development opportunities are more likely to be identified, the KSF is more likely to have been used to help formulate the appraisal, and radiographers are more frequently satisfied with their pay banding. The responses from the assistant practitioners and HCAs were similar too in that they were more likely to be satisfied with their banding in departments which recognised the CPF. Therefore, in view of the apparent influence of the CPF it is of concern that 33% of assistant practitioners and HCAs, 30% of diagnostic radiographers and 20% of therapeutic radiographers did not know if the CPF was in place at their centre or not.

Results indicate that in therapeutic departments there is a slightly better understanding of the KSF and utilisation of the appraisal system; more therapeutic radiographers (76%) compared to diagnostic radiographers (64%) are aware of the KSF competencies required to perform their role and therapeutic staff are appraised more frequently than diagnostic staff. However, there was no difference in how frequently the KSF was applied at appraisal (61% compared to 60% respectively). Reasons for this may be related to the fact that therapeutic departments are often smaller than diagnostic ones, which may make the appraisal process more manageable for appraisers. There were also comments from the stakeholder interviews suggesting that, overall, therapeutic radiographers were frequently banded higher than their diagnostic counterparts, which may account for their apparent greater awareness of the KSF and how to use it to further their career. This idea is supported by evidence from

the survey which indicates that radiographers in lower bands have more uncertainty regarding the use of the KSF compared to those in higher bands. Arguably, higher band staff will be more confident about their current role remit and their future career direction.

There was a strong indication that younger diagnostic staff were more likely to be given career development opportunities than older ones, but this trend was not apparent among the therapeutic workforce, which again suggests that their use of the appraisal system is more effective and more equitable. As we did not pursue this question further in the survey or interviews it is unclear why older staff are not offered development opportunities: amongst the possible reasons are that managers may believe them to be experienced and hence to not need development; or that managers do not perceive them as being interested in learning about the new technologies becoming available. Irrespective of the reason, this leads to inequitable treatment and, arguably, sets up a situation in which the skills of older workers may be underutilised. Managers and appraisers of diagnostic staff may need support to address and meet the needs of their older workforce, and harness this valuable source of expertise, especially in view of the fact that diagnostic imaging has an ageing workforce, more so than in radiotherapy.

Although few participants believed that the career development opportunities identified at appraisal would facilitate their progression to the next band the majority still wanted to access these opportunities. This is reassuring since arguably it indicates that although there were many reports of a loss of motivation and goodwill as a consequence of poor banding, there are still large numbers of staff who do wish to develop professionally even in the absence of any overt reward. The recent survey by Price et al (2009) revealed many examples of radiographers developing extended roles and, whilst some may acquire these roles with the hope of gaining increased pay, many are doing so solely out of enthusiasm for their work and professional pride. It is disappointing therefore that although AfC was designed to reward skills without the need to wait for vacancies to arise most participants report that the 'dead man's shoes' culture is still very much alive within their department. There were very few reports of centres where the acquisition and utilisation of additional skills allowed the individual to be escalated to a higher band in the absence of a vacancy, even though this is what AfC was supposed to facilitate. Most reported that they still had to wait for a vacancy and then apply in the usual manner, even if it was evident that their skills exceeded their current banding.

In addition to providing a new pay structure, AfC was also heralded as a means to develop new ways of working to improve service delivery (DH 2004). Although very few of the career development opportunities identified in this survey were new or innovative there were a few

examples where participants felt that, were it not for AfC they would not be accessing this particular role. These included some reporting radiographers, and one or two therapeutic activities including radiographer-led applicator removals within brachytherapy, and radiographer-led volume definition for CT planning. Some of the stakeholder interviewees claimed that many managers were not adequately prepared for AfC and therefore had to invest all their time and energy into job matching rather than developing new ways of working. A recent report from the National Audit Office (2009) supports this claim stating that most staff are not working differently from when they were on their old pay contracts. As disputes and inequities among the radiographic workforce are resolved over time, perhaps we will then start to see the emergence of more new roles and improved patient pathways as per the original AfC remit. Certainly stakeholders predicted that one of the anticipated benefits of AfC further in the future may be the development of more high end staff and more advanced roles amongst the radiographic workforce, which will, of course, facilitate career progression for some.

In line with predictions for future career progression and more advanced staff, it was evident from our survey that, in general, staff occupying higher band positions were less negative towards AfC and more positive towards their own career development. The most negative were those in bands 5 and 6 and who had been qualified the longest. Solutions to improving the experiences and attitudes of these staff are not easy to find but efforts to identify ways to improve parity of banding between trusts and addressing blocks to progression would be a start. It is also worth noting that, as professionals, radiographers are expected to maintain and improve their practice regardless of reward. The Health Professions Council (HPC) is due to commence its audit of evidence of radiographers' Continuing Professional Development (CPD) later this year (HPC 2009). Those radiographers who currently feel disillusioned and that their career is stagnant will need to be mindful of this. For the benefit of their patients they will be required to continue to remain up-to-date regardless of personal grievances or else opt for other employment.

