Greater Manchester Diagnostic Workforce Review - Endoscopy

Research briefing

August 2022

www.gmcancer.org.uk

Contents

1 Summary and recommendations

1.1 Summary

This project was an opportunity for Greater Manchester (GM) to focus on understanding more of its own specific challenges and successes around its diagnostic cancer workforce from a qualitative research perspective to ensure future workforce developments are driven by the workforce.

Information was collated through interviews and questionnaires with the Endoscopy teams across GM.

The findings have been developed into the following recommendations for consideration (details behind the recommendations can be found in section 5)

1.2 Recommendations

- Improve awareness of the Endoscopy roles in the local area to recruit a local workforce through promotional campaigns.
- Build on recruitment schemes that work well and see where else it could be applied.
- Develop a GM Diagnostic staff bank and explore the use of the NHS Reservists.
- Ensure pastoral packages are in place to support international recruits to gain confidence in the workplace and in their new culture to retain them.
- Engage with staff close to retirement to establish how they would like to work and ringfence attractive roles to retain them.
- Support succession planning for known leavers or planned retirement.
- Network to consider mitigation for attrition of Endoscopy Nurses due to 7-day working and subsequent recruitment and training for new Nurses
- Improve retention of lower banded grades/roles by growing our own and upskilling current workforce. Identify training opportunities and reduce barriers for progression e.g., Developing bookings team & clinical support worker/Technicians to Band 4.
- Develop clear development pathways for Nurses to access training opportunities to become a Clinical Endoscopist and Associate Nurses and support staff/Technicians to access Endoscopy specific training and remain in Endoscopy services.
- Support the network or Trusts to employ Practice education facilitators to improve training. Consider having one GM Endoscopy PEF spoke
- Provide CPD, support and mentorship for learners at every level. Explore development of a shared e-learning platform.
- Develop standardised roles with job descriptions, scopes of practice, pay bands and training curriculums to support network working.
- Engage with NW Endoscopy Academy & HEI's to identify opportunities to address GM issues and develop new and existing Endoscopists skills.
- Explore working with the NW Endoscopy academy to develop standardised training for new staff and introducing new roles.
- Develop a GM strategy to support improved recovery of services by increasing skill mix, upskill the current workforce and support the increase in the number of apprentices, assistant/associate practitioners, Clinical Endoscopists and Physician Associates to support recovery .
- Utilise the Digital Staff Passport to expedite training.
- Support the increase in number of trainers and assessors in GM linked to the NW Endoscopy Academy.
- Train non-registered staff to cannulate patients to improve workflow.

- Trusts to ensure bookings teams are adequately resourced, trained and well led. This will support maximum utilization of every available appointment in Endoscopy units.
- Explore hybrid posts/roles to provide development opportunities and improve retention e.g., joint clinical/educational/academic roles, professional bodies or working with other GI advanced practitioners.
- Review all payment rates across GM including overtime, additional shifts, and Waiting List Initiatives (WLI) to increase uptake and avoid staff leaving for the independent sector.
- Identify opportunities for new roles and working differently at Community Diagnostic centres (CDC).
- Agree GM standardised down time (appropriate for the room) between patients.
- Explore acceptable numbers of scoping procedures to be done each day/week by an endoscopist to reduce occupational injury. Support this with varied job plans.
- Senior leaders to meet and agree standardised staffing models and operating procedures. Define what staff are required in an Endoscopy room during a procedure.
- Standardisation of patient documents across GM to facilitate movement of staff.
- Support Medical Endoscopists to do more advanced Endoscopy. Explore benefits to undertake one list per week in a tertiary centre to support the workload and improve knowledge and skills.
- Trusts to regularly review their establishment in line with changes in demand – 1 room working per department at weekend by December 2023.
- Identify ways to make senior leadership roles attractive and support staff to gain skills to fulfil these roles.
- Develop a sustainability/green network across GM Endoscopy teams.
- Ensure every unit has a strong and clearly identified governance lead.
- Identify, promote and support BAME development and leadership opportunities.
- Improve access to health and wellbeing for all.
- Trusts to explore with staff how they can improve staff working conditions

2 Background

Health Education England (HEE) funded a Diagnostics workforce project via the Cancer Alliance Workforce Development Initiative funding, led by Greater Manchester Cancer Alliance (GM Cancer). The project aimed to work with providers across Greater Manchester (GM) to conduct an in-depth qualitative workforce review of the diagnostics workforce, focusing on the Endoscopy workforce. The core purpose of the review was to inform future diagnostic workforce solutions.

The need for radical investment and reform of diagnostic services was recognised at the time the NHS Long Term Plan[1] was published in 2019. The impact of COVID-19 on diagnostic services has been profound and has resulted in significant delays for cancer patients. This workforce review will support GM to implement some of the recommendations in the Mike Richards review[2] 'Diagnostics: Recovery and renewal', particularly 'Changing the shape of the diagnostics workforce'. The review will support new workforce models based on skill mix, competencies and the skills needed to deliver these services, rather than being restricted by professional group.

As a Region the NW has already made progress on starting to scope the potential requirements for our diagnostic workforce and particularly with regards to Endoscopy, including workforce planning priorities, training opportunities and much more. This work will allow GM to take ownership of understanding their own gaps and needs to enable efficient and effective implementation of the NW Endoscopy Workforce Strategy which is currently being finalised. It will also inform the implementation of initiatives to help drive forward the recommendations in the Mike Richards Review[3].

Endoscopy teams across seven NHS Foundation Trusts were invited to complete e-surveys and take part in detailed interviews. This was an opportunity to focus on understanding GM and EC specific challenges and successes around its Endoscopy workforce.

3 Methodology

A Qualitative approach was chosen to give the current and future workforce the opportunity to shape GM priorities as they are the experts. Quantitative data has its limitations and often there is a tendency to jump to solutions before fully understanding the true picture. This project has allowed a greater understanding of complex issues by breaking responses down into meaningful inferences, that are easily readable and understood by all. There has been a focus on how participants view their role and how they are valued within the wider system, looking at job satisfaction to understand how to best retain and recruit in the current and future challenging environment.

By using a more local approach to scoping the current situation and recognising the impact of any initiatives focused on retention of participants, this project has collated information that will inform any diagnostic workforce strategy by providing a realistic view of the current Endoscopy Workforce in GM.

[1] Framework is available following this link - https://www.england.nhs.uk/ournhspeople/

[2] Framework is available following this link - https://www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/

[3] NHS England » Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England

The main aims were to:

• Review the current Endoscopy workforce across Greater Manchester, with a focus on Endoscopy.

• Support the development of a GM Endoscopy workforce strategy and ensure alignment with the GM cancer workforce strategy.

• Inform what the priority areas are for the GM Endoscopy workforce and develop innovative Endoscopy workforce models in GM.

• Work with GM and NW Endoscopy workforce groups to develop proposals for potential diagnostic workforce pilots.

