Greater Manchester Diagnostic Workforce Review – Imaging

Research briefing

July 2022

www.gmcancer.org.uk

Contents

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1 Summary and recommendations

1.1 Summary

This project was an opportunity for Greater Manchester (GM) and East Cheshire (EC) 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 imaging teams across GM and EC and the findings have given us a better understanding of the complexities of the GM and EC imaging workforce. This information will be shared with the Greater Manchester Imaging network to utilise to support implementation of the North West (NW) imaging strategy at a local level.

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

1. Improve awareness of the imaging careers in the local area to recruit a local workforce.
2. Build on recruitment schemes that work well and explore how to upscale these.
3. Engage with staff close to retirement to establish how they would like to work and ringfence attractive roles to retain them.
4. Review payment rates across GM for overtime, additional shifts, and Waiting List Initiatives (WLI) to increase uptake and avoid staff leaving to work for the independent sector.
5. Identify ways to make senior leadership roles attractive and support staff to gain skills to fulfil these roles.
6. Provide leadership and management training for all staff groups to support development of future leaders at all levels.
7. Develop a GM strategy to support increasing the number of apprentices, assistant practitioners, advanced and consultant Radiographers.
8. Support succession planning for known leavers or planned retirement.
9. Grow our own workforce and upskill current workforce by identifying opportunities and reducing barriers for progression.
10. Demonstrate imaging career pathways with various entry and exit points to allow people to develop when they are ready and an opportunity is available e.g., using the National ACCEnD model.
11. Utilise the Digital staff passport to expedite training.
12. Support international recruits to gain confidence in the workplace and in their new culture to retain them.
13. Engage with HEI's and NW Imaging Academy to develop a programme to address GM needs e.g., direct entry, upskilling support staff, Assistant Practitioners etc..
14. Identify opportunities for new roles and working differently at Community Diagnostic centres (CDC) e.g., multi-skilled support worker roles.
15. Review of Ultrasonography services to improve retention and support their development and leadership needs.
16. Explore how to make plain film Radiography more attractive , provide early careers support and retain the workforce.
17. Develop standardised job descriptions and scopes of practice with appropriate pay band.
18. Regular review of establishment in line with increased demand including support roles.
19. Explore potential for adoption of networked working with a strategy to support development implementation and quality standards.

20. Provide accessible CPD e.g., a shared e-learning platform to promote learning and connect people. Promote opportunities and mentorship for learners at every level with protected time built in to retain staff.
21. Explore hybrid posts/roles to provide opportunities and improve retention e.g., joint clinical and educational role or examiner with professional body.
22. Develop a GM Diagnostic staff bank.
23. Identify, promote and support BAME development and leadership opportunities.
24. Improving access to health and wellbeing for all.

2 Background

Health Education England (HEE) funded a Diagnostics workforce project for Greater Manchester Cancer Alliance (GM Cancer). The project aimed to work with providers across Greater Manchester (GM) and EC to conduct an in-depth qualitative workforce review of the diagnostics workforce, focusing initially on the imaging 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 Richard's 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 have already made progress on starting to scope the potential requirements for our diagnostic workforce and particularly with regards to imaging, including workforce planning priorities, training opportunities and much more. This work will allow GM and EC to take ownership of understanding their own gaps and needs to enable efficient and effective implementation of the NW Imaging Workforce Strategy, published in 2021but most importantly will ensure priority areas are driven by the workforce. It will also inform the implementation of initiatives to help drive forward the recommendations in the Richards Review[3].

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.

[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

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 Diagnostic Workforce in GM and EC.

The main aims were to:

• Review the current diagnostic workforce across Greater Manchester and East Cheshire, with a focus on imaging.

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

• Inform the development of innovative diagnostics workforce models in GM and EC.

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

3.1 Pilot approach and deliverables

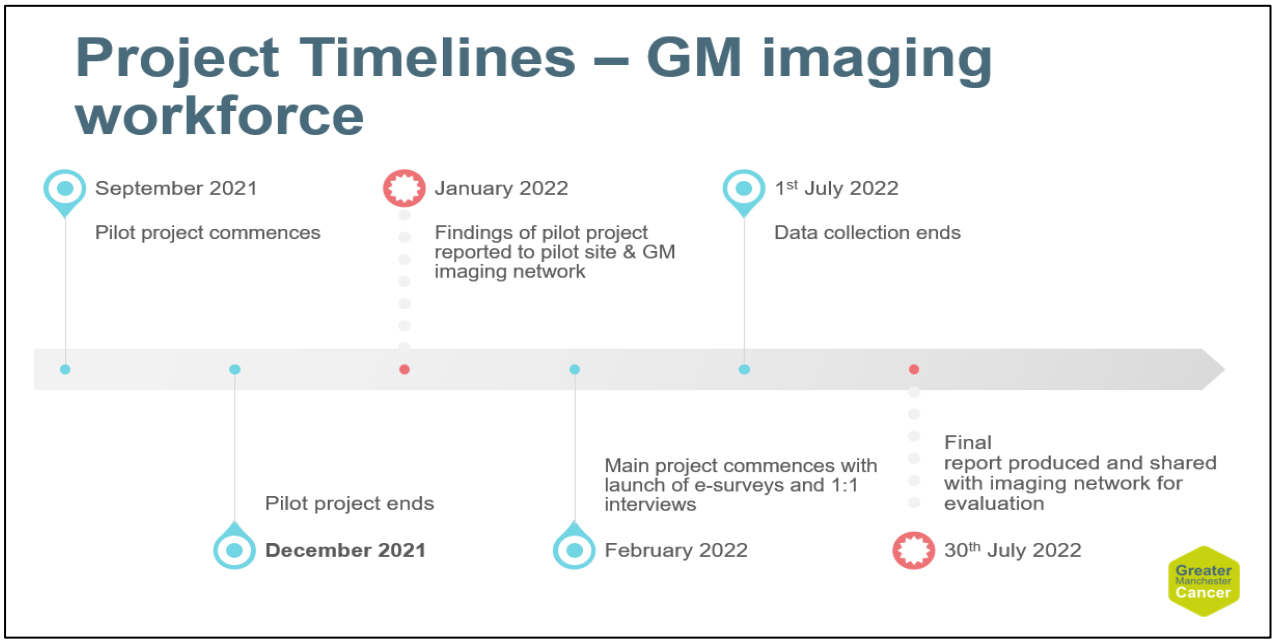
To support the project a subject matter expert (SME) was recruited. The SME was based at Bolton NHS Foundation and so it was agreed to pilot an approach at this site initially. Participants were invited to take part in an interview to talk about their views of their role within the Imaging Department at Bolton NHS Foundation Trust, 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=13 or 16% of total workforce) were transcribed for analysis and key findings were produced. The findings from the pilot report were presented to the senior management team in Radiology at the pilot site and following approval it was presented to the GM and EC imaging network.

3.2 Main project approach

Feedback received indicated that it would be difficult to proceed with 1:1 interviews with the imaging workforce at every Trust across GM and EC with just 1 project manager in GM Cancer Alliance. The project included medical staff, non-medical staff, and unregistered clinical staff. Poor staffing levels, the pandemic, and increasing demand for imaging services. would make it difficult to release participants at each Trust. The agreed approach was that e-surveys would be sent out to all Radiology 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.

Additionally, to explore the views of the future workforce, GM student radiographers from two universities (University of Salford and University of Cumbria) were invited to participate in an e-survey. 6% of the student Radiographers in GM engaged with the e-survey. 19 out of a total of 345 students responded.