In view of the impending HPC audit, it was disappointing to see that very few participants from any quarter of the workforce enjoyed protected study time from their employer. Only approximately 13% receive any regular study time and, for some, this was as little as one hour per month. Therapeutic radiographers receive, on average, more than diagnostic radiographers. While the majority recognised a variety of CPD opportunities within the workplace most (87%) claimed to receive no time to access them. Research continues to be the CPD activity accessed least often, and even smaller numbers of participants claim that research form a regular part of their duties. This is frustrating considering undergraduate

degrees have been in place now for almost two decades. Evidence from the Scope of Radiographic Practice 2008 survey (Price et al 2009) indicated that large numbers of therapeutic radiographers were engaged in active research compared to far fewer in imaging. Our results show that only 13% of therapeutic radiographers claimed that research formed a significant part of their regular duties but, proportionally, this is still more than double the diagnostic responses, which indicated only 6% were research active. According to the recent 'High Quality Care For All' publication (DH 2008) which advocates new ways of working, and in line with the philosophy of AfC employers should provide more opportunities for radiographers to engage in collaborative research for the benefit of patient services, to raise the profile of the profession, and as a method of enhancing and improving radiographers' career development.

### **5.3 Barriers to career development and progression**

It is inevitable given that so many respondents have antipathy towards AfC that they would also see it as being a barrier to career progression. This was the case for all categories of staff, the highest proportion of these responses coming from assistant practitioners and HCAs at 68%, but with 58% of diagnostic radiographers and 52% of therapeutic radiographers also indicating they believed this to be the case.

Although the barriers perceived by the respondents were varied there were common themes. Many cited financial barriers to career progression and were unhappy that they had been required to fund further study themselves. Even when they did (and frequently respondents did report doing so), many were still not allowed any protected study time, having to attend courses in their own time.

Under-staffing and increased pressures from government targets were also cited by many as key barriers to career progression. Even if funding can be found, it seems rare that participants are afforded time off to attend. These 'vicious circle' situations sap the morale of staff, make them feel undervalued, and powerless to progress.

In addition, a lack of investment was frequently identified as a problem in other respects, as highlighted by a respondent who stated that for many years radiographers had x-rayed orbits prior to MRI and, when no radiologist was available, had also decided whether or not to proceed with the MRI examination if no foreign body was seen. Under AfC they had been prevented from continuing this practice as it was alleged it would have led to the radiographers being banded at 7. Clearly in this case financial expediency had been put before patients' interests and had taken priority too over decisions about the best utilisation of individuals' skills.

In another case, one respondent's view was that some radiographers do the job of a radiologist but are not supported with anywhere near the study time or available resources to which medical staff have access. There are reports also of radiographers and assistant practitioners being told by their managers not to bother with accessing career development opportunities because their pay band will not change in spite of what they do. This is in complete opposition to the ethos of AfC. One radiographer was told that although there would be no career advancement beyond band 7 she would be trained to consultant level and her skills would be utilised. To utilise someone's skills but not recognise them for banding purposes is a prime illustration of taking advantage unfairly of an employee's goodwill and enthusiasm. Equally, the willingness of the employee to develop their skills regardless is another example of radiographers' dedication and professionalism. One possible response by a radiographer placed in such a position may be to take the development and move on, but moving may not always be an option. There are often very good reasons, including commitments outside the workplace, why sometimes people are unable to move. This was supported by the fact that only just over 11% of respondents had moved to another employer since the advent of AfC. Those who had, had relocated largely for career progression purposes. It was clear that others were looking to move to advance their careers, but as one respondent said "I shouldn't have to move to progress" and if the intention of AfC is for individuals to develop their skills and progress, why indeed should they still have to move in order to do so?

Further disappointment was evident from the belief that in a number of cases radiographers were not supported by their line manager; some respondents going so far as to say that their line managers were disinterested and others saying that they felt discriminated against on grounds of age, gender or race. In one case, a radiographer who was also a working mother was told by her manager "You choose a career or children, not both". With a number of the examples given there would seem to be the basis for radiographers pursuing these matters in another forum.

As for some of the barriers cited above, many of the other examples given by staff of challenges to progress did not have their origins in AfC. For example, as in the earlier study by Price et al (2009) it is still reported that radiologists constitute barriers to career progression for some diagnostic staff. Several respondents claimed that they had developed accredited reporting skills but were 'not allowed' to practise these skills because of radiological opposition. This was clearly preventing staff from utilising post graduate qualifications and becoming advanced practitioners. It was suggested that radiologists were reluctant to release certain examinations to radiographers as there is sometimes hostility from other medical consultants "who see radiographers' reporting as sub standard to a

radiologist's report when it can be the other way round." This is a key point which needs to be challenged. If there is evidence that radiographers cannot perform at the required standard that is one issue but there does need to be clear evidence of this and such decisions should be consistent and not on the whim of individuals. Resistance from radiologists, however, does seem to be decreasing rather than increasing. It was heartening to see that more participants in this study cited radiologists as a help to their career progression than a hindrance.

Interestingly, history appears to be in the process of repeating itself, since some assistant practitioners now claim radiographers are a barrier to their progression. There are reports of hostility from radiographers towards the role of assistant practitioner, and claims that radiographers' development needs are put before those of the assistants. These claims were supported by events at a recent conference where a motion was put to an audience of over 200 radiographers to investigate the possibility of facilitating progression of band 4 assistants to band 5. The conference voted overwhelmingly against the motion (SoR 2009).

The 'glass ceiling' phenomenon was felt acutely by many groups of respondents in this survey, and arguably solutions to this major barrier to career progression will remain difficult to find. Staff in bands 4, 6, and 7 complained frequently that they are 'stuck at the top of their band' with no hope of progressing, and this is a significant contributing factor to low morale. Many participants can see no incentive for taking on more study, more responsibility, or more commitment in relation to their role when they will not be rewarded financially or even have it acknowledged in their job title. Equally, they state that currently they are working alongside others who do less for the same salary. Clearly this situation is totally at odds with fuelling career development and needs to be addressed as soon as possible. In theory, a new nationally accepted system of professional titles, which reflect workers' skills and experience, may go some way to restoring, in those who have lost it, the incentive to progress.