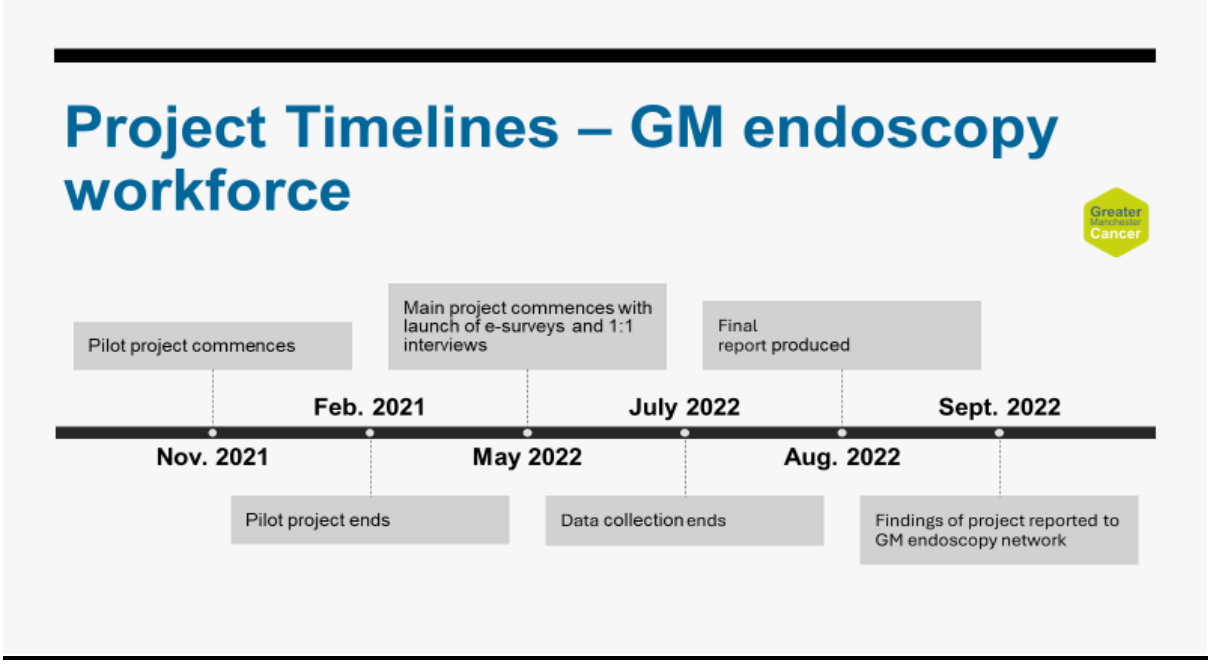
3.1 Pilot approach and deliverables

To support the project a subject matter expert (SME) was recruited. The SME was based at Salford Royal hospital and so it was agreed to pilot an approach at this site initially. Participants were invited to take part in an interview to talk about their views of their role within the Endoscopy Department at Salford Royal hospital, to discuss barriers/facilitators to the running of the service and to offer suggestions or ideas for improvements that could be made. The interviews (n=12) were transcribed for analysis and key findings were produced. The findings from the pilot report were presented to the senior management team in the Endoscopy department at the pilot site and following approval it was presented to the GM Endoscopy network.

3.2 Main project approach

Feedback received indicated that it would be difficult to proceed with 1:1 interviews with the Endoscopy workforce at every Trust across GM and just 1 project manager. Poor staffing levels, the pandemic, and increasing demand for Endoscopy services. would make it difficult to release participants at each Trust. The agreed approach was that e-surveys would be sent out to all Endoscopy service managers and a request was made to share the survey with their teams. Participants would be able to complete the e-survey at a convenient time from any location and indicate on the e-survey if they were available for an in-depth interview at a time convenient to them. Participants were also invited to contact the project manager directly if they did not wish to complete the e-survey and an interview was arranged.

3.3 Project timeline



4 Findings

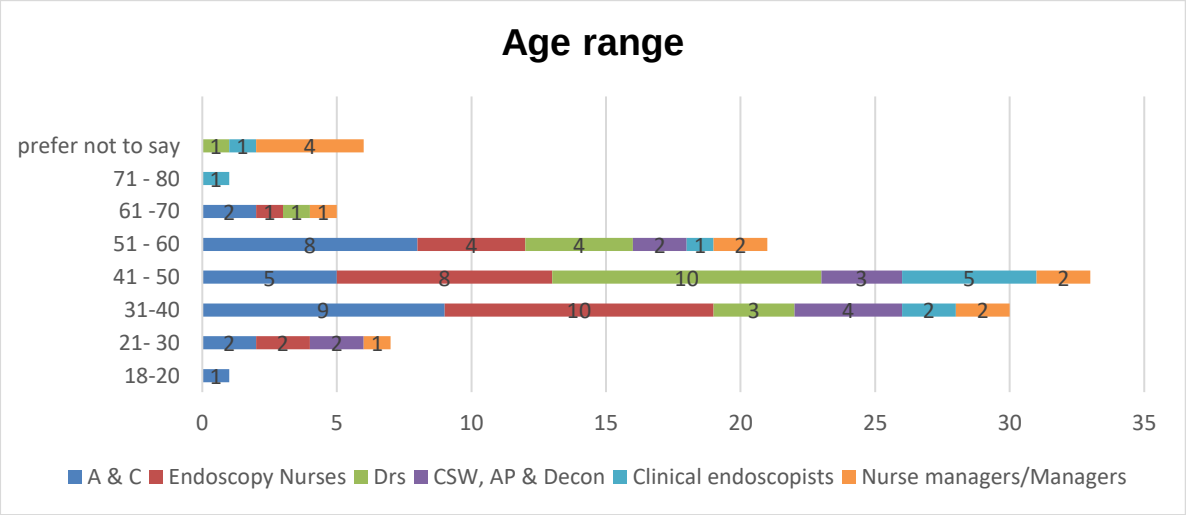
Thematic Analysis was used to explore patterns that emerged from the qualitative data. A summary of each theme may be found in the following tables.

The participants were very open with comments during their interviews. Many of the participants used emotive language to respond to some questions, describing their feelings, frustrations, and experiences of working in an Endoscopy role. Some thoughts and suggestions would not be achievable at a local level but would require GM, NW, or national support to introduce. Wider standardisation of services and roles would allow local services to focus on delivery and a coordinated GM approach to support benefits across the GM Integrated Care and address any inequalities.

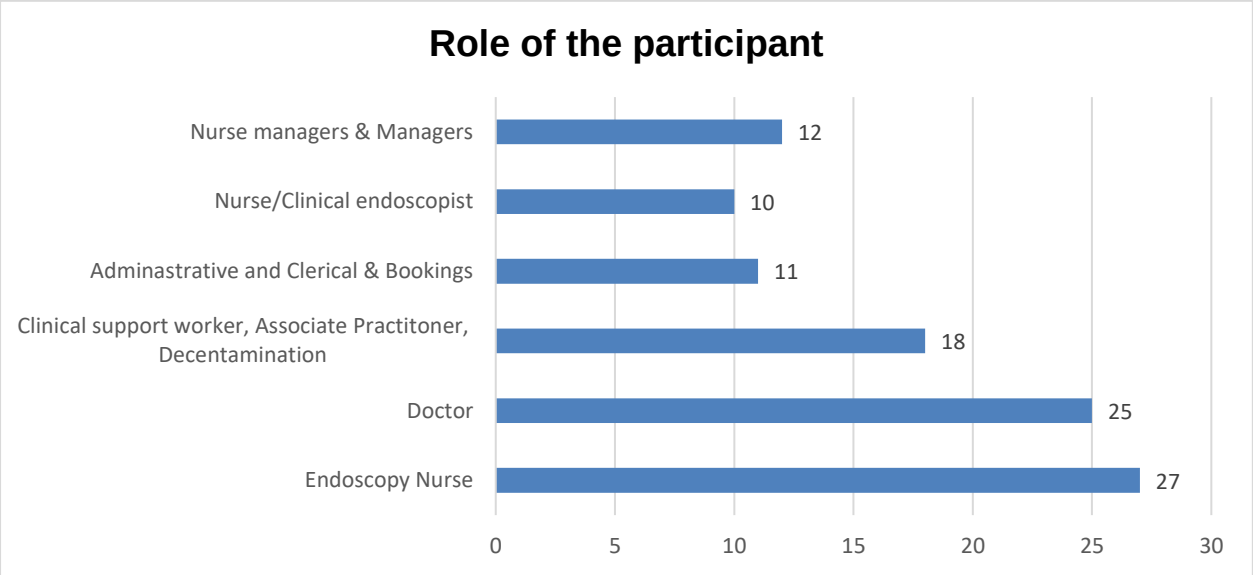
4.1 Who did we talk to?