3.3 Project timeline



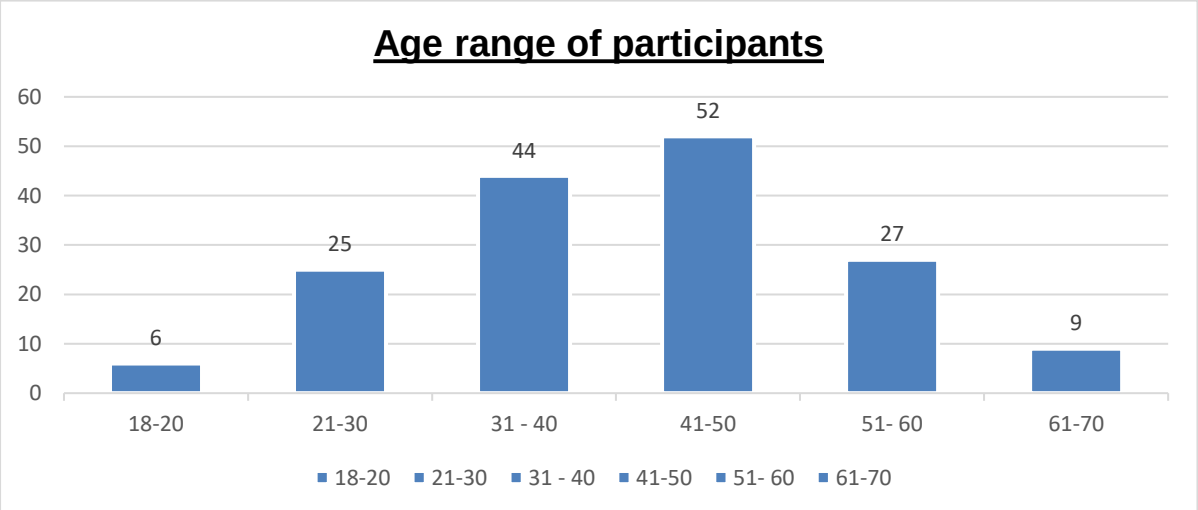
4 Findings

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.

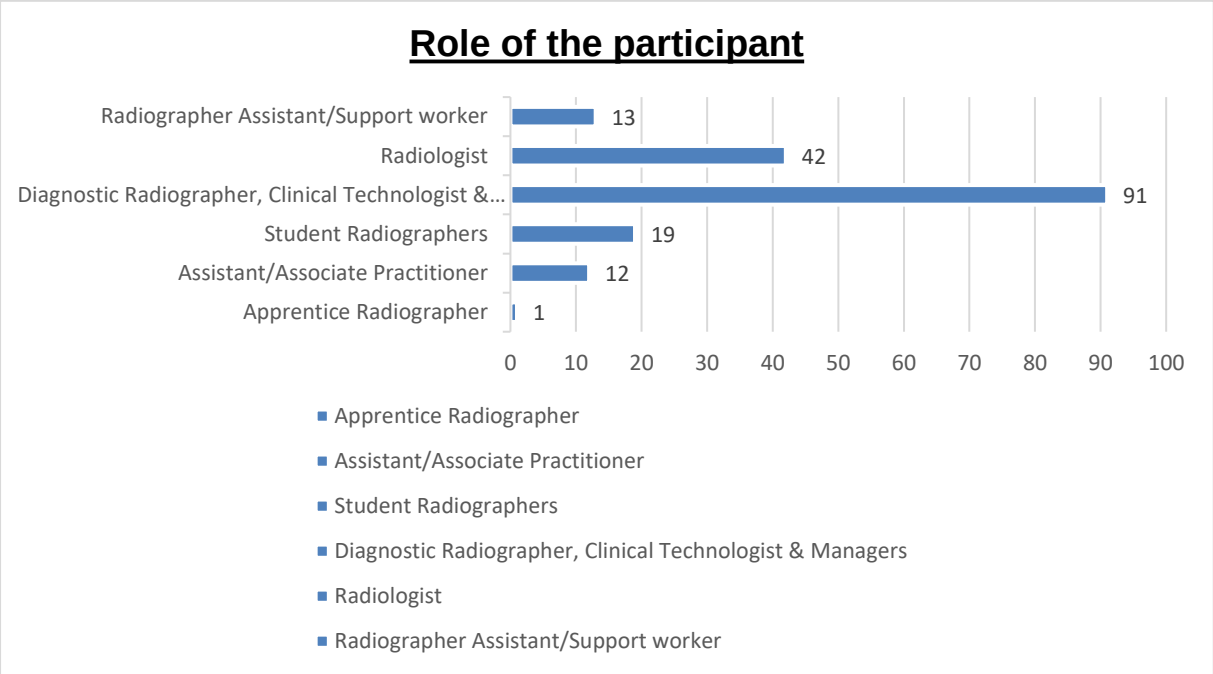
The participants were very open throughout their interviews. Many of the participants used emotive language to respond to some questions, describe their feelings, frustrations, and experiences of working in an imaging role. Some thoughts and suggestions would not be achievable at a local level but would require GM, NW or national support to introduce. Wider adoption of the ideas 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?

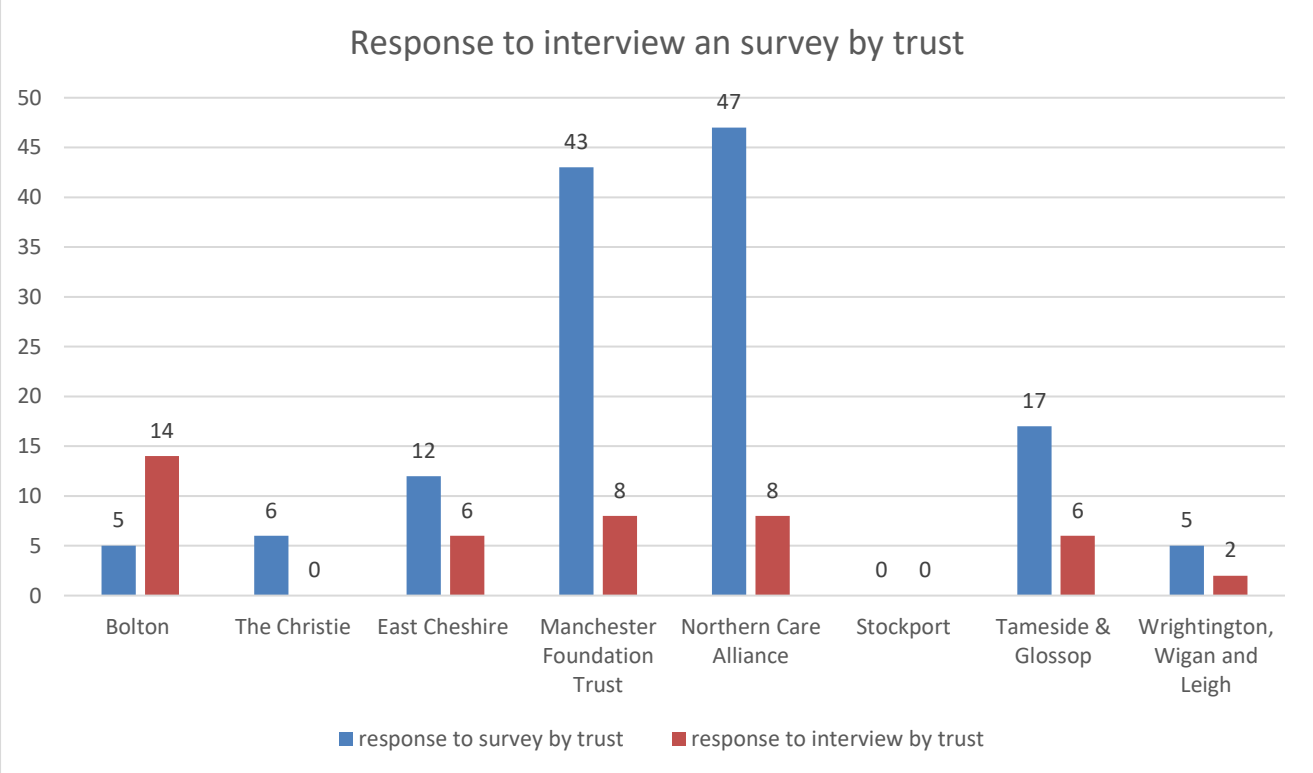
4.1.1 Age range of participants



4.1.2 Role of the participant



4.1.3 Response to interview and survey by Trust



Total number of participants in the project n=175

Total number of participants who were interviewed n= 44

Total number of participants who completed an e-survey n= 131

More detailed information about participants can be found in the appendices

4.2 Themes

4.2.1 Entry routes into imaging services

Participants all had a different route into an imaging service and varied academic and professional backgrounds:

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

- Patient care
- Technology
- High impact on patient pathway
- Inspired by personal exposure to imaging professionals e.g. the quality of service and care they had experienced as a patient or carer
- Positive placement or exposure to imaging services / inspirational Radiologist during medical degree & post graduate medical training. This positive experience highlighted the importance of imaging the pathway for patients
- Recommendation by friends/family
- Opportunity for personal and professional development
- Qualification with a professional/Consultant role at the end of it
- Ability to earn additional money
- Diversity of different imaging modalities
- Team working
- 'Foot in the door' to imaging services with a view to future development (highlighted specifically by support staff, Assistant practitioners and apprentices)
- Hospital careers events and open days where schools are invited to into the hospital and visit the imaging department meet the staff.

4.2.2 Recruitment & retention

4.2.2.1 Recruitment

There are recruitment issues in most imaging teams in GM for registered and non-registered staff however factors cited as improving recruitment include linked grade roles, preceptorship programmes, four tier structure in radiography, Radiographer reporting, medical specialities, and a culture of support from mangers and Radiologists.

Proximity to home was the most common factor in choosing a Trust to work at. Participants voluntarily stated they were very proud to work at their local hospital, and reduced travel time supported their life outside of work. Some participants said they plan to leave their local Trust to gain experience as it is not available locally but would probably return to their local Trust and the NHS in the long term.

Size of Trust was not a contributing factor with described benefits to both e.g., participants working at smaller centres reported preferring this environment as it offered the ability to become competent across several modalities faster than larger Trusts whereas participants at larger Trusts reported enjoying a more diverse range of imaging modalities, exposure to regional services e.g., trauma or neuro imaging.

The link grade scheme and preceptorship were a strong incentive for recruitment and retention at sites where it is offered. Since the introduction of the link scheme the number of Trusts offering link grade roles has diminished. Reasons included financial, too many staff at Band 6 and potential for staff to be put into a Band 6 role when technically competent but not

necessarily ready for leadership. Those that have continued to offer link grade schemes often use the Society of Radiographers (SoR) model which focuses on twelve activities which the preceptee needs to complete. [4]

A positive training experience was identified as a recruitment incentive. The importance of the team leaders including clinical educators, Radiologists and lead Radiographers were highlighted as a major influence on learners aspiring to work at the Trust where they trained. It was commonly felt that clinical educators and Radiologists needed more time to support all learners.

HEI's are delivering recruitment events for final year radiography students where employers present opportunities and Radiographers talk about the day-to-day job, prospects for progression, CPD and job opportunities. This year these events were online, and the IS were especially well represented. Network led collaborative recruitment events and talent pools would provide a central point for prospective Radiographers to apply for vacancies in GM. An event in January 2022 at The University of Leeds included only one GM Trust (out of 28 employers presenting). Similar recruitment schemes have been successful for other AHP's and has supported students to get a role at their preferred location as posts became available.

4.2.2.2 Retention

Additional external roles and responsibilities e.g., examiner, advisor, or lecturer, was an incentive for staff to remain at a Trust and in clinical practice. These opportunities were felt to raise the profile of the department nationally, make the department an attractive place to work and support development whilst remaining in post.

Several participants reported that their Trust was not currently identifying why staff are leaving and offering exit interviews. Managers had not discussed resignations or explored potential ways to retain staff who had left.

Some teams have not reviewed their shift patterns for many years or decades as it a difficult job to undertake and some managers commented that they did not have the time to dedicate to such a lengthy process. Staff reported historical shift patterns no longer suited current demand or the staff. Staff shortages have put a huge amount of pressure on all teams, but this is especially true for plain film/general Radiographers who reported that they are working a high level of night and shifts. This is influencing people to look at securing roles in other modalities and not working in plain film/general roles.

Several participants had experienced barriers with international recruits. International Radiographers arrive with HCPC registration and standards of skills has varied greatly. A common barrier described was lack of confidence and reluctance to say 'NO' to challenge a decision. Support to empower International recruits would allow them to be confident in their new role and culture.

HEE are currently running a global educational programme for healthcare professionals from other countries who would like to spend three years in the UK on an earn, learn, and return scheme. Doctors with suitable radiology experience can be recruited from the UK or internationally and can increase the Radiology workforce by bringing their experience with them. Fellowships are an opportunity to undertake training focused on an area of subspecialist interest. The expectation is that they will spend 60% of their time on general duties, with the remainder devoted to developing a specialty interest through a mixture of supervised service work and learning opportunities. For 20% of their time, they will have no

[4] International Journal of Practice-based Learning in Health and Social Care
Vol. 8 No 2 December 2020, pages 57-67

service delivery expectations, allowing them time for development e.g., new services and management.

Experienced participants reported that they are now in the minority and are feeling the pressure to deliver service and train colleagues. This was stated to be a leading influence for early retirement for some. Radiologists & Radiographers who have retired & returned were tempted back to deliver training, mentorship & support. These roles were very attractive but, staff have subsequently been used for routine service delivery. Trusts need to engage with staff close to retirement to establish where they would like to work and ringfence attractive roles to retain them e.g., governance, training, mentorship, development of workforce/future leaders. Other participants close to retirement stated they had observed how others had been used to deliver service rather than the 'interesting role' they were promised. As a result, they will not return once retired.

Radiographers in leadership and management roles described a loss of advanced clinical skills due to the increase in managerial tasks. These advanced practice skills have been lost and have reverted to being Radiologist led with longer waiting times. One Radiographer described spending more time coordinating a team than they spent delivering the service directly to patients by themselves. Supporting practitioners in leadership roles to maintain some element of expert clinical practice could lead to efficiencies, retain experienced staff and improve motivation.

Radiologists commented that there was a perception that Trusts who have focused on Radiologist's job planning have fewer vacancies. Although no evidence could be found to substantiate this, good job planning could be used as a recruitment incentive to attract prospective Radiologists and Clinical Directors.

Ultrasound services have experienced high attrition over the last few years. There is a national shortage of Sonographers and six Trusts are struggling to recruit. However, some services have remained consistently well-staffed with no vacancies. A structured support and leadership plan for lead Sonographers has made the roles more attractive at some Trusts and has assisted in development of skills to manage and lead change effectively.

These successful services reported that they are led by -

• Sonographers at management grade 8B to reflect the complexity of the service & regulation expertise.

• Governance Sonographers who have created a robust governance structure.

• Clinical leads at Band 8A with specialisation e.g., MSK ascitic drains, steroid injections. These roles have developed the service and retained the workforce.

These successful departments have -

• Prioritised leadership in Ultrasound.

• Created research and development opportunities to motivate and deliver a quality service.