Following The NHS Plan (2000) and Meeting the Challenge: A Strategy for the Allied Health Professions' (2000) the introduction of AfC and the CPF made it a reality for radiographer consultant posts to be introduced. However, one respondent was told by their manager "there is only progression if there is a vacancy despite working above banding" as an explanation for being denied access to training courses, with the follow-up comment allegedly being that there would "never be a consultant radiographer in our trust". What hope is there for opportunities and progression if leaders and managers of the radiographic profession are not forward thinkers?

Irrespective of whether they arise as a consequence of the arrival of a new pay structure or if they arise through either old prejudices or operational issues, barriers are there to be overcome. Radiographers have proven themselves to be a resilient and tenacious workforce. As one consultant radiographer commented “once individual issues are resolved, and this takes time, then career development can usually happen”. Certainly, it is within the scope of the SCoR to address some of the issues reported here.

#### **5.4 Incentives for career progression and development**

Approximately a third of all respondents acknowledged that, in addition to experiencing barriers, they had also experienced certain incentives, events or catalysts which had helped their career development. Some 37% of assistant practitioners and HCAs acknowledged these incentives, compared to 34% of therapeutic radiographers and just 29% of diagnostic radiographers. The primary incentive or advantage that all groups, and in particular assistant practitioners, recognised as being a help was having good support from managers and peers. Conversely, poor managers were frequently blamed for stalling career progression, as some of the cameos above illustrate. The importance of good guidance from enthusiastic and professional managers should not be underestimated and this was underscored by some of the key stakeholders who observed that AfC was, in their opinion, a vehicle which exacerbated poor management. Many participants have indicated that they agree in principle with the AfC intentions but that they have been manipulated and selectively implemented by managers:

*The concept of AfC remains a good one. The implementation of it is a positive disgrace, and one which the radiology department should be deeply ashamed of being a part.*

Our findings indicate that this point may be fundamental to much of the animosity shown by the workforce. If this is the case, the only remedy to improve harmony may be enforced standardisation. Further incentives for career progression identified by radiographers (in addition to good managers) include self motivation and supportive radiologists. Again, this demonstrates the tenacity of this workforce, and equally, highlights the fact that whilst some radiologists can be obstructive to diagnostic radiographers' progression, this should not allow the fact that many radiologists are facilitators of progression to be eclipsed. In general, those in higher pay bands acknowledge more frequently factors which have helped their progression, which suggests they are perhaps less preoccupied with hours and banding and more in tune with their overall career development.

## 5.5 Morale

The majority of the radiographic workforce, in every area of practice, claim that their morale is lower since the implementation of AfC and this is unsurprising in view of the experiences described. The experience of the radiographic workforce correlates with the experiences of nurses (Ball & Pike 2006). Few have positive feelings towards AfC although there are more examples of staff in higher pay bands and staff who qualified recently who report an increase in morale as a consequence of AfC compared with those in the lower pay bands or who entered the profession some years ago.

Particularly noticeable is the steady increase in morale in radiographers in pay bands 8a and above, which concurs with Buchan & Evans' (2007) findings that those who felt as if they were the 'winners' in AfC tended to be senior health professionals. Radiographers in bands 5, 6 and 7 most frequently reported decreased morale. Equally, only assistant practitioners paid at band 4, the highest possible for assistants, felt an increase in morale since AfC. Not one individual in bands 2 or 3 reported that their morale had improved.

There are, however, many radiographers in the higher bandings who do not feel that their morale has increased under AfC even though they now receive a higher salary than if they were paid at Whitley Council rates. The reasons for this are multi-faceted, and clearly morale in the workplace is a complex issue (NAO 2009). One of the most important factors may be length of time in the profession. Diagnostic radiographers who had qualified in 2003 or earlier, and therefore had worked under both Whitley Council and AfC terms and conditions, were significantly more likely to feel their morale was lower since the introduction of AfC. This trend was most noticeable amongst band 5 radiographers. At first this seems at odds with the revelation that band 5 radiographers were the group that most frequently reported the identification of career development opportunities at appraisal. However, on closer inspection it transpires that it was band 5 radiographers who qualified before 2004 who were most likely to report lowered morale.

Interestingly, voting patterns correlated with responses on morale. Participants were invited to say how they would vote with regards to AfC, if a ballot was held today. Diagnostic radiographers who qualified in 2004 or later were significantly more likely to vote in favour of AfC compared to those who qualified earlier. Conversely, among the therapeutic cohort there was no difference in voting intentions regardless of how long the individuals had been qualified. Again this indicates that, as with appraisals, bandings, and career development opportunities, therapeutic staff fared better in some instances compared to their diagnostic colleagues. Equally, staff in higher pay bands were more likely to vote in favour of AfC.

Our findings demonstrate that morale is not only linked with length of time qualified but also with access to career development opportunities. Those who qualified after 2003 were significantly more likely to have had development opportunities identified at appraisal, which is a probable factor for maintaining their morale. Indeed, this same group were far more optimistic, compared with those who qualified in 2003 or earlier, that the opportunities to enhance their professional development might also facilitate their progression into the next pay band. However, it is acknowledged that some staff who may have personally benefitted from AfC may still feel their morale is lower; if they work in an environment where they perceive inequity among staff or if they have friends or colleagues at other sites who may have been 'losers' in AfC (to use Buchan and Evans' phrase), these staff may still feel negative as demonstrated by this respondent: *'Whilst AfC has been beneficial to my own personal circumstances I feel it has been divisive in many ways for other staff leading to discontent and staff feeling disillusioned.'* Equally, it could be argued that newly qualified staff are obviously more likely to be offered career development opportunities to help them reach the required level of a more experienced member of staff. And conversely, the more experienced staff will not need some of the more basic career development activities since they will be competent already in these areas. Unless the types of opportunities identified by participants were analysed in more detail, it remains difficult to assess accurately any potential inequalities.