Total number of participants was 103. 44 people were interviewed and 59 completed an e-survey.

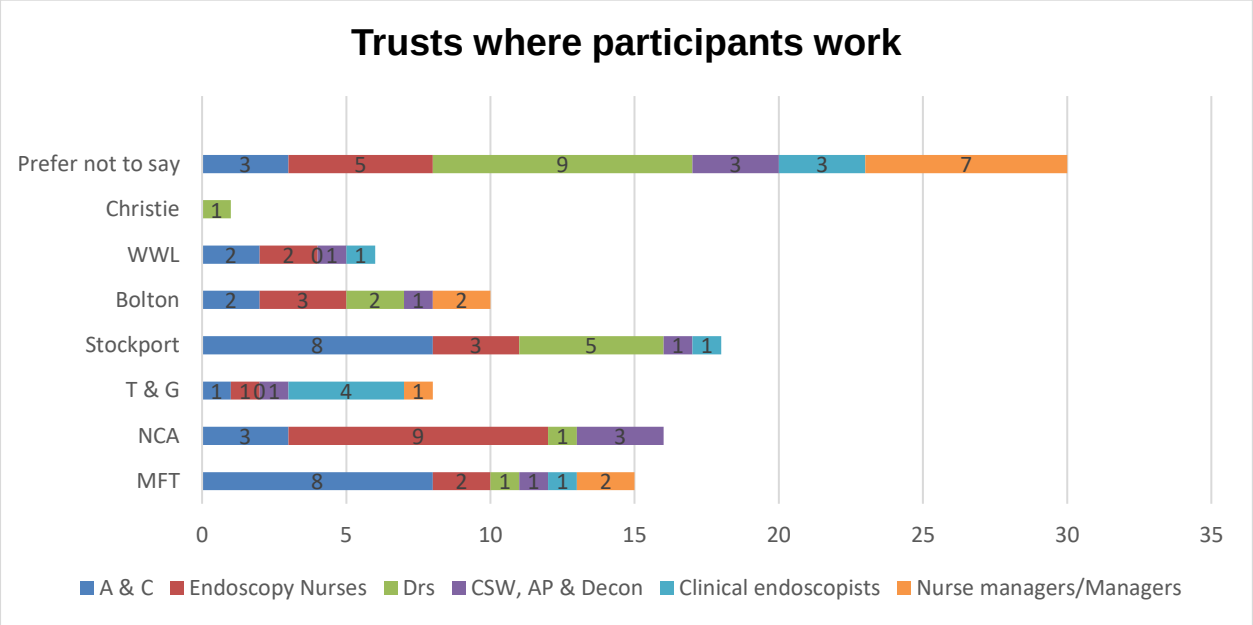
4.1.1 Age range of participants



4.1.2 Role of the participant



4.1.3 Response by trust



We were not able to establish why participants choose not to identify the Trust they are employed by.

Additional information from the e-survey can be found in Appendix 1

4.2 Themes

4.2.1 Entry routes into Endoscopy services

Participants described different routes into Endoscopy services and had varied backgrounds. No participant started their career journey with Endoscopy in mind, but everyone applied for posts or undertook training as a further skill post initial training or qualification.

Key takeaways – Introduction and motivating factors to enter an Endoscopy environment

- Family friendly & flexible working hours e.g., no nightshift & weekend working
- Location
- Personal & professional development opportunities
- Inspired by colleagues during training
- School careers event – (introduced a route into nursing or medical profession)
- Locum role
- Foot in the door to Endoscopy services
- Excellent placement experience during training
- Attracted by the combination of technical and clinical skills
- Opportunity to earn more money
- Aspirational skill for junior Doctors.
- Mix of technical skills and quick gratification from helping patients make Endoscopy a popular skill to acquire.

4.2.2 Recruitment & retention

There are recruitment issues in Endoscopy teams in GM for registered and non-registered staff with Endoscopy Nurses being the most difficult to recruit group due to national workforce shortages of Nurses[4]. A factor cited as recruitment incentives was Monday to Friday working (no weekends). Several Trusts reported they are unable to recruit Endoscopy Nurses and are routinely reducing lists on weekdays and outsourcing to the independent sector at weekends where staffing is plentiful.

Proximity to home was very important and participants were proud to work at their local hospital, and their reduced travel time supported their life outside of work.

The long shifts were described as family friendly, and not all units have a requirement to work nights or regular weekends which helped retention.

GM have an ambition to deliver 7-day NHS services in at least 1 room in every Endoscopy department by December 2023. This will require an increase in the NHS workforce to deliver this service. Services who have introduced weekend and on call working reported losing staff once the change had been introduced. 41% (16 out of 39) of Endoscopy Nurses expressed concern about the anticipated move to 7-day working which they anticipate will result in their leaving Endoscopy units for a different role in the same Trust to support their lifestyle.

Staff turnover is higher at lower banded grades/roles but less frequent for experienced registered staff e.g., Nurse endoscopists or Doctors. This was due to several factors including training and development opportunities. Unregistered staff and staff Nurses were able to find other roles in their trust which would allow them to transfer their skills into a new environment outside Endoscopy and retain their preferred hours of working at their chosen Trust.

Several trusts have recruited internationally. People welcomed these new staff but would like to see more support for new colleagues, so they are retained, empowered, feel valued and introduced to their new culture.

[4] The UK nursing crisis – 2021 and beyond | Nursing Times

Trusts were supportive to ideas for new roles to grow the workforce. Staff are rarely employed with the right skills in Endoscopy and are trained once in post. There was a high level of support to develop staff already working in the service and any development opportunities were a retention motivator.

Peer and professional support were a strong influence for participants' retention. All respondents also stated their service was very safe and high quality for patients.

All participants described their unit as having an open change culture and embraced change where improvement to patient outcomes could be seen e.g., early adoption of new or innovative techniques like cytosponge, pillcam, LumenEye or AI. 90% of participants also stated they feel listened to by managers and clinical leaders within their service who were easily accessed. Senior clinical staff were approachable, appreciative, and supportive of non-registered staff by 90% of participants.

Trusts that have employed an Endoscopy specific Practice Education Facilitator (PEF) reported better training, competence of new staff and upskilling existing staff. It was also a strong recruitment tool to provide 'wrap around support'.

Several people reported a lack of understanding around Endoscopy services within the trust and wider community.

Participants stated their facilities were inadequate and not fit for purpose due to the age of the estate and high demand for Endoscopy post pandemic. Some trusts are developing purpose-built facilities that support new working ways post pandemic. Poor staff facilities and a lack of basic requirements was widespread and demotivating. Facilities that were requested included -

- Handbag lockers
- Staff changing facilities as staff should not be traveling to/from work in uniforms
- Staff break room as staff cannot have drinks in clinical areas
- Staff toilets (in the vicinity)

Medical endoscopists stated they were motivated by having additional roles outside their Trusts e.g., work with professional bodies or clinical trainer/assessor/examiner roles.

Participants were satisfied with their shift patterns and flexibility offered by their managers, however Medical Endoscopists stated their job plan was unsatisfactory and their workload was the cause of any delay to starting their Endoscopy sessions on time. A surgeon stated it was '*becoming untenable for surgeons to perform Endoscopy within their current job plans'.*

Different Trusts offer different incentives for staff to work additional hours, shifts, waiting list initiatives and weekend work. Although most people remain with the NHS as their main employer, clinical staff work for the independent sector or agencies in their spare time. Some staff have reduced their NHS hours to allow them to work regularly for the independent sector which is well paid. There was a reported lack of standardisation across GM for rates of pay for overtime, weekend working or waiting list initiatives. Independent sector workers reported receiving their payment the next day following a shift. There are also significant pension tax issues deterring the most experienced Doctors from volunteering for additional NHS work as they have previously done.