• Job planning to ensure maintenance of clinical skills. Workloads are realistic and regularly reviewed when there is a change is service delivery as well at annual appraisals.

• Increased training opportunities when identified and succession planned.

• Recruited a mix of Radiographer trainees & direct entry routes for trainees with transferable skills outside of Radiography – link to Richards report recommendation 18

• Developed business cases for funded training places and demonstrated why this is cheaper than outsourcing work in the long run. Ultrasound managers engaged with Trust executive teams and finance directors to get them on board.

• Provided support to get accreditation as Advanced Practitioner roles covering 4 pillars of advanced practice

There was a reported lack of standardisation across GM for rates of pay. Rates for overtime, waiting list initiatives and additional shifts vary between Trusts and all are lower paid than the independent sector or locum roles. Locums receive payment the day following each shift worked. Significant tax issues are deterring Radiologists from volunteering for additional work as they have previously done. Issues resolving pay discrepancies took several months to resolve. Participants stated that their managers were so busy that resolving pay issues was no longer seen as a priority. This has led to demotivation and resulted in reduced retention.

Key takeaways – recruitment & retention findings

- Every Trust has recruitment issues.
- Location was the most important factor when choosing an employer however, offering opportunities to develop cross-site utilizing the digital staff passport could support retention.
- 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.
- Link grade and preceptorships are strong recruitment tools.
- Experienced staff with external roles e.g., examiner, remain motivated.
- Offering a diverse range of high-quality training and teaching for all learners is a strong recruitment incentive
- Historical shift patterns and anti-social hours can be demotivating if not regularly reviewed.
- Senior staff and leaders aspired to maintain some expert clinical skills rather than just management roles.
- Personal development is important for all staff to motivate and retain.
- Not all Trusts are offering exit interviews when staff leave their service.
- International recruits require support to adjust to cultural differences in the UK workplace.
- 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.
- Radiologist job plans require regular review.
- Pay discrepancies are common and payment for additional work is lower than the independent sector.

4.4 Covid 19 recovery

The pandemic has led to participants focusing on what ‘they’ want. This has led to a variety of unanticipated consequences.

Respondents reported the following changes to their working lives -

- Better work/life balance linked to reduced hours worked and home working
- Achieved new roles or promotion into a leadership position
- New role/different modality to move away from shift and weekend working

- Unplanned and early retirement
- Later retirement or retire and return due ability to work from home
- Move to a less clinical/physical role

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

People reported fewer opportunities for the more junior staff to develop post pandemic. Previous opportunities included link roles e.g., infection control, dementia champions, equipment Quality Assurance or managing incidents. Introduction to these roles exposed people to new skills, new networks and gave ownership to a service. These roles also gave people a short break from 'relentless workload' which has been removed during the pandemic. There was also a perception of reduced number of audits and reduced communication of audit results. Communication amongst teams was felt to have deteriorated since the start of the pandemic and staff meetings are infrequent or have stopped. Participants stated that there was such a focus on service delivery that this was perceived to be more important than anything else.

Key takeaways – Covid-19

- Many career changes were reported post pandemic e.g. promotion, reduced hours etc.
- Home reporting offers additional flexibility to work remotely improving quality of life.
- Learning and development opportunities have been reduced during the pandemic
- A reduction in team meetings has occurred and communication is less frequent
- Communication links for home workers need to be established

4.5 Learning and development

Most participants highlighted the importance of development opportunities in their role.

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

Experienced staff shared what their Trusts had done to develop them. Examples included –

- A joint clinical and educational role at the Trust, local HEI or professional body.
- A reduction in generic service delivery/reporting and specialization in a chosen area of expertise.
- Retire and return in a mentorship, governance and training role.

There was little incentive for Radiologists to become Clinical Director. It was felt that they received little Trust level support or contact. Participants reported that Trust leaders only contacted their Director when a problem occurred. Several Radiologists who had previously been a Clinical Director felt like a forgotten speciality and wanted more consistent support to make this a more desirable role.

56% of Radiographers did not feel a Radiology Service Manager role was aspirational and they did not want to become clinically deskilled. 75% of Radiographers did want a level of management responsibility and clinical expertise. Leadership roles described as appealing retained an element of clinical practice.

Lack of leadership and management skills were a barrier in staff confidence to apply for leadership roles. Participants felt leadership learning opportunities were Nurse focused and the imaging workforce would benefit more from a programme tailored to diagnostics. The exposure suggested included finance, attending modality leads groups, shadowing colleagues in more senior roles, practical training/experience and skills to support learners. HEE are currently investigating the development of a diagnostic service management leadership course.

Participants reported a reduction in engagement with development opportunities since the pandemic. Areas felt to be receiving less exposure included audit, governance, safeguarding, infection control. These were described as essential development opportunities for people and support for the wider team. Service delivery was perceived a priority over staff development.

There was variation and inconsistency in the use and scope of practice for Assistant Practitioners (AP) outside of breast imaging. Most APs continued to work at the Trust where they trained and work in a variety of modalities. Some Trusts have APs well established in their culture with clear development pathways whereas other Trusts reported significant barriers. This was due to many factors including a lack of funding, access to imaging specific training programmes, lack of placements and the requirement for supervision within a stretched workforce. Despite this the AP role was reported as being 'indispensable' in several Trusts as part of their 4-tier structure and are utilising APs to release Radiographers to undertake more complex work. The variation of AP roles was a source of frustration for Radiographers with previous experience of working with APs. Junior Radiographers expressed concern that a lack of APs may hinder their development into advanced practice roles in the future. One manager stated, 'If it had been easy, I would have employed more APs years ago'. Radiographers who had successfully worked with AP's attributed their success to good governance, specific scope of practice and visible policies to ensure everyone's role is clear.

The last workforce audit of imaging staff in 2021 showed there are only 4 Consultant Radiographers. It was not possible to establish the number of Advanced Practitioner Radiographers in GM from the collected workforce data. It is unknown how many Advanced Practitioners are professionally accredited. There is a variation in what modalities have developed these roles. Not all Trusts have supported their development or accreditation of those who are already working at an advanced level. Some staff have independently applied and been accredited with advanced practice status.

Frustration was reported around a lack of opportunity to progress from a clinical support role to a Radiography role and beyond. Appropriate education has not always been available to facilitate career progression and Trusts have struggled to fund opportunities. People who have not been able to progress have become demotivated and left the imaging workforce. Clarification on education pathways to support career progression from CSW to Consultant Radiographer was requested by participants.

The role of the clinical educator was considered key but it was felt that there is insufficient time to address students and staff CPD in almost all services. The demand for clinical education has grown since many of these roles were introduced and there are now more and different types of learners in imaging departments. Radiology departments only have funding for a part time clinical educator. This was perceived as a demanding and stressful role but very rewarding.

CPD was considered a high priority by all participants but opportunities for CPD were reduced post pandemic with more offerings available as e-learning which does not suit everyone and can be difficult to access due to lack available computers in imaging departments. The current lack of opportunity for personal and professional development post pandemic is leading to boredom, demotivation, feelings of becoming a 'workhorse' for

service delivery, and ultimately restlessness for junior staff. However, several participants with no desire to gain more responsibility enjoyed developing themselves and gained enormous satisfaction supporting learners with fresh skills.

Other networks and professional groups have combined CPD resources to deliver a much wide variety of opportunities for learners supported by their network. The full range of learning and development opportunities are available in one location to support staff access to all clinical and leadership learning opportunities e.g., regional AHP fellowship programme which is fully funded and would provide leadership and support as part of the NW regional delivery of HEE's national AHP Reform Programme. Department CPC sessions can be shared across the network, reach a large audience at a time to suit them. A digital learning platform also include a directory of functional skills across for the development of CSWs. Functional skills relate to numeracy and literacy attainment (mathematics and English). They are a core element of all healthcare apprenticeship standards. Digital skills have now become an essential skill. Information on accessing these skills should be widely available. Related to Functional Skills are English for Speakers of Other Languages (ESOL) programme that help, for example, staff employed through international recruitment to become more proficient in the English language.