Lower morale amongst staff who have been qualified for longer or are in lower pay bands could, however, be related to their perception of the appraisal system. Many participants thought appraisals were a waste of time and just a 'paper exercise' with no value. Others said their managers were simply not interested in helping them develop their careers. What is not clear from this study is where the fault lies within the system. Perhaps managers have more time for newly qualified staff. Perhaps they see them as the future and therefore offer them more development opportunities whilst neglecting to provide equity for the longer serving staff. On the other hand, some of these longer serving staff may be more reluctant to take on additional tasks and responsibilities for reasons already stated and would prefer to stay within their 'comfort zone'. Comments from participants support both suggestions. However, as the Health Professions Council prepares to begin auditing radiographers' continuing professional development evidence at the end of this year, it is clear that all staff must be encouraged to engage in lifelong learning (HPC 2009). Perhaps the impending audit may help to minimise apathy towards professional development, regardless of whether it is on the part of the appraiser or appraisee. Nevertheless, further research into attitudes of staff towards appraisals and how to improve the appraisal system is recommended.

Although the majority of the workforce felt their morale was lower since the implementation of AfC, well over a third felt that AfC had had no effect at all on their morale. In view of the general negativity which tends to accompany discussions involving AfC it is important to acknowledge that many staff feel it has had little, if any, impact on their working lives. This opinion was held also by some of the key stakeholder interviewees who felt that AfC had had much less impact than anticipated or expected. Evidence obtained from this study and previous studies indicate that other factors, which participants do not attribute to AfC, continue to affect morale and these include under-staffing and under-funding (Arnold et al 2006; Price et al 2009).

In a similar vein, although the majority of all divisions of the workforce would vote against AfC, a significant minority (around 25%) are unsure how they would vote if a ballot were held today. Arguably, this group feels ambivalent towards some aspects of AfC and is still waiting to be convinced of its value. Our results indicate also that people are not just responding automatically in order to stay consistent with their original position if they voted against AfC in the SoR ballots. Comments from both key stakeholders and from survey participants frequently implied that the principles of AfC are good and that Whitley Council was out-dated, but that the implementation of AfC has been patchy and inequitable. If trusts were encouraged to apply the AfC terms and conditions more uniformly it is likely that many staff may feel more positive towards AfC and therefore their own careers.

In summary, morale among the radiographic workforce appears to be lower since the implementation of AfC. Equally, the majority state they would vote for dissolution of AfC if given the chance. But would a return to Whitley Council conditions solve the current dissatisfaction? Many participants and stakeholders recognised that Whitley was outmoded and needed replacing, and that AfC per se may not be responsible for all it is accused of.

## **5.6 Annex T**

Since the implementation of Annex T is directly related to career progression for new graduates to the profession and is endorsed by the SoR (2005), it was appropriate to investigate the experiences of new graduates within their trusts. As anticipated, the new workforce appeared enthusiastic and mobile with the majority claiming that they would be prepared to change employers in order to progress to the next pay band. What was surprising, however, was that the majority also (59%) did not know whether their current employer recognised Annex T or not. Clearly, although the place of work for some new graduates will be governed by personal factors, efforts are undoubtedly required from the SoR to heighten awareness of Annex T so that new graduates may be more discerning

about their choice of employment. This is likely to have the knock-on effect of encouraging more employers to recognise Annex T if recruitment may become more difficult in its absence.

## **5.7 On-call arrangements**

Although payment for on-call and emergency cover was not the focus this work, it was still relevant to investigate current arrangements since they impact on staff morale and perception of equity. The old Whitley Council payment arrangements stated that radiographers working on call under clinical supervision of a senior radiographer or above would receive the mean of the radiographer scale plus 50%. Lone working unsupervised radiographers would be paid at the minimum point of the senior II salary scale plus 50%. This was in recognition that in working alone the radiographer would be required to work at a level requiring skill and responsibility which was above that of a nearly qualified radiographer. Section 2 of the AfC NHS Terms and Conditions of Service Handbook (NHS Staff Council, 2009) describes how assimilation from Whitley Council to AfC on call payments would occur. No longer would band 5 radiographers be paid at a higher grade for unsupervised work as in Whitley, but those on the 1<sup>st</sup>, 2<sup>nd</sup> or 3<sup>rd</sup> increment of band 5 would be paid at the 4<sup>th</sup> increment as a minimum. In addition, under AfC radiographers on call are given a percentage pay enhancement, with the more on-call cover provided, the higher the percentage, up to a maximum of 9.5% (CSP 2007; NHS Staff Council, 2009; NHS Whitley Council 2004).

It was interesting to find that the majority (67%) of respondents in the study still retained Whitley Council payment arrangements for on-call duties, with most being paid at senior II grade. Only a third of respondents had been assimilated to the AfC payscale for on-call payments. Since the AfC and Whitley Council on-call rates do not match, this is another example of inequity between trusts.