Key takeaways – recruitment & retention findings

- Location was the most important factor when choosing an employer.
- Personal development and learning is important for all staff to motivate and retain for every group in the Endoscopy team.
- Working hours supports work/life balance and are family friendly.
- Some staff will leave roles if operational hours are changed to 7 day working.
- Every trust has recruitment issues.
- Clinical educators and senior team leaders have a major influence in creating a positive work culture and make a department an attractive place to work.
- Staff are rarely recruited with required clinical skills and are trained in house.
- Clinical and non-clinical staff are rarely recruited with the correct skills and are mostly trained in house. This requires lots of support.
- International recruits require strong pastoral and clinical support to adjust to cultural differences in the UK.
- Not all Trusts are doing exit interviews when staff leave their service and so unable to tackle issues impacting on retention.
- Experienced staff with external roles remain motivated e.g., Examiner or trainer
- Quality teaching and training environment for learners are valued.
- Willingness to develop and introduce new and innovative roles.
- Varied roles with technical and clinical skills keep people interested.
- Pride in quality patient centered care and safe service.
- Medical and Clinical Endoscopists job plans require regular review.
- Willingness to adopt innovative Endoscopy techniques benefitting patients.
- Poor staff facilities and department layout not suited for post pandemic working.
- Poor awareness of Endoscopy services in trusts, senior executives and the community.
- Retire and return staff have been asked to deliver service needs rather than specific roles they were offered. This is dissuading other staff from returning post retirement.
- NHS staff are reducing their hours to allow them to work regular shifts for the independent sector which is lucrative.
- Pay for working additional hours is significantly less than independent sector pay.

4.3 Covid 19 recovery findings

Participants commented the pandemic had reinforced that they wanted to remain in an Endoscopy service due to the shift patterns.

The pandemic has led to participants focusing on what ‘they’ want. This included a more varied role working with specialist Nurses in clinic. This was less physically demanding and motivational as new skills were being learnt and influencing practice.

Several people reported a strong sense of job security working for the NHS through the pandemic compared to family and friends.

Previous opportunities including CPD and formal training e.g., Clinical Endoscopy HEE training scheme, have reduced. Participants described fewer training lists and opportunities post pandemic. Interest remains very high for Clinical Endoscopist training posts amongst Nurses. Several Trusts have not recruited new Clinical Endoscopists this year as the trust has decided to protect training lists for Doctors in training. Participants stated that there was such a focus on service delivery that this was perceived to be more important than training.

Communication amongst teams has deteriorated since the start of the pandemic and staff meetings are less frequent. Some Trusts have successfully introduced daily huddles which remain post pandemic. Staff meetings have not resumed in all units following the pandemic.

A variety of new stresses were commonly reported post pandemic. Turnaround times for Endoscopy rooms are longer and staff employed post pandemic are working at a slower pace than pre-pandemic. Support is required to clean the Endoscopy suites between patients and speed up staff to pre-pandemic levels. The layout of several Endoscopy departments is no longer conducive to post pandemic working practices.

Senior participants reported a high level of skill and appreciation for clinical and non-clinical support staff who had worked tirelessly during the pandemic and the recovery period. They stated that these groups were undervalued, received inadequate training, and pay.

Several Trusts have experienced a loss of ringfenced beds for their patients which is extending the length of the working day and resulting in overtime payments.

Key takeaways – Covid-19 findings

- A small number of career changes were reported post pandemic, and only 1 participant stating they wanted to leave an Endoscopy environment.
- Learning and development opportunities have been reduced during the pandemic.
- Fewer training lists are available post pandemic. This has led to low uptake of funded training places for Clinical Endoscopists.
- A reduction in team meetings has occurred and communication is less frequent.
- Additional cleaning is reducing Endoscopy suite activity.
- Team cohesion, flexibility, dedication, and commitment to high quality care were acknowledged and praised.
- Increase in stress and time taken for routine service delivery e.g., loss of ringfenced beds, inexperienced staff & cleaning.
- Earlier retirement is planned across all staff groups

4.4 Learning and development findings

Training, development and CPD opportunities were reported to be a significant motivator, even for those not wanting to progress in their career but still develop new knowledge and skills. People wanted improved knowledge of contemporary issues, improved service delivery and confidence when training others.

Medical Endoscopists reported that they had more access to CPD and training than non-medical staff. Lack of access to opportunity was resulting in experienced Nurses leaving Endoscopy for other departments at the same Trusts as they were ‘stagnating’. There was ‘no expectation’ for non-medical staff to attend training/conferences/courses unlike medical staff who can access opportunities with fewer barriers.

A lack of space is also hindering Endoscopy training as there is no further capacity to provide training lists for learners. Some Medical Endoscopists reported their scope of practice has already been reduced due to limited room availability. They are unable to maintain their skills working for the NHS so have opted to work for the independent sector in their spare time and maintain competence. Poor facilities have been highlighted in JAG reports, but some Trusts have still not planned to invest in improving the Endoscopy environment.
Experienced Clinical Endoscopists stated they would like to extend their role to include new scoping techniques, incorporate innovative practice and work with other services e.g., IBS

services. This opportunity for development would retain them and diversify their role. It would also allow time to rest between the more physical procedures.

60% of Endoscopy Nurses who participated stated they would like to train as a Clinical Endoscopist, but opportunities are very rare. Nurses commented that the pathway to develop into a Clinical Endoscopist is not well known and opportunities *happen 'by chance'.* Several said they would be prepared to move to a different Trust if a training post became available, but they have never seen an opportunity advertised. Several experienced Nurses are already seeking an opportunity to train as a Clinical Endoscopist stated they will leave Endoscopy for another service in the same Trust if a development opportunity does not become available. Several concerns were raised about the potential introduction of Physician Associates in Endoscopy as their arrival would reduce the already small number of training opportunities available for Nurses and demotivate the Nursing workforce. Although not opposed to the introduction of PA's, experienced Endoscopy Nurses explained that they could deliver more activity, upskill faster, utilise existing experience and prescribe medication.

The role of the endoscopy specific clinical educator was reported to be key in every department where they have been appointed but there was not enough time to address all learners and a CPD programme. Not all departments in GM have an endoscopy specific clinical educator. This was perceived as an aspirational and rewarding role by experienced Nurses. One Endoscopy department with an endoscopy specific PEF has reported reduced attrition by 88% in a year.

All participants supported development of clinical support worker/Technicians to grow the workforce. Clinical support worker/Technicians were described as 'highly skilled' and *'indispensable'*. Not all Trusts have trained their non-registered staff to cannulate patients which was suggested as a *'quick win'* to improve workflow of the department. The grade, job description and scope of practice varied between sites even within different sites at the same Trust. Clinical support worker/Technicians continued to work at their local Trust and would look to move to a different department if they became bored or dissatisfied with their current role as there are no clear routes to progress in Endoscopy. Clarification on any education opportunities to support career progression would support retention of this group. Some support worker/Technicians stated they did not have the correct level of education to progress and did not know where to access functional skills training. Functional numeracy and literacy skill attainment are core elements of all healthcare apprenticeship standards and should be signposted by all Trusts. Related to Functional Skills are English for Speakers of Other Languages (ESOL) programmes that help staff employed through international recruitment to become more proficient in the English language.

There was variation in the use and scope of practice of Nursing Associates in Endoscopy across GM. Some Trusts have Nursing Associates well established in their culture, but some have none. Progression for Nursing Associates would require them to leave an Endoscopy environment and complete training to become a registered healthcare professional.

Lack of leadership and management skills were a barrier and impacted on staff confidence to apply for leadership roles. The exposure participants suggested to support confidence included finance, attending MDT's, shadowing colleagues in more senior roles, practical training/experience, and skills to support learners.