Succession planning was not possible at the majority Trusts due to financial constraints, but some Trusts have embraced an opportunity to plan by providing opportunities for potential candidates to shadow leaders, attend meetings and get exposure to a potential future role. Many services 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 may take up to a year recover.

Many participants expressed a desire for engagement in audit early in their career and suggested inclusion of all staff groups in the imaging workforce. Involvement in audit was described as motivational and supported development.

Participants from a Black, Asian and minority ethnic background commented that they felt a role in leadership was unachievable due to their ethnic background. They were not aware of any support or specific opportunities to develop people from Black, Asian and minority ethnic backgrounds e.g., Stepping up programme from the NHS Leadership academy[5].

Key takeaways – Learning and development findings

- Offering a range of training and development opportunities and CPD is a recruitment and retention tool.
- Hybrid roles with external organisations may support retention e.g., professional body
- Specialised clinical roles are desirable and generic work is less desirable for experienced staff
- There is little incentive for people to move into senior leadership roles.
- Leadership and management training specific to diagnostics is desirable.
- Lack of development opportunities post pandemic
- Roles of Assistant Practitioners vary across GM
- There are few Consultant or advanced practitioner Radiographer/Mammographer roles in GM.
- Pathways for 'end to end' career development are not clear.
- Junior staff are seeking development opportunities e.g., link workers and audit.
- Lack of confidence and low awareness of opportunities to develop underrepresented groups e.g., a Black, Asian and minority ethnic backgrounds.

[5] Stepping Up Programme – Leadership Academy

4.6 New ways of working

Every Trust has some Reporting Radiographers, but modalities and scope of practice varies between Trusts. The range of reporting skills is currently decided locally depending on need, availability of supervision and Radiologist support. The EMRAD Reporting Radiographer network is 2/3rd cheaper than outsourcing reporting for MSK plain film for Outpatients and General Practice reporting where patients were on average waiting 1 to 3 weeks for results. The success of the scheme led to an introduction of CT head reporting across their network and now these Radiographers provide a first on call service for head CT reporting. Huge savings have been realised due to the reduction is outsourcing. EMRAD now have over 50 Reporting Radiographers across their network and have seen a huge increase in insourcing as all reporters have home reporting access and dedicated time to report in job plans.

Innovative roles including Radiographer led discharge from the emergency department (E.D.) – link to Richards report recommendation 2. This service is successfully running at Bolton NHS Foundation Trust and will resume in Salford Royal hospital late 2022. The service reduces the waiting time for patients attending minor injuries within the emergency department by allowing eligible patients to be discharged directly from emergency radiology if no bony injury is demonstrated on their x-rays. This service utilises highly qualified and skilled Reporting Radiographers, images can be reported immediately, and the patient informed of the result from the individual responsible for the report. For patients who would only require treatment if their x-rays demonstrated a fracture, this eliminates the requirement to return to the ED if no fracture is demonstrated. Where bony injuries are present, the Emergency Unit (EU) clinician will receive the official report immediately from the Reporting Radiographer, meaning the risk of potential delayed diagnosis is eliminated. Further work is required to explore ways to scale and spread this new way of working across GM.

The GM levels of Radiographer reporting are high compared to the national median of 31.4% and peer median of 23.8% (January 2022). In the last 12 months 50-60% of chest x-ray reporting in GM has been done by reporting Radiographers (Data is unvalidated and approximate). Radiographer reporting varies between Trusts and by modality.

All of the plain film or general Radiographers reported their teams were short staffed. Plain film Radiography was perceived as a ‘gateway’ to different modalities, and they are sustaining ‘brain drain’ into cross sectional imaging. A general feeling that there was ‘no end in sight’ for the high demand and low staffing levels currently experienced. Frustration was expressed as people are regularly asked to work additional shifts by their manager, often at short notice and at unsocial hours. Radiographers felt their welfare was no longer being taken into consideration but understood their managers had no other option but to ask. There was a perception that managers in plain film radiography are in a lower pay band than counterparts in other modalities or Trusts despite having identical level of responsibility. This made progression in plain film imaging less attractive.

Radiographers said they are very interested in cross site/Trust working that would facilitate them to work in different imaging modalities. This could provide interest and development of new skills which they could potentially bring back to their host Trust and offer locally whilst maintaining quality. This would improve patient access and reduce inequalities. This could be facilitated using the digital staff passport (DSP)[6].

Radiologists described some routine tasks that could be delegated to other registered members of the imaging workforce. A small investment in training to develop the approval skills had subsequently released Radiologist’s time to report on more complex work. An

[6] NHS Staff completing a temporary move - NHS COVID-19 Digital Staff Passport (staffpassports.nhs.uk)

example given was Radiographer vetting of MR requests. This has proved to be successful and hs a low rejection rate for referrals. Other suggestions included additional administration staff to improve efficiency of MDTs.

Training to lead an MDT was described as essential prior to becoming a Consultant or advanced practitioner. Learning to identify inappropriate referrals, coordination skills, presentation skills and conflict resolution would ensure efficiency at these meetings. GM Cancer is piloting an MDT Leadership Training Course for Chairs and Leads but is looking to expand wider to aspiring Chairs/Leads and those who attend or contribute such as CNS's & ACPs.

The HEE breast clinicians programme[7] is supporting experienced Clinicians to become part of the Radiology workforce without becoming a Radiologist. The Breast Clinicians pilot has recruited Clinicians with a relevant background into a standardised funded training programme where they gained accreditation to become part of the breast clinician workforce to support breast screening and symptomatic services.

Breast imaging services have introduced the new apprentice and associate Mammographer roles which are an incentive for people to join the team, remain and develop in a service. Support workers can join the team and progress to training as an apprentice Associate Mammographer. One participant said this progression pathway was the reason they had applied for a support role in breast imaging. They were very keen to progress to an Associate Mammographer role as soon as opportunities arise.

Apprenticeships have only recently been introduced for APs and Radiographers. Funding has been provided by HEE to support the process and an apprenticeship levy is available to Trusts. There were several barriers reported by Trusts wishing to implement apprenticeship schemes. Apprentices can normally only be recruited when a vacancy and associated salary is available. Although some funding has been made available by HEE it is limited to £10,000 for one year and is non recurrent.

The apprentice Radiographer course was described as tough as the apprentice works and studies often in their own time. It needs to be very clear to the apprentices what will be expected of them and getting the right candidate is the key to success. Balancing working, studying and family life can be difficult and requires careful time management. Recruiting apprentices has created a diverse workforce from the local community. It was a popular role with lots of applicants. Introducing apprentices is an excellent way to support the diversity, equality & inclusion whilst growing a local workforce. A reported benefit by apprentices was arriving in the workplace much earlier than student Radiographers which expedited their clinical skills and improved confidence compared to students.

Participants who reported images discussed their opinions on networked reporting. Concerns were raised about loss of control over quality and opportunity to learn or improve through targeted feedback. There was also perceived to be a disconnect from the ‘customer’ (referrer). A lot of emphasis was placed on the value of understanding who the report is being written for and what it will be used for.

Radiologists expressed concern over a lack of autonomy and demotivation as they are sometimes perceived as a service provider rather than a clinician. Networked reporting may remove the feeling of ownership due to the perception of a ‘network cushion’ and remove the incentive to complete one’s own work.