The NHS Staff Council is reviewing on-call arrangements and completion for this review is expected by September 2009 (DH 2007). The review promises equal pay for work of equal value but since this pledge does not appear to have been honoured in some other areas of radiographic practice it is likely that inequities will continue. Implementation of new on-call payment arrangements is anticipated for April 2010 and until then, sites will keep their current local agreements. In view of past experiences around implementation of earlier AfC terms and conditions, it is appropriate for the SoR to work closely with the NHS Staff Council in order to ensure a fair system is introduced across the radiographic workforce.

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## 6. Conclusion

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The Whitley Council framework adopted by the NHS at its outset had clearly ceased to be fit for purpose. The failure of the framework to recognise radiographers wishing to develop a clinical career pathway or align this with a fair system of pay was a real shortcoming. On reflection it is difficult to see how the Whitley Council arrangement survived for nearly 60 years in the NHS.

The concepts of AfC and the NHS KSF were sound and represented an admirable attempt to introduce transparency in determining levels of pay relative to the knowledge and skills of the workforce. The potential for aligning career progression with a pay structure that recognised clinical career pathways promised much, although a majority of members of the SoR, as evidenced by the ballots on AfC, were not impressed or considered other factors to be more important. Many would feel their misgivings had been justified by the findings of this research although it appears that opinions have in many cases been influenced by the way in which implementation of AfC was managed.

The judgement of the majority of the respondents to the study is that poor implementation of AfC has hindered acceptance despite any promises it may have held. To expect that in an organisation the size of the NHS everyone would be satisfied with their individual outcome was unrealistic despite the appeals system to deal with any objections. Evidence from this work suggests AfC has been implemented selectively and variably, and inequity is rife both within organisations and between organisations. Many staff were disillusioned from the start and have found it impossible to recover from what they perceive as the insult of being wrongly banded initially. Many other senior staff report a feeling of loss of professional identity by being banded equally with individuals with often far less experience and qualifications.

The overriding beliefs were that under funding, understaffing, feeling 'stuck' in their band and poor support from managers are the main factors hindering progression. Furthermore many

believe that AfC was a money saving exercise, and that appraisals are not taken seriously by managers.

The SCoR had the foresight to introduce the CPF at the beginning of the decade. The introduction of AfC and the KSF was timely in that they could have been the vehicles and the opportunities of promoting the CPF. Indeed this was the case with those managers who had the foresight, the means and leadership skills to grasp the moment. However, it would also be fair to say that not all managers would appear to have been persuaded by the merits of the CPF and even if they were there is evidence to suggest that financial restrictions in a number of organisations constitute substantive barriers. Overall, there is little evidence of AfC positively influencing new ways of working and career progression for the radiographic workforce. This was certainly the view of the majority of respondents in this study although staff in centres where the CPF is recognised appear more satisfied with their career progression and claim to enjoy more development opportunities. Since appraisals and the KSF lie at the heart of the career progression element of AfC, these findings may provide a fundamental insight into the actions that could be taken to improve career progression for the radiographic workforce.

Almost equal numbers in this study indicate that AfC has had little influence either way on their career development and believe that other unrelated factors have helped or hindered their progress.

Not all of the views were negative. There was a small minority within the study who felt that AfC exerted a positive influence over their career. These tended to be staff on the higher bands, therapeutic staff and recently qualified radiographers as opposed to others on lower bands, diagnostic radiographers as a whole and those who have been qualified many years. Arguably, it could be said that the former groups are more pro-active in taking responsibility or had the means at their disposal to influence for their own career progression.

The SCoR is clearly concerned with the current situation of its membership and this is demonstrated by the commissioning of this investigation. Our findings will assist the SCoR in influencing changes within the working environment of the radiographic workforce to ensure more of the potential benefits of AfC are realised.

Finally, one participant sums up the feelings of the many who contributed to the study:

*The philosophy of everyone being equal regardless of profession and location hasn't worked out. The same jobs in different trusts are different bands. Even in the same trusts, jobs are not banded equally. The suggestion of one on-call system for all is*

*unworkable. The success of KSF depends more on the manager than anything else, and good managers don't need KSF to ensure training opportunities.*

## 6.1 Summary

AfC promised much but inequitable implementation has thwarted full realisation of its potential.

The majority of the radiographic workforce is dissatisfied with AfC in relation to their career progression. A large proportion feels it has had no effect, and less than one in ten has a positive view of AfC.

The CPF is viewed positively and staff are more satisfied with their progression in sites where it has been adopted.

Staff are against being defined by their salary band, and feel that professional identity and status has been lost with the removal of the Whitley Council grades.

## 6.2 Recommendations

In view of the findings emerging from this investigation the following recommendations to the SCoR are made:

- Encourage and facilitate greater standardisation and harmonisation of roles across trusts in line with the spirit of AfC
  - i) by pursuing high level discussions with the Departments of Health
  - ii) by working closely with the NHS Staff Council to guarantee as fair a system as possible in advance of new on call arrangements
- Expedite the integration of the CPF in all departments, and encourage the use of the KSF at appraisals
- Increase support and develop better training programmes to help managers value appraisals and conduct them more effectively
- Promote the advantages and benefits of protected study time for the workforce, and promote radiographers' active engagement with research
- Develop a new contemporary system of professional titles, which may go some way to restoring professional identity, which many feel has been eclipsed by AfC banding

- Through the use of the SCoR website, invite trust managers to provide information on whether they recognise the CPF and Annex T, whether they provide protected study time, and whether they appoint consultants. This will enable the mobile workforce to be more discerning as to where they seek employment.