Participants were not aware of support or opportunities to develop people from Black, Asian and minority ethnic backgrounds for leadership roles e.g., Stepping up programme[5] from the NHS Leadership academy. Supporting staff from a Black, Asian and

[5] Stepping Up Programme – Leadership Academy

minority ethnic backgrounds would deliver a workforce more representative of the patient population. See appendix 9.1 for ethnicity data of participants.

Succession planning was not identified at 4 Trusts due to financial constraints, but some Trusts have embraced an opportunity to plan and supported existing staff to gain experience in readiness for upcoming opportunities. 50% of units stated they are unable to proactively recruit when highly skilled people plan to leave, and their successor would require training. Generally, roles are not recruited to until after the person has left the service. This results in a loss in service activity which participants reported will take up to a year recover.

Staff who have been working across sites (at the same Trust) have enjoyed the opportunity and have brought back learning to their department. This suggests some staff would be supportive of working as a network. Participants who are working additional hours for the independent sector or as a locum on an NHS site also reported learning from the experience. No participants reported enjoying working for the independent sector and worked to earn additional money.

Experienced staff shared what their Trusts had done to develop and retain them. Examples of good practice included –

- Succession planning by progression of Endoscopy Nurses to the Clinical Endoscopy training scheme before a known retirement.
- Progression for clinical support worker/Technicians to become Band 4 assistant practitioner in Endoscopy (rather than a Nurse associate) and retained in Endoscopy team.
- Retire and return in a mentorship and training role.
- New staff are given a formal training plan. Structured training supported them to achieve competency faster.

Key takeaways – Learning & Development findings

- Learning and development is one of the highest motivators for staff choosing a role
- Practice educator role seen as a pivotal role to support training delivery
- Not all new staff have a formal training plan
- Nurses, Nurse associate and clinical support worker/Technicians lacked development opportunities
- Few education programmes exist for clinical support worker/Technicians or Bookings teams
- Nurses perceive Clinical Endoscopy training aspirational but difficult to access
- Access to training lists is not equitable for all e.g., surgical trainees struggle to access training lists
- Access to CPD and training is inequitable between professions
- Few incentives to develop into a Clinical Director in Endoscopy
- Experienced endoscopists would like to extend their scope of practice
- Few staff know how to access leadership, business & management training
- Succession planning is not commonly done
- Lack of awareness of opportunities to develop people from Black, Asian and Minority Ethnic backgrounds for leadership roles
- Trusts where staff are working across sites enjoy this and are sharing innovative practice
- Cannulation training was requested for all clinical support worker/Technicians as a '*quick win'*
- Job titles, scope of practice and pay bands vary for the same roles across GM

4.5 New ways of working and new roles findings

Not all Trusts have a Housekeeper in their Endoscopy unit. Nurses reported doing many of the tasks done by Housekeepers in other clinical environments.

Trusts reported different down times between procedures and different advice was being given from each Trust infection control team. Having an agreed GM standardised down time (appropriate for the room) between patients would support the most efficient and safest service delivery.

Post pandemic there is reported a reduction in traditional development opportunities for junior staff wanting to progress. Roles that were seen as prestigious included quality improvement projects and or link worker roles e.g., Dementia. Participants reported they would like to see a return to these roles.

Medical Endoscopists spend several PA's per week in Endoscopy as part of a varied job plan which gives them time to physically recover from delivering the procedure. Clinical Endoscopists reported spending most of their time scoping patients which can give rise to work related injuries. It was suggested that Clinical Endoscopists should have a more balanced job plan which allows recovery time between procedures. Some Clinical Endoscopists changed their roles during the pandemic and have remained working collaboratively. They reported an improvement in their physical health and improved skill set. A Medical Endoscopist suggested that *'No Endoscopist should be scoping more than 4 PA's per week to maintain good health'.* No occupational standards or recommendations have been produced by professional bodies yet, but all Endoscopists need a balanced job plan to allow rest between procedures. Clinical Endoscopists described the expectation to deliver more procedures as *'as ongoing battle with service managers'.*
Medical Endoscopists commented that there are several roles which could be delegated to experienced Clinical Endoscopists or Nurses. This would release time for more complex procedures which cannot be outsourced to the independent sector and reduce waits for patients. Some have been introduced successfully and could be reproduced across GM including –

- Nurse led consent
- Clinical Endoscopists and Nurses to make more clinical decisions e.g., full assessment of patients attending for 2 week wait referrals and managing those patients along with post procedure administration
- Formalised training roles of experienced Clinical Endoscopists
- Pre-Endoscopy clinics to ensure bowel prep, anti-coagulation issues etc. are addressed, like the role played by Specialist Screening Practitioners in the Bowel cancer screening programme.

Medical Endoscopists were keen to do more advanced Endoscopy and less routine work. Participants suggested it would be beneficial to the network to undertake one list per week in a tertiary centre. They suggested this would help the tertiary centre with the referrals of advanced Endoscopy and improve their own knowledge and skills.

Longer patient waiting times are for complex procedures which cannot be outsourced to the independent sector. To address this high demand, it was suggested that experienced Clinical Endoscopists are upskilled to deliver more complex procedures. Training experienced Endoscopy Nurses to become Clinical Endoscopists would support delivery of routine procedures and release experienced Endoscopists.

Participants were not aware of the introduction of the CDC but those who were aware had concerns largely around how these services would be staffed. Participants requested

reassurance on the long-term plans to deliver services at the CDC's and how these will impact the Endoscopy team.

All Trusts have staff with different titles, roles, skill sets and grades in an Endoscopy room during a procedure. Some Trusts have 2 Nurses and others have 1. Several comments were made challenging the need for two Nurses unless one person is in training. Too many staff in a room was reported to be intimidating for the patient and described as wasteful and was not experienced in the independent sector.

Medical Endoscopists who are already working across sites report a positive experienced. Over 60% of the respondents stated they would support cross Trust working if it improved the service to their patients. Issues to be addressed to improve experience included access to staff parking and welcomeness from host sites. Standardisation of roles, standardised operating procedures and strong governance roles in every unit were also suggested to make cross region working safer and sustainable.

Nurses and Endoscopists commented that a small increase in numbers of support worker/Technicians to streamline cleaning and preparation of clinical areas improve the flow of patients post pandemic. Where additional support staff have been made available, improvements in efficiency were reported to have been realised and registered staff were able to focus on the patient in front of them rather than preparation for the next patient. There is a pilot project led by the NW Endoscopy academy looking at upskilling Band 3 staff into a band 4 role. Results of the pilot will be available soon.

All participants reported regular repeated loss of efficiency and poor patient experience due to issues with portering services resulting in regular delays. This leaves the team with no work and equipment unutilised. Participants admitted it was 'easier' to do the portering themselves and improve experience for the patient. Some Trusts have successfully introduced dedicated support workers to transport the inpatients at a time to suit the service and patients.

All Trusts stated they were short of endoscopy Nurses. Participants from one trust stated they had sufficient Endoscopists but a lack of Nurses which had led to lists being outsourced to the independent sector at weekends. The recent introduction of Nursing Associates to support the Nursing workforce was described by respondents as partially successful. There are, however, limitations of the role and it was acknowledged that a Nursing associate could not entirely replace a registered Nurse. One Trust described how they are exploring all avenues with safety and quality at the forefront. All aspects of the role were being considered and discussed e.g., consultation with safe medicines committee. Patient discharge and a reduction in overtime was highlighted as specific improvements since the introduction of Nursing Associates.