[7] Breast clinicians - credential in breast disease management | The Royal College of Radiologists (rcr.ac.uk)

Some specialist/tertiary services reported a creep of inappropriate referrals from secondary care for procedures which could have been done back in secondary care and closer to the patient's home. Specialist services are being overwhelmed and Radiologists in secondary care risk becoming deskilled for some procedures not done routinely.

Radiographers felt their workload may be more suited to networked working for reporting images e.g., chest x-rays, providing robust governance, feedback, and audit mechanisms were in place. Larger Trust already reported images for several sites and felt there would be little change in reporting across GM.

Examples given where networked working may work well in GM included chest, renal and neuro to support people in district general hospitals struggling with complex work, improve confidence, skills and speed.

Established networks e.g., EMRAD are already demonstrating the benefits of system wide working. Benefits reported including sharing of images, joint procurement, sharing of best practices, sharing of workload, learning from each other, training together and wider access to specialist opinion.

Clinical support workers were found to be a well-established part of the imaging workforce in some Trusts. Some Trusts reported struggling to access imaging specific education programmes for both support workers and assistant practitioners which has resulted in following a generic health care programmes. Developing imaging support workers into registered practitioners continues to be a national issue.

Key takeaways – New ways of working findings

- Radiographer led discharge from ED is improving patient pathways
- Student and Junior Radiographers expressed an interest in cross site and cross modality working
- Education schemes have pulled new people into the imaging workforce for Breast imaging
- Apprenticeship schemes are growing the imaging workforce with funding from HEE.
- Concerns around networked working should be addressed with Radiologists to maintain quality and productivity
- Identify what the biggest gain could be from networked working and use of new technology

4.7 Health and wellbeing

Health and wellbeing support varied at each Trust in GM and EC. People reported various success contacting support services and people at some Trusts never received support after referring themselves or one of the team.

Key takeaways – Health & wellbeing

- Access to mental health services has been varied. Some services have supported staff to remain in work and others have taken months to respond to referrals
- Not all departments have regular or private access to computers to review health and wellbeing offerings.
- On site access to Physiotherapy services has supported staff to remain in work
- Staff routinely experience verbal and physical abuse from patients especially out of hours and weekends

4.8 Review of establishment

Every participant commented on the pride in their team and the quality of service they provide despite their high level of activity and increasing demand for imaging 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 and last-minute amendments to rota. The significant increase in demand and new ways of working have not attracted any increase in establishment in some Trusts. Several managers confirmed there hadn't been a review of the establishment over a decade.

All participants reported regular repeated loss of efficiency and poor patient experience due to issues with portering services. Patients and staff are both regularly waiting for portering services leaving participants with no work, underutilised equipment, and poor patient experience. Participants admitted they were doing the portering themselves to improve workflow.

Managers and team leaders reported feeling under tremendous pressure and 'embarrassed' to repeatedly ask staff to work additional shifts to maintain the service as demand has exceeded capacity. This has led several leaders experiencing significant anxiety which has contributed to mental health issues. Managers reported staff are no longer responsive to repeated requests to work more hours at current pay rates. In turn this has led to experienced staff feeling overburdened and less experienced Radiographers feeling unsupported or unable to cope.

5 Recommendations – RRR= Richards report recommendations

5.1 Entry route recommendations - RRR 12, 13 & 18

5.1.1 Adopt a coordinated approach to promoting roles in imaging amongst the community. Attending school careers events, open evenings to meet the team, work with FEI's (e.g., Bury college) and HEI's to promote imaging as a career choice. A coordinated approach would be more efficient than individual Trusts developing resources and delivering it to their local communities at a time of workforce shortages.

5.1.2 Develop an end-to-end career pathway for radiography from imaging support worker to Consultant Radiographer. This would demonstrate the path to become a registered professional and provide unique opportunities for learners who are otherwise excluded from becoming a registered professional.

5.1.3 Raise the profile within GM of careers in imaging services.

5.1.4 Promote quality learning experiences to influence learners e.g., junior Doctors.

5.1.5 Promote STEM ambassador programme[8] across GM to help Trusts connect with young people, inspiring them to become the next generation of imaging professionals. Engage with outreach programmes in schools, colleges, and out-of-school groups to attract future workforce into an imaging role. Encouraging employees to sign up and allow them time off for occasional volunteering.

5.2 Recruitment and retention recommendations- RRR 12 & 13

5.2.1 Consider a combined GM network led recruitment programme run in partnership with HEI's including those outside of GM.

5.2.2 Collation of the benefits of working in the NHS compared to be shared with Trusts to support their recruitment and retention materials e.g., robust governance structures, pension

[8] Employers engaging in the STEM Ambassador programme | STEM

scheme, annual leave, sickness absence, personal and professional development, link grade, annual personal development reviews.

5.2.3 Development of a GM wide preceptorship scheme to attract more Radiographers into the region, avoid duplication, and provide a high-quality level of preceptorship to all. Preceptorship plans could still be tailored to suit the needs of each Trust but would ensure the basic skills are covered and support assured. A similar scheme could be investigated to attract Radiographers into harder to recruit Band 6 roles e.g., fluoroscopy or interventional radiography.

5.2.4 Consider wider introduction of Link grade Band 5-6 as a strong recruitment tool using learning from trusts who have successfully embedded this role.

5.2.5 Connecting with national schemes like Refuaid[9] to engage with international recruitment and attract experienced refugees. Provide support to have qualifications accredited for working in the UK.

5.2.6 Ensure all international recruits are fully supported upon arrival in their new role and retained in service.

5.2.7 A review of exit interviews and annual staff surveys will identify specific reasons staff are leaving. This information will support development of an improvement plan for staff experience and retain staff. Support Managers to have a discussion with staff if they discuss leaving and identify if any support could be provided to dissuade them from leaving.

5.2.8 Reviewing what Trusts can offer to encourage 'retire and return'. Roles including training, governance and mentorship are aspirational. Managers supported to have a discussion to identify individual's motivation for retirement and see if support mechanisms can be introduced to retain them e.g., experienced Clinicians struggling with post pandemic cleaning routines could be supported by a CSW. Home reporting is desirable and would retain people in the workforce longer and offer support to learners.

5.2.9 Introduce an annual GM positive celebration of improvement in imaging services. This would promote imaging roles and celebrate the good work being done by the workforce. Teams could nominate themselves or colleagues for successful change or improvement. The improvements don't need to be innovative but would recognise the scale of improvement e.g., who/what has changed/improved, where has the biggest impact been seen, who helped you to get there. This would raise the profile of the imaging network on social media and professional journals to celebrate the outstanding work of the imaging workforce in GM.

5.2.10 Further work is required to standardise enhanced rates of pay for overtime, waiting list initiatives and additional shifts. Establishing an attractive standardised pay rate for people to encourage NHS working instead of the independent sector. A GM diagnostic staff bank with enhanced rates of may encourage staff to work additional hours for the NHS rather than independent providers. Managers should be supported by Finance teams to resolve staff payment issues rapidly when reported.

5.2.11 Sonographer pay rates for additional work requires additional consideration to allow Trusts to offer pay that is competitive with independent sector payrates. This may retain Sonographers and be an incentive to work additional hours for the NHS rather than the independent sector.

[9] RefuAid

5.2.12 Support experienced staff to have external or hybrid roles to retain in the service.

5.2.13 Develop a regular and diverse range of CPD activities to engage team members at every level.

5.2.14 Support experienced leaders to retain some clinical elements to their role to motivate and retain.

5.2.15 Promote regular job planning to ensure people have a timetable that accurately reflects what is required and it is achievable.

5.2.16 Regular review of all shift patterns to ensure shifts deliver the required service and meet the needs of the current staff group.