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## **Appendix 1: Online survey**

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## Effect of Agenda for Change (AfC) 2009 Questionnaire

Please complete this survey only if you are a therapeutic or diagnostic radiographer, assistant or helper working in the NHS in England or Wales. If you are completing it at work please ensure you are not delaying any patient service.

All questions are optional and there are 44 questions in total. Tick one response only unless asked to give multiple responses. Completing the questionnaire should take less than 20 minutes.

### Section 1: Demographics & Personal Information

**1. Please indicate the type of establishment in which you work:**

- |                           |                          |                                  |                          |
|---------------------------|--------------------------|----------------------------------|--------------------------|
| NHS teaching hospital     | <input type="checkbox"/> | NHS foundation trust             | <input type="checkbox"/> |
| NHS non-teaching hospital | <input type="checkbox"/> | Primary care trust/Community     | <input type="checkbox"/> |
| Cancer centre             | <input type="checkbox"/> | Other ( <i>please describe</i> ) | <input type="checkbox"/> |
- .....

**2. Please indicate the health region in which you work:**

- |               |                          |                  |                          |                      |                          |
|---------------|--------------------------|------------------|--------------------------|----------------------|--------------------------|
| Wales         | <input type="checkbox"/> | South East Coast | <input type="checkbox"/> | East Midlands        | <input type="checkbox"/> |
| London        | <input type="checkbox"/> | North West       | <input type="checkbox"/> | East of England      | <input type="checkbox"/> |
| South West    | <input type="checkbox"/> | North East       | <input type="checkbox"/> | Yorkshire and Humber | <input type="checkbox"/> |
| South Central | <input type="checkbox"/> | West Midlands    | <input type="checkbox"/> |                      |                          |

**3. Please identify the type of location in which you work:**

- City                       Town                       Rural setting

**4. Please state your gender:**

- Male                       Female

**5. Please tick the category which best describes your ethnic origin:**

- |   |   |
|---|---|
| <b>White:</b>                                   | <b>Black or Black British:</b>                  |
| British <input type="checkbox"/>                | Caribbean <input type="checkbox"/>              |
| Irish <input type="checkbox"/>                  | African <input type="checkbox"/>                |
| Other White background <input type="checkbox"/> | Other Black background <input type="checkbox"/> |

**Mixed:**

- White and Black Caribbean   
 White and Black African   
 White and Asian   
 Other Mixed background

**Asian or Asian British:**

- Indian   
 Pakistani   
 Bangladeshi   
 Other Asian background

**Chinese or Other Ethnic background:**

- Chinese   
 Any other Ethnic background

**6. Please indicate your age range:**

- |         |                          |         |                          |         |                          |
|---------|--------------------------|---------|--------------------------|---------|--------------------------|
| 18 – 25 | <input type="checkbox"/> | 36 – 40 | <input type="checkbox"/> | 51 – 55 | <input type="checkbox"/> |
| 26 – 30 | <input type="checkbox"/> | 41 – 45 | <input type="checkbox"/> | 56 – 60 | <input type="checkbox"/> |
| 31 – 35 | <input type="checkbox"/> | 46 – 50 | <input type="checkbox"/> | 61+     | <input type="checkbox"/> |

**7. Please indicate your area of practice:**

- Diagnostic Imaging  Radiotherapy  Both Diagnostic & Radiotherapy

**8. Are you full-time or part-time?**

- Full-time  Part-time

**9. If you are a qualified radiographer please indicate your qualification on entry to the profession and the year you gained registration (*non-radiographers please go to question 10*):**

- DCR(R)  DCR (T)  DCR (R&T)  BSc (R or T)  BSc (or equivalent) Other

Year: ..... (Please enter four digits e.g. 1986) Now go to question 11.

**10. If you are a Healthcare Assistant or Assistant Practitioner please state your highest relevant qualification and the year that you obtained this.**

- Healthcare assistant  Assistant Practitioner

Qualification:.....

Year: ..... (Please enter four digits e.g. 1986)

**Section 2: Current Role and AfC:**

**11. Please state your current job title and Agenda for Change (AfC) pay band:**

Job Title:.....

- |        |                          |         |                          |         |                          |
|--------|--------------------------|---------|--------------------------|---------|--------------------------|
| Band 2 | <input type="checkbox"/> | Band 6  | <input type="checkbox"/> | Band 8C | <input type="checkbox"/> |
| Band 3 | <input type="checkbox"/> | Band 7  | <input type="checkbox"/> | Band 8D | <input type="checkbox"/> |
| Band 4 | <input type="checkbox"/> | Band 8A | <input type="checkbox"/> | Band 9  | <input type="checkbox"/> |
| Band 5 | <input type="checkbox"/> | Band 8B | <input type="checkbox"/> |         |                          |

**12. Diagnostic staff: Which of the following areas best describe your current role? (you can indicate more than one choice if they are part of your *regular* duties)**

- |                |                          |                             |                          |             |                          |
|----------------|--------------------------|-----------------------------|--------------------------|-------------|--------------------------|
| General        | <input type="checkbox"/> | MRI                         | <input type="checkbox"/> | Mammography | <input type="checkbox"/> |
| Trauma         | <input type="checkbox"/> | CT                          | <input type="checkbox"/> | Education   | <input type="checkbox"/> |
| Orthopaedic    | <input type="checkbox"/> | PET                         | <input type="checkbox"/> | Research    | <input type="checkbox"/> |
| GI             | <input type="checkbox"/> | RNI                         | <input type="checkbox"/> | Management  | <input type="checkbox"/> |
| Interventional | <input type="checkbox"/> | Ultrasound                  | <input type="checkbox"/> | PACS/IT     | <input type="checkbox"/> |
| DEXA           | <input type="checkbox"/> | Other (please specify)..... |                          |             |                          |