All respondents reported lack of resource for bookings teams. Bookings and clerical teams were perceived as the 'biggest issue' for efficiency and are key to effective management and utilisation of resources. Trusts who have invested in their bookings team were able to demonstrate a higher utilisation of their lists and higher attendance rates. One Medical Endoscopist stated - '*weekday lists aren't fully booked and there's lots of DNA's. However, there will be a list of 32 points on the weekend due to them being contracted to a private firm. I could scope them during the week or even at the weekend. For this we need more staff in all roles, especially bookings, and staff that are willing to work the weekend.'*

Inappropriate booking of patients was reported to result in late running lists and staff working until all patients are discharged. Patients are not always booked to arrive at an appropriate time, especially in the evenings which does not allow adequate time for preparation. Participants reported that improved liaison between clinical and bookings teams is required to update requirements as they change. Teams who have brought clinical staff together with

the bookings teams to review their booking process and looked at where the biggest gaps occur reported streamlined bookings and improved utilisation of all lists.
Some Trusts have a high number of patient DNA's. Participants suggested that this was due to

- Late receipt of information by the patient.
- Shortage of Bookings team to respond to cancelations and utilise all appointments.
- Poor patient compliance with bowel prep.
- Inadequate training & investment in bookings teams.

Trusts with Nurse led bowel prep service have improved list utilisation through improved patient compliance[6]. These bowel prep services are running at trusts in the UK and is a proven concept. Some units reported poor compliance on the wards with preparation prior to Endoscopy procedures. It was suggested that an increase in education and understanding of Endoscopy with ward staff could improve compliance. Some Trusts in GM with established bowel prep services are looking to extend the service to cover inpatients using Nurse and (non-Nurse) endoscopy navigators to support this process.

Several participants described a desire to make Endoscopy a greener and more sustainable environment. One Trust is engaged with a national Endoscopy sustainability group to reduce waste and review their working practices. They suggested this could be replicated across GM.

A GM Trust is piloting Artificial Intelligence for the detection of polyps. This is already used in the USA and Australia where rapid uptake of the technology has been proven to compensate for human limitations by improving endoscopic treatments accuracy, consistency, and speed. Data is being collected as part of clinical trials and results will be shared across the UK.

Key takeaways – Examples of good practice identified in GM

- Housekeepers, support staff and Technicians are essential for releasing registered staff for direct patient care, improving efficiency, and improving patient experience
- Standardised down time between procedures between sites
- Resumed audit and link worker roles post pandemic
- Medical Endoscopists delegated some specific duties to experienced Clinical Endoscopists to release them to deliver the more complex procedures
- Clinical Endoscopists working with other associated services to develop patient care and reduce work related injury
- Uptake of HEE funding for training Clinical Endoscopists
- Benefit from Medical Endoscopists working 1 or 2 PA's per week at Tertiary centres
- Trusts working towards standardising roles, job titles, job descriptions, competency frameworks, pay rates and pay bands
- Standardising working practices across units including number of staff, skill mix and documentation
- Endoscopists supporting cross site/Trust working
- Clinical support worker/Technician role successfully upskilled to Band 4
- Introduction of Nurse Associates to grow the workforce
- Medical & Clinical Endoscopists developing new Endoscopy skills
- Well trained and supported bookings teams ensuring weekday lists are fully utilized
- Nurse led Triage and bowel prep services resulting in improved patient compliance

[6] Layout 1 (gettingitrightfirsttime.co.uk)

4.6 Health and wellbeing

Health and wellbeing support varied at each trust in GM. People reported various success contacting support services at some Trusts. Some leaders have taken their team health and wellbeing very seriously.

Several participants identified their clerical and bookings teams were under immense pressure and one has established a local wellbeing group. They have arranged pamper days (out of work time) and produced their own bespoke monthly newsletters to highlight support services.

One participant successfully reported application for lottery funding which has improved staff facilities. They have purchased microwaves and lockers which has boosted morale. Their manager continues to look for ways to secure funding to improve facilities for staff and make a good working environment. This team have also introduced bimonthly staff meetings and an ideas board for staff suggestions.

One trust is offering smoking cessation and weight loss services which participants reported to be well subscribed but found it difficult to access the service during worktime and reported accessing these services in their own time. Clinical Endoscopists reported repetitive strain injury from scoping patients. Medical endoscopists scope fewer sessions a week (two to five) but demand for Endoscopy has increased. Most Clinical Endoscopists scope every day which has resulted in more work-related injuries.

Key takeaways – Health & wellbeing findings

- Access to mental health support has been varied.
- Some services have supported staff to remain in work e.g., onsite Physiotherapy.
- Not all departments have access to computers to review health and wellbeing offerings.
- Paper copies and noticeboards are still a popular way of sharing health and wellbeing information.
- Union representatives are advocates for staff support services.
- Endoscopists were not aware of risk assessment for staff doing a high level of scoping and at risk of injury.
- Managers struggled to release staff during working hours to access health and wellbeing services.
- Participants did not know how to access risk assessments for desk, chair & screen placement.
- People appreciate leaders who are working to improve their environment and facilities despite many barriers.

4.7 Review of establishment findings

Every participant commented on the pride in their team and the quality of service they provide despite their higher level of activity and increasing demand for Endoscopy services. Few additional resources have been provided to deliver these services. All participants expressed concern at the consistently low staffing levels which has led to time wastage, poor patient experience and last-minute amendments to rota. The significant increase in demand has not resulted in an increase in establishment.

Participants who are managers and team leaders reported feeling under tremendous pressure and ‘embarrassed’ to repeatedly ask staff to work additional shifts or overtime to maintain the service as demand has exceeded capacity.

Significant numbers of participants have reduced their working hours to allow them to work for the independent sector for improved payment opportunities. This has reduced the size of the experienced workforce and resulted in agency staff being recruited or outsourcing. The Endoscopy workforce is aging, and staff are planning to retire earlier or reduce their hours worked. The bowel screening programme is lowering the age for screening which will increase the demand for Endoscopy. Large CDC's will also house Endoscopy services and require experienced staff to work at these sites.

Key takeaways – Review of establishment findings

- Establishment and staffing required to provide current demand is too low and does not include a plan to staff CDC's.
- Succession plans are not in place to deliver sufficient well-trained staff to cover planned retirement, service expansion, changes to screening programmes and new technology.
- Staffing levels are consistently low in most teams.
- Lack of key staff are leading to inefficiencies, poor patient experience and increased cost (overtime payments and agency staff).

5 Recommendations for the Greater Manchester Endoscopy network (linked to Richards report recommendations (RRR))

5.1 Entry routes recommendations - RRR 18

5.1.1 Promote quality learning experiences and environment to influence learners who may be attracted to Endoscopy later in their career.

5.1.2 Adopt a coordinated approach to raising the profile of a career in Endoscopy / promoting Endoscopy roles. Attending Nursing school careers events, open evenings to meet the team, work with FEI's and HEI's to promote Endoscopy as an aspirational career choice to student Nurses, Medical students and junior Doctors (rather than school leavers). Highlight the training opportunities, technical skills, and caring skills.

5.1.3 Use social media to support recruitment materials to showcase Endoscopy as an aspirational role and ensure prospective employees understand how an Endoscopy service runs and recruit the right people first time around e.g., 'a day in the life of an Endoscopy Nurse' video. Direct the materials to the appropriate people i.e., those already in a health care role.

5.1.4 Promote flexible working – including 7-day working for all new posts

5.2 Recruitment and retention recommendations- RRR 18

5.2.1 Support to empower international recruits to allow them to be confident in their new role and culture.

5.2.2 Connecting with national schemes like Refuaid[7] will support GM to engage with international recruitment to attract experienced refugees & support to have qualifications accredited for working in the UK.

5.2.3 Introduce 'Stay' or 'Grow' conversations if staff express an intention to leave. Share templates to support managers having these conversations when needed.

5.2.3 Collation of all the benefits of working in the NHS compared to working for the independent sector shared with Trusts to support their recruitment and retention materials

[7] RefuAid

e.g., excellent governance structures[8], pension scheme, annual leave, sickness absence, personal and professional development, link grade, annual personal development reviews, maternity benefits. Ensure staff are aware of these benefits, how to access and identify governance leads.