5.2.17 Trusts to engage with succession planning. Identifying people likely to leave would allow time to prepare a business case, share developmental opportunities or exposure with the team and encourage a successor and to prepare them for progression, e.g., shadowing, to allow an insight into potential future roles.

5.2.18 Utilisation of the DSP could support staff retention by allowing staff to gain experience elsewhere temporarily rather than leave and return.

5.3 Learning & Development opportunities recommendations- RRR12 & 13

5.3.1 Increase the number of Practice/clinical educators across different modalities. A named individual in each modality would support clinical education. Several clinical educators have achieved accreditation and professional status with the College of Radiographers Practice Educator scheme[10]. This scheme supports clinical educators to develop and identify any gaps in their portfolio.

5.3.2 Development of a shared digital learning platform for CPD and training.

5.3.3 Support increased utilisation of the Digital Staff Passport to facilitate movement across Trusts, improve access, expedite learning and clinical experiences as a means of retaining staff, improving quality and reducing variation in service delivery.

5.3.4 Introduce leadership development for all staff groups. Every staff group expressed a desire to improve their leadership skills. This would improve confidence to progress and make team lead roles attractive and aspirational.

5.3.5 Support for future leaders to develop MDT leadership skills to support the transition into senior roles. GM Cancer is piloting an MDT Leadership Training Course for Chairs and Leads but is looking to expand wider to aspiring Chairs/Leads and those who attend or contribute such as CNS's & ACPs.

5.3.6 Appointing audit or governance link workers in departments or modalities may provide development opportunities and mentorship whilst improving standards and ownership in the team for Radiographers or Speciality level trainee Radiologists.

5.3.7 Identifying support for Clinical educators would allow them to focus on supporting learners and reduce tasks that could be completed by administration support staff.

5.3.8 Investigate bulk buying CPD and to provide an economical way to motivate staff in plain film imaging. e.g., Commissioning places for all Band 5 Radiographers to complete a Red Dot course in their first-year post-graduation to develop plain film skills, provide early careers support for junior staff, maintain interest of experienced staff, and acknowledge the

[10] Practice Educator | CoR (collegeofRadiographers.ac.uk)

importance of plain film imaging. Plain film Radiographers spend most of their time in direct clinical delivery. Building small amounts of time into a service model will retain and motivate new and established workforce.

5.3.9 Partnership working with HEI's and the NW imaging academy will support the development of an appropriate range of educational services in GM. This provision will change over time, but engagement with a representative from local HEI's to join workforce and modality lead groups will support a stronger link between clinical services and HEI's.

5.3.10 Development of a GM end-to-end workforce strategy signposted with access to educational opportunities.

5.3.11 Support direct entry routes into Ultrasound and establish if there is further demand for other modalities or staff groups e.g., AP training for MRI. AP programmes haven't covered cross sectional imaging and require the learner to complete the relevant 'plain film' imaging modules first.

5.3.12 Identify a programme of support and leadership training specifically for Ultrasound services to address the current issues.

5.3.13 Engage with HEIs/ FEI's to support development pathways for imaging support workers and delivery of Radiography specific programmes.

5.3.14 Establish a GM support network for aspirational Advanced Practitioners and consultant roles to provide mentorship and support training opportunities.

5.3.15 Promote routes for Advanced Practitioners to gain accreditation using the NHSE e-portfolio toolkit. They work with a HEI to identify gaps and support is provided to fill the gaps. This should be coordinated with the NW imaging academy at scale. It should also support recruitment for roles which are hard to fill. Rolls could be advertised with support to gain advanced practice status as a recruitment incentive.

5.3.16 Engage with the University of Salford to develop a gateway for Advanced Practitioners and Consultant Radiographers to undertake the Prof Doc qualification into a predominantly clinical role.

5.3.17 Engage with HEI's and the NW imaging academy to ensure the range of educational requirements match current need e.g., open reporting modules for niche areas like defecating proctograms or interventional radiography. Ensuring alignment with the NW imaging academy to ensure a standardised and regional approach rather than delivering Trusts specific standards.

5.3.18 Engage with the NW imaging academy to identify different and alternative types of support for Reporting Radiographers when local Radiologists are unable to support training.

5.3.19 Invest in training and development for all support staff to take blood or cannulate to improve the patient pathway where not already done.

5.4 New ways of working recommendations- RRR 3, 5, 7, 12, 13, 18 & 19

5.4.1 Identify additional new roles to grow the workforce across GM. There is large variation across GM with success in introducing innovative roles. Some Trusts have been more successful in developing new roles and growing its own imaging workforce, so there needs to be further sharing of workforce models.

5.4.2 Rapid evaluation of artificial intelligence (AI) to improve patient pathways e.g., Improved turnaround times for chest x-ray reporting.

5.4.3 Consider Introducing point of care testing in imaging departments to provide efficiencies where an increase in imaging is anticipated e.g., blood test prior to CT scan. Introduction needs to be properly resourced, and training delivered to get maximum gain from investment.

5.4.4 Utilise the improved connectivity offered by PACS as an opportunity to identify new ways of driving efficient seamless care across traditional boundaries. Explore *'totally new ways of delivering systemwide working'* rather than making PACS fit in with our current ways of working. Further work could identify where the technology and networked reporting could achieve the biggest gains but requires careful consideration & wide engagement with the Radiologists to get the best solution, devise reporting standards and methods of quality assuring networked reporting.

5.4.5 Investigate if networked working could be an opportunity to support subspecialty areas for Radiologists.

5.4.6 Conduct a GM review of outsourced reporting to provide information on any efficiencies. A review of outsourced work across GM could generate more time for colleagues to provide a tertiary and more out of hours service. Further work could identify what gains could be achieved by working smarter with outsourcing. An example given of a gain was to create 2 GM emergency hubs to provide out of hours work with a blended team made from of subspecialty radiologists, consultants, a few specialist trainees working in a hub because 'you can sit anywhere and deliver it'.

5.4.7 Conduct a review of Radiologist tasks to identify what elements could be delegated to other people in the workforce.

5.4.8 Explore how to upscale and spread Radiographer led discharge from E.D. This could be replicated at more sites across GM to improve discharge times for patients and release facilities.

5.4.9 Identify which modalities could benefit from introducing AP's. Further work should be undertaken to identify where the biggest impact could be seen with increasing the numbers of AP's e.g., plain film, MRI, DEXA, lithotripsy. Identify if split role AP's could support smaller modalities where a full time AP could not be sustained e.g., interventional and plain film imaging to support areas difficult to recruit into for Radiographers. Establish how AP's have been introduced into a theatre environment as part of a skill mixed imaging team outside GM with a view to piloting it in GM.

5.4.10 Use the introduction of CDC's as an opportunity for AP's to expand the imaging workforce and release Radiographers to undertake more complex tasks like reporting. This may be an opportunity to blend the role of AP's to support other services e.g., point of care testing – blood test, urine tests, ECG.

5.4.11 Develop a GM standard set of advanced practice scopes of practice and job descriptions. This could support Trusts to introduce or increase the range of advanced or Consultant Radiographers. Promoting methods to extend scopes of practice could increase capacity, improve access and support earlier diagnosis.

5.4.12 Develop a GM Reporting Radiographers strategy to provide a consistent approach and recommend what reporting should be routinely offered to make the biggest impact. Gain a better understanding of high performing Trusts for Radiographer reporting to support those wishing to increase to 50%. Identify which images/modalities could deliver more reporting by Radiographers.

5.4.13 Utilize the ACCEnD (Aspirant Cancer Career and Education Development) framework as a model for developing an end to end career framework for the imaging workforce. This

could address and provide solutions to key issues that challenge the workforce both now and into the future.