**13. Therapy staff: Which of the following areas best describe your current role? (you can indicate more than one choice if they are part of your *regular* duties)**

- |                             |                          |                              |                          |           |                          |
|-----------------------------|--------------------------|------------------------------|--------------------------|-----------|--------------------------|
| CT Planning                 | <input type="checkbox"/> | Radiotherapy Isotopes        | <input type="checkbox"/> | Research  | <input type="checkbox"/> |
| Brachytherapy               | <input type="checkbox"/> | Treatment review/prescribing | <input type="checkbox"/> | Treatment | <input type="checkbox"/> |
| Counselling                 | <input type="checkbox"/> | Information & Support        | <input type="checkbox"/> | Dosimetry | <input type="checkbox"/> |
| Mould room                  | <input type="checkbox"/> | Treatment verification       | <input type="checkbox"/> | Education | <input type="checkbox"/> |
| Management                  | <input type="checkbox"/> | Pre treatment simulation     | <input type="checkbox"/> |           |                          |
| Other (please specify)..... |                          |                              |                          |           |                          |

**14. How long have you been in your current AfC band?:**

- Less than a year       1 – 2 years       2 – 3 years   
 3 - 4 years       Since implementation of AfC

**15. If you were employed on the same contract before AfC implementation, what was your previous grade (under Whitley Council terms and conditions)? (Please select one option only)**

- |                        |                          |                  |                          |                         |                          |
|------------------------|--------------------------|------------------|--------------------------|-------------------------|--------------------------|
| Healthcare assistant   | <input type="checkbox"/> | Senior 1/Supt 4  | <input type="checkbox"/> | District Superintendent | <input type="checkbox"/> |
| Assistant practitioner | <input type="checkbox"/> | Superintendent 3 | <input type="checkbox"/> | Other (please describe) | <input type="checkbox"/> |
| Radiographer           | <input type="checkbox"/> | Superintendent 2 | <input type="checkbox"/> | .....                   |                          |
| Senior 2               | <input type="checkbox"/> | Superintendent 1 | <input type="checkbox"/> |                         |                          |

**16. If you were employed before AfC implementation, what band did you expect to be placed on?**

- |        |                          |         |                          |                        |                          |
|--------|--------------------------|---------|--------------------------|------------------------|--------------------------|
| Band 2 | <input type="checkbox"/> | Band 6  | <input type="checkbox"/> | Band 8C                | <input type="checkbox"/> |
| Band 3 | <input type="checkbox"/> | Band 7  | <input type="checkbox"/> | Band 8D                | <input type="checkbox"/> |
| Band 4 | <input type="checkbox"/> | Band 8A | <input type="checkbox"/> | Band 9                 | <input type="checkbox"/> |
| Band 5 | <input type="checkbox"/> | Band 8B | <input type="checkbox"/> | No expectations/Unsure | <input type="checkbox"/> |

**17. Did you have to undergo an appeal process for your banding?**

Yes  No  (If No – please go to question 18)

**Was your appeal supported by your line manager?**

Yes  No  Unsure

**Were you successful in your appeal?**

Yes  No  Awaiting outcome

**18. Do you work on a split contract (this is where you are paid some of the time on one pay banding and some of the time on another)?**

Yes  No  Unsure

*If yes, please explain*

.....  
 .....  
 .....

**19. If you are a qualified radiographer acting as a lone worker on-call, at what rate are you paid? (if you don't work on-call please go to question 20)**

**Old Whitley Council rates:**

Radiographer <input type="checkbox"/>	Superintendent 3 <input type="checkbox"/>	District 2 <input type="checkbox"/>
Senior 2 <input type="checkbox"/>	Superintendent 2 <input type="checkbox"/>	District 1 <input type="checkbox"/>
Senior 1/Supt 4 <input type="checkbox"/>	Superintendent 1 <input type="checkbox"/>	Unsure <input type="checkbox"/>

**AfC Rates:**

Band 5  Band 6  Band 7  Band 8A  Unsure

**20. In terms of responsibility, do you feel your AfC band is fair?**

Yes  Unsure  No

*Please explain*

.....  
 .....  
 .....

**Section 3: Career Progression and Development:**

**21. Has your department implemented the Career Progression Framework (four tier system)?**

Yes fully  Partially  No  Unsure

**22. Do you know which of the NHS Knowledge & Skills Framework (KSF) competencies are required for individuals undertaking your current role within your AfC banding?**

Yes  No  Unsure

**23. When was your last appraisal?**

- Less than 1 year ago
- Less than 2 years ago
- Between 2 and 3 years ago
- Between 3 and 4 years ago
- Not since the introduction of AfC

If you have not had an appraisal since the introduction of AfC, please explain (*Then go to question 30*)

.....  
.....  
.....

**24. At your appraisal was the KSF used in formulating your personal development plan (PDP)?**

- Yes  No  Unsure

**25. Following your appraisal, were any career development opportunities identified for you? (If no, please go to question 30)**

- Yes  No

**26. Do you feel that the career development opportunities identified could facilitate your progression to the next pay band?**

- Yes  No  Unsure

*Please explain*

.....  
.....  
.....

**27. Do you feel that the identified career development opportunities were ones that you personally wanted to help support your long term career plans?**

- Yes  No  Unsure

*Please explain*

.....  
.....  
.....