5.2.4 Annual review of exit interviews and annual staff surveys[9] to identify specific reasons staff are leaving. This information will support development of an improvement plan to improve staff experience and retain.

5.2.6 Review 'Retire and return' offerings to encourage more flexible retirement. Roles including training, governance and mentorship of more junior colleagues are aspirational. Instigate discussions to identify an individual's motivation for retirement and identify if support mechanisms can be introduced to retain experienced people.

5.2.7 Offer prospective candidates an opportunity to 'try before you buy' with a visit to the Endoscopy unit and ensure candidates know what to expect in their new role. Include the offer on recruitment materials.

5.2.8 Support experienced staff to have external roles e.g., examiner or academy trainer, to motivate and retain in the service.

5.2.9 Develop a regular and diverse range of CPD activities to engage team members at every level. Explore using a shared platform like 'Future NHS' website to deliver a variety of opportunities for all learners across GM.

5.2.10 Promote regular job planning to ensure people have a timetable that accurately reflects what is required of them and it is achievable. Review annually plus whenever a change is anticipated.

5.2.11 Engage with succession planning. Trusts can't predict all leavers, but some things can be predicted e.g., retirement. Identifying people likely to retire would allow time to prepare a business case, recruit and train a successor and prevent a reduction in service.

5.2.12 Network to consider how to mitigate against attrition of Nurses due to a 7-day working. Engage with staff and union representatives to begin discussions around 7-day working well in advance of services starting and understand staff concerns. Plan how new staff will be recruited and trained in time for this change.

5.2.13 Departments with an endoscopy specific PEF should highlight this in recruitment materials to demonstrate their supportive training environment and commitment to staff development.

5.2.14 Trusts to identify funding for staff facilities e.g., handbag lockers, changing facilities and break rooms – linked to the people plan[10].

5.2.15 GM to investigate developing a diagnostic staff bank to offer a standardised rate of pay for additional hours worked and offer rapid payment for work done. Explore the use of NHS Reservists in GM Endoscopy units[11].

5.2.16 Equal and standardised renumeration of enhanced rates applied to all team members for additional work, for on-call, waiting list initiatives or weekend working. Remove inequity of enhanced pay between professional groups to encourage staff to work additional hours at their own trust rather than the independent sector.

---

[8] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

[9] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

[10] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

[11] NHS reservists | Health Careers

5.2.17 Develop GM retention strategy including development of GM preceptorship scheme to reduce attrition of learners. Link into the GM spoke of the NW Endoscopy academy.

5.3 Learning & Development opportunities recommendations- RRR 18

5.3.1 Introduce endoscopy specific clinical educators/PEF into all GM Endoscopy units. Consider cross site sharing for smaller units or where funding is a barrier.

5.3.2 GM Endoscopy network to work with the NW and GM Endoscopy academies to ensure appropriate educational opportunities are developed and provided e.g., Increase the number of Endoscopy trainers and assessors to work across GM & the NW to link in with the NW Endoscopy academy.

5.3.3 Utilise the NW Endoscopy academy / GM spoke to support the increased number of learners accessing training lists. Work across GM and the NW to offer training lists outside of own Trusts when available.

5.3.4 Explore with the NW Endoscopy academy the feasibility of developing a simple e-learning module to support the bowel prep process for ward staff to increase the number of successful procedures and reduce cancelations due to incomplete bowel prep[12].

5.3.5 Engage with the NW Endoscopy academy to develop training for new starters in clinical and non-clinical roles. Ensure training is signed off before staff start JAG training programs.

5.3.6 Trusts to register staff and learners and trainers for the Digital Staff Passport to expedite training opportunities across GM.

5.3.7 Support staff to identify how to access leadership, business & management training through the NHS Leadership academy. HEE are currently investigating the development of a diagnostic service management leadership course.

5.3.8 Trusts to provide equitable CPD for all groups. Provide opportunities to attend appropriate courses/conferences etc. with an expectation that staff will be developed, do CPD, remain engaged and be retained in Endoscopy.

5.3.9 Trusts to explore cannulation training for non-registered staff to improve patient flow and release Nursing staff for more complex duties.

5.4 New ways of working recommendations- RRR 4, 5, and 7

5.4.1 Standardise roles, job titles, job descriptions, clinical competency frameworks across GM – linked to the NW Endoscopy academy. Develop agreed skills and progression points. Quality assured training provided across all sites allowing staff to move between sites seamlessly regardless of where they trained.

5.4.2 Standardisation of patient documents across GM to facilitate movement of staff e.g., consent and checklist documents. Develop electronic e-documents so Trusts can access at any of their sites.

5.4.3 Leaders to discuss and agree standardised staffing models e.g., one Endoscopist, one Nurse and one Clinical Support worker/Technician in every room.

5.4.4 Ensure mechanism is in place to improve communication within Endoscopy teams e.g. a seasonal GM Endoscopy newsletter. This could promote contemporary issues,

[12] Layout 1 (gettingitrightfirsttime.co.uk)

learning opportunities, workforce issues, celebrate developments and highlight the good work being done in GM.

5.4.5 Consider Clinical Endoscopists running rapid direct access/STT/one stop clinics.

5.4.6 Consider introduction of symptom specific clinics, such as dysphagia and rectal bleed that can rule out cancer on the same day as a patient is seen in clinic.

5.4.7 Introduce WHO or standardised GM checklists.

5.4.8 Encourage early, collaborative, and rapid adoption of innovative proven techniques. Development of standardised training to support staff to use new techniques safely and quickly.

5.4.9 Develop a sustainability/green network across GM Endoscopy teams.

5.4.10 Consider how CDCs could be used as a training opportunity. Use this environment to rapidly pilot new technology and train staff e.g., cytosponge or pillcam. Deliver an appropriately skilled, well supported workforce who can work effectively in new and different ways.[13]

5.4.11 Standardise down time between procedures for all Endoscopy units. Ensure this is appropriate for the individual room air handling system or other appropriate factors.

5.4.12 Review working hours of all units e.g., 3 sessions per day per room with potential to include evening work.

5.4.13 Support Medical Endoscopists to work across Tertiary centres to deliver the most complex procedures and improve knowledge & skills of staff at these centres and reduce waiting times. Support Medical Endoscopists to work at the top of their licence.

5.4.14 Support for Consultants experiencing barriers to accessing Endoscopy lists to maintain their competence.

5.4.15 Trusts to review bookings teams to ensure they are adequately resourced, have access to training, fully equipped and are well led. Ensure maximum utilisation of appointments for every session and have capacity to respond to last minute availability. Develop good communication with clinical staff to respond to changes and minimise the input required by clinical staff to ensure patients receive correct information and arrive at an appropriate time in the evening.

5.4.16 Introduce Nurse led consent and triage of 2 week wait referrals where not already done.

5.4.17 Introduce bowel prep services like the service already provided within the bowel screening programmes, in line with other trusts to improve patient compliance[14].

5.5 New roles recommendations- RRR 5 and 14

5.5.1 Review support service provision to deliver improvements and support efficient working. Consider introducing a Housekeeper, Porter, or a multi-skilled support role to release clinical staff time and support functioning of the department

[13] NHS England » NHS People Plan

[14] Layout 1 (gettingitrightfirsttime.co.uk)

5.5.2 Develop career pathways to ensure Endoscopy Nurses have a route to access training to become Clinical endoscopists and Nursing Associates have access to Endoscopy specific training to retain them in Endoscopy services.

5.5.3 Exploration of introduction of Physician Associates (PA) roles in GM Endoscopy. Linking into the NW Endoscopy academy to support pilot schemes and training. Ensure their introduction does not have a negative impact on training of Nurses to become a Clinical Endoscopist.

5.5.4 Explore the introduction of more Nurse Associates to release registered Nurses, improve efficiency, patient experience, and deliver service improvements e.g., reduction in overtime pay and supporting rapid discharge of patients.