**28. Are there any career development opportunities that you would have liked to have explored but have been prevented from accessing?**

- Yes  No

*Please explain*

.....  
.....

**29. In general, when career development opportunities are identified, how many are realised before your next scheduled appraisal/PDP meeting?**

All  Most  Some  Not many  None

**30. Have career development opportunities been identified for you outside of the appraisal system? (If no, please go to question 32)**

Yes  No

Please give example(s)

.....  
 .....

**31. Are these opportunities likely to assist your career progression and banding under AfC?**

Yes  No  Unsure

**32. Do you have regular access to Continuing Professional Development opportunities in the work place?**

Yes  No

If yes, please identify the activities:

- |                                     |                          |                              |                          |
|-------------------------------------|--------------------------|------------------------------|--------------------------|
| Attending occasional study days     | <input type="checkbox"/> | Attending in-house meetings  | <input type="checkbox"/> |
| Attending conferences               | <input type="checkbox"/> | Undertaking Audit            | <input type="checkbox"/> |
| Reading journals                    | <input type="checkbox"/> | Conducting original research | <input type="checkbox"/> |
| Being supervised/mentored by others | <input type="checkbox"/> | Training/teaching others     | <input type="checkbox"/> |
| Formal education courses            | <input type="checkbox"/> | In-house training            | <input type="checkbox"/> |

**33. Protected study time: on average, approximately how many hours per month protected study time does your department offer you?**

**Hours:**

- None
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8 or more

**34. Do you believe there have been any barriers to your career development and progression?**

Yes  No

If yes, please explain

.....

**35. Has anyone or anything really helped with your career development and progression?**

Yes  No

If yes, please explain

.....  
 .....

**36. Do you feel that the AfC has helped your career progression?**

- Yes definitely helped  Hindered a little   
 Yes a little  Definitely not helped   
 Neither helped nor hindered

*Please explain*

.....  
 .....

**37. Have you chosen to move to a different employer in order to achieve career progression since the implementation of AfC?**

- Yes  No

*If yes, please identify the influencing factors*

.....  
 .....

**38. How has AfC affected your own personal morale?**

Since the introduction of AfC my morale is

- Higher   
 Lower   
 Unchanged

*Please explain*

.....  
 .....

**For New Radiography Graduates only who qualified in 2008 (all others please go to Q 43):**

**39. Does your Employer recognise Annex T of AfC?**

- Yes  No  Unsure

**40. If Annex T has not been implemented is there an alternative linked-grading system in place?**

- Yes  No  Unsure

**41. How soon would you expect to progress to Band 6 level?**

- Within the next year  In 1 – 2 years  In more than 2 years  No expectation

**42. Do you feel that this likely time prior to progression will influence the time you remain with your current employer?**

- Yes  No  Unsure

*Please explain*

.....  
.....

**Section 4: AfC and voting**

**43. In 2003, if you were eligible to vote in the ballot organised by the Society of Radiographers, did you vote in favour or against the introduction of AfC?**

For  Against  Did not vote  Prefer not to say  Cannot remember

**44. If you had the opportunity to vote today, would you vote in favour or against AfC?**

For  Against  Unsure  Prefer not to say

*Please explain*

.....  
.....

**45. Please add any further comments regarding your opinions on AfC implementation and career development. If you are willing to be contacted in the near future by a member of the research team to discuss your views please leave your email address here. You will then receive an email providing instructions and further information if you still wish to contribute. Confidentiality is guaranteed, and you may withdraw at any time.**

.....  
.....

**Many thanks for completing this survey. Please return it in the envelope provided by 28.2.2009.**

Should you have any questions regarding your personal career progression under AfC please raise these with your Society Officer who can be contacted on 020 7740 7234.

If you require further information about the questionnaire please contact  
Hazel Edwards on 01707 285117

If you wish to be entered for the prize draw please leave your name and email address here.

.....

Winners will be announced in a future edition of Synergy News, however, your responses to this questionnaire are confidential and will not be linked to your contact details.

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## **Appendix 2: Key responses from the specialties**

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<b>Key responses related to area of practice</b>									
<b>Specialty (numbers of individuals)</b>	<b>Full survey (2373)</b>	<b>MRI (223)</b>	<b>Ultrasound (306)</b>	<b>Mammo- graphy (247)</b>	<b>RNI (73)</b>	<b>Diagnostic manager (251)</b>	<b>Pre-treatment simulation (124)</b>	<b>Treatment verification (156)</b>	<b>Therapeutic manager (132)</b>
<b>OPPORTUNITIES</b> Career development opportunities have been identified at my last appraisal	53%	57%	49%	58%	48%	56%	68%	59%	50%
<b>EXPECTATIONS</b> I believe these identified opportunities may aid my progression to the next band	21%	17%	13%	29%	17%	19%	29%	32%	23%
These development opportunities are the ones I wanted and will support my long term goals	54%	54%	57%	60%	52%	59%	66%	59%	59%
<b>BARRIERS</b> I feel I've been prevented from accessing some career development opportunities	37%	38%	38%	35%	45%	29%	33%	34%	31%
AfC has helped my career	8%	8%	8%	12%	6%	13%	4%	8%	12%
My morale is higher since AfC	3%	1%	3%	5%	3%	5%	1%	5%	7%
My morale is lower since AfC	60%	72%	61%	59%	67%	59%	62%	59%	52%
Today I would vote for AfC	8%	4%	11%	9%	3%	11%	6%	10%	11%
Today I would vote against AfC	71%	84%	68%	71%	82%	71%	68%	64%	62%