5.5.5 Explore piloting Endoscopy Navigator roles to reduce administration currently done by Nurses and bookings teams, maximise attendance, improve compliance with bowel prep, eliminate duplicate requests, ensure patient has the correct information/appointments, reduce anxiety, and improve patient experience.

5.5.7 Communicate plans for CDC workforce and identify opportunities for new roles and ways of working. Increase training of staff to grow the workforce.

5.5.8 Identify apprenticeship routes as a retention plan for training lower banded roles e.g., support worker/Technicians and Assistant Practitioner roles (Band 4).

5.6 Upskilling current staff & skill mix - RRR 14 & 18 - WE ARE THE NHS:People Plan 2020/21 – 5 - Growing for the future[15]

5.6.1 As part of the GM Endoscopy workforce strategy there is a need to ensure skill mix is thoroughly explored to support recovery. Ensure good governance of new or changed roles, varied job plans and ensure access to Endoscopy specific developmental opportunities.

5.6.2 Consider Upskilling experienced clinical support worker/Technicians and bookings teams to a Band 4 role. Non-clinical staff to access specific training through the NW Endoscopy academy. Use standardised job descriptions to attract and retain people and pay at a level that reflects the complexity of their role.

5.6.3 Upskill experienced endoscopists to deliver the most complex procedures and upskill to become Specialist Screening Practitioners (SSP) to reduce waiting times and meet the change in demand for bowel screening.

5.6.4 Introduce more diversity in Clinical Endoscopists roles by working alongside other expert practitioners, continue developing and alleviating boredom. e.g., working with specialist Nurses in clinic. This would reduce occupational injury e.g., RSI, and be motivational.

5.6.5 Strengthen links with NW Endoscopy academy to support increasing numbers of Endoscopy nurses/AHP's enrolling on the HEE Clinical Endoscopist course and remain in Endoscopy services. Identify barriers stopping Endoscopy Nurses training to become Clinical Endoscopists.

5.6.6 Trainee Clinical Endoscopists to start non-medical prescribing training in the early part of the programme.

[15] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

5.7 Leadership and culture recommendations – RRR 21 & WE ARE THE NHS:People Plan 2020/21- 3- Belonging to the NHS[16]

5.7.1 Staff supported to be involved in audit and link worker roles.

5.7.2 Support staff in the transition to 7-day services and recruit new staff with contracts to support weekend working.

5.7.3 Introduce a GM Senior Nurse/Clinical Endoscopist network to provide peer support and promote standardisation across the region.

5.7.4 Introduce an annual away day for leaders to identify specific workforce issues to be addressed in the coming year e.g., development of a standardised competency pack. All Trusts commit to sending representatives and include people from all staff groups to contribute.

5.7.5 Leadership should be prioritised in all staff groups. Development of a GM structured support and leadership plan for the Endoscopy workforce should make the leadership roles more attractive. Identify people who want to develop into a leadership position, support them to identify gaps and provide relevant experience to progress.

5.7.6 Promoting leadership opportunities by fostering a culture of inclusion could support staff to develop a workforce more representative of the patient population. Promoting opportunities like the Stepping up programme[17] would prepare staff from Black, Asian and minority ethnic backgrounds for leadership roles – linked to the people plan[18]

5.8 Health & wellbeing recommendation – linked to NHS people plan – 2 looking after our people[19]

5.8.1 Leaders to develop a sustained focus on staff experience, especially 'health and wellbeing' to deliver the elements of the People Promise. Improved engagement and listening to improvement ideas may support the development of a plan to deliver a more sustainable workforce.

5.8.2 Improve access to health and wellbeing support. Network and leaders to discuss with with staff how they would like to receive the information. Consider introducing local Health and Wellbeing champions to deliver a more bespoke approach through sharing of information relevant to the unit e.g., monthly health & wellbeing newsletter.

5.8.4 Ensure equity of access for staff wellbeing events or rewards at a time that clinical staff can access. Leaders to feedback if teams are routinely unable to access Trust offerings and agree how their unit can be included.

5.8.5 Trusts to work with staff to identify and develop plans to improve staff facilities and improve the working environment e.g., functioning lockers, microwaves and staff break areas.

5.8.6 Regularly review risk assessments for all staff. Ensure endoscopists who frequently scope are regularly risk assessed and have adequate breaks programmed into their job plans to reduce occupational injuries. The network to explore if an acceptable limit for Clinical Endoscopists scoping patients can be agreed for to minimise occupational injury e.g.no more than 4 sessions scoping colons per week to allow time for recovery. Ensure

[16] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

[17] Stepping Up Programme – Leadership Academy

[18] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

[19] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

administrative staff have access to Digital Screen Equipment (DSE) Workstation Checklists and their equipment is fit for purpose.

5.8.7 Support for flexible working should be supported where possible but may not always be achievable due to service requirements. Roles that can sustain flexible working should be advertised to support staff and improve retention.

5.9 Review of establishment recommendations[20] - RRR 21

5.10.1 Trusts to regularly review the establishment to ensure staffing levels matches demand to deal with current capacity and future changes e.g., CDC's.

6 Limitations of the project

The survey was distributed to all Trusts across GM via Endoscopy service managers and promotion was done through the GM Endoscopy operational and workforce groups. This method of engagement could have introduced unwarranted bias and resulted in a lack of anonymity for participants.

Findings and recommendations have come directly from participants and due to the small sample size of some groups may not be representative of the whole endoscopy workforce across GM.

The project was run during a pandemic which meant engagement was challenging and impacted on number of staff being released from their clinical duties to take part in the study.

GM does not have data collected on the number of people working in each Endoscopy unit but this data is currently being collected by the network and should be available by December 2022. We are unable to indicate what percentage of the total workforce engaged with the project.

Not all Trusts or participant groups were able to attend interviews due to clinical demand and low staffing numbers. Every Trusts in GM responded to the e-survey, but some Trusts only had a small number of participants.

Participants volunteered to be interviewed but some were unable to secure time during working hours to attend an interview. Four participants attended interviews in their own time outside working hours as they felt motivated to contribute to the project. Some participants volunteered following discussions with colleagues who found participation a positive experience and appreciated being listened to. Links to the survey and contact details of the project manager were shared between staff who had felt motivated following their interview. Throughout the project 15% of volunteering participants cancelled their interview due to unexpected clinical demand and colleague sickness. 40% of these cancelled meetings were not rescheduled due to work pressures.

7 Lessons learnt

- Recruiting participants took longer than anticipated and was more difficult than anticipated.
- Having a well-respected SME was extremely beneficial to help steer the project and gain peer engagement.
- The value of stakeholder engagement from the start and throughout the project with regular updates was important.
- A focus on scope of the project is required to avoid creating too much information to review and impact on delivery of the project.

[20] We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf (england.nhs.uk)

- Visiting a team in person supported high levels of data collection and is an efficient use of everyone's time but requires support from a local manager.
- Adopting a flexible approach to collecting information in person or by a e-questionnaire will engage more participants. Salford Royal hospital and Stockport NHS Foundation Trust facilitated participation with a site visit which proved to be an efficient method of collecting data from a wide range of staff in a day. This flexible approach supported the workforce who were motivated to engage with the project.
- The importance of listening to staff and the positive impact this can have on morale and feeling valued cannot be underestimated.

8 Next steps

This report will be shared with all key stakeholders across GM and relevant regional groups including Health Education England as the funding organisation. Key themes and findings will be presented to the GM Endoscopy network and GM Cancer alliance and discussions will ensue with the GM Endoscopy workforce Group to agree priority areas of focus over the next 12 months. There will be a recommendation for the Endoscopy network to provide a response and action plan relative to the findings in this report.

9 Appendix

9.1 Appendix 1

Endoscopy-Appendix-9.1.pdf (gmcancer.org.uk)