5.4.14 Work to identify and address perceived inequalities to make Plain film/general Radiography more attractive and stabilise the workforce.

5.4.15 Explore split roles for Radiologists across two Trusts to attract Radiologists and support the complex workload at specialist services/Trusts e.g., Paediatrics or Oncology. This would provide a bigger pool of staff, support Radiologist development and provide a more resilient Radiology service across GM.

5.4.16 Conduct a review of referral patterns and support solutions to avoid specialist services being overwhelmed and prevent Radiologists in secondary care becoming deskilled for some procedures not done routinely.

5.4.17 Ensure all opportunities are taken to expose trainees to speciality Radiology services at regional centres of excellence. Exposure to these services may inspire junior Doctors to train in a Radiology role. Further communication with Deaneries would identify how to get maximum exposure to these specialist services and attract the Radiologists of the future.

5.4.18 Collaborate with the NW imaging academy to develop a range of bespoke radiology education resources across the GM network e.g., masterclasses in specialist areas like vascular and neuro radiology imaging.to support Radiologist development. Include a range of contributors e.g., surgical experts, tech partners and applied PACS uses. This should include leadership and clinical skills to specifically address the requirements of professional bodies curriculum.

5.4.19 Review if more Clinical Fellows can be introduced in GM.

5.4.20 Support Radiographers in leadership/managerial roles to maintain some advanced clinical skills to remain motivated, support training to develop future workforce, encourage experienced staff to remain in the workforce for longer, release Radiologist time, provide value for money and improve patient access to services.

5.5 New roles recommendations- RRR 3, 4, 12, 13, 18, 19 & 21

5.5.1 Develop a GM standardised Reporting Radiographer strategy with ‘standard’ roles expected in GM Trusts e.g., chest reporting. This would support Trusts who have been unable to implement Radiographer reporting in the areas of most need. Further work could develop a standardised scope of practice and job descriptions but would still require buy in from some Trusts.

5.5.2 Adopt a standardised approach for progression of experienced mammography assistant practitioners. Ensure they are paid appropriately for their skill and experience and are retained in the workforce.

5.5.3 Conduct a review of lessons learnt from the successful Breast clinicians programme to identify other areas where experienced Clinicians could support the overstretched Radiology workforce e.g., Gynaecological radiology.

5.5.4 Further adoption of imaging pathway navigators and measure benefits to patient pathways.

5.5.5 Explore an increase of blended imaging roles working across two modalities. A blend of two modalities or clinical/academic roles would provide variety, motivate the workforce, provide increased flexibility and robustness for Radiologists, Radiographers and AP’s.

5.5.6 Develop an end-to-end imaging workforce strategy to support GM growing its own local workforce from apprentice to consultant level practitioner. This should contain education

information and exit points where learners could exit and re-join when the time to progress is right for the Trust and the learner. This would create opportunities for people to develop who may not otherwise be able to train. Bolton NHS Foundation Trust are currently leading on a HEE project to communicate clear pathways for progression from a Band 2 support role to a Band 4 role and then onwards to a registered practitioner role.

5.5.7 Produce standardised job descriptions for specific roles. Job descriptions and scope of practice for Assistant Practitioners and Advanced Practitioners may support Trusts trying to introduce or increase the number of these roles. Standardised scope of practice and job descriptions would also ensure any training objectives are consistent with the national AHP support workforce programme. It may also ensure people are working at the top of their ability.

5.5.8 Identify how apprentices can be accommodated to grow own local workforce that is representative of the population as recommended in the NHS People plan[11].

5.6 Leadership and culture recommendations – RRR 21 & 24

5.6.1 Leadership should be prioritised in all staff groups. Development of a structured support and leadership plan should make the roles more attractive. Identify people who want to develop into a leadership position, support them to identify gaps and provide relevant experience to progress. Explore benefit to introducing GM wide leadership for smaller modalities e.g., interventional radiology. A network approach to leadership could drive innovation and oversee improvement. This would release Radiology service managers to focus on more strategic issues.

5.6.2 Promote leadership opportunities by fostering a culture of inclusion to support staff to develop a workforce more representative of the patient population. Promoting opportunities like the Stepping up programme[12] would prepare staff from Black, Asian and minority ethnic backgrounds for leadership roles. Ensure effective job planning with a regular review is implemented for all staff.

5.6.3 Introduce regular reviews of establishments including support services to improve workflow, efficiency, equipment utilisation, staff morale, patient experience and reduce costs in line with GIRFT recommendations[13]

5.6.4 Ensure sound governance with dedicated roles with protected time/inclusion in job plans across Radiology and Radiography teams.

5.6.5 Services to be led by modality specific Radiographers at management grades to reflect the complexity of the service & regulation expertise.

5.6.6 Identify training opportunities for advanced practice to support service delivery and release Radiologist time.

5.6.7 Provide Trust support for accreditation of advanced skills and ensure roles cover the four pillars of advanced clinical practice.

5.6.8 Actively promote research and development opportunities to motivate people and deliver service improvement.

[11] NHS England » NHS People Plan

[12] Stepping Up Programme – Leadership Academy

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

5.7 Health & wellbeing recommendation linked to NHS People plan[14]

5.7.1 Trust leaders should develop a sustained focus on staff experience, especially 'health and wellbeing' to deliver the elements of the People Promise[15].

5.7.2 Improve access to health and wellbeing support. Discuss with staff how they would like to receive the information e.g., notice boards in staff areas.

5.7.3 Sharing the GM Wellbeing toolkit amongst teams[16]

5.7.4 Support flexible working where possible to improve retention.

5.7.5 Trusts to treat staff safety as a priority and improvements communicated to demonstrate commitment to a safer workplace.

6 Limitations of the project

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

The project was run during a pandemic which meant engagement going to be a challenge.

Unfortunately, not all Trusts or participant groups were able to attend interviews due to clinical pressures. One Trust did not engage at all however, given the similarities across trusts we would anticipate they are facing similar issues.

Equal representation for all staff groups/modalities was not possible due to lack of availability and the vast number of different modalities in imaging services.

The imaging workforce in GM and East Cheshire is large and diverse. It was not possible to establish the total number of people working in imaging across GM and East Cheshire or calculate what percentage of the imaging workforce this project has engaged with.

A range of people engaged with the project, but some were unable to negotiate time to be released from their clinical duties due to high service demand and low staffing numbers. More people volunteered to be interviewed than were eventually interviewed as they were unable to secure time during working hours to attend an interview. 15 participants attended interviews in their own time outside working hours as they felt they wanted to contribute to the project. Some participants volunteered following discussions with colleagues who had found it a positive experience and appreciated being listened to. Links to the survey and contact details of the PM were shared on social media by some participants who had been motivated by the interview. Several participants contacted the PM directly and volunteered for an interview, stating they did not want to complete the survey but were happy to contribute through an interview outside a work environment to provide anonymity.
Throughout the project 35% of participants had to cancel their interview due to unexpected clinical demand and colleague sickness. 40% of these cancelled meetings were not rescheduled due to work pressures.
Due to academic deadlines the student Radiographers were unable to dedicate time for 1:1 interviews but were able to complete e-surveys and contribute to the project. Numbers completing the survey were limited and so findings may not be fully representative of the student population.

[14] NHS England » Looking after our people
[15] NHS England » Our NHS People Promise
[16] Greater Manchester Wellbeing Toolkit and programme - GMHSC

7 Lessons learnt

- Recruitment of participants was difficult due to timescales and it took longer than anticipated.
- Adopting a flexible approach to collecting information in person or by a e-questionnaire will engage more participants.
- A focus on scope of the project is required to avoid creating too much information to review and non-delivery of the project.
- The value of stakeholder engagement from the start and throughout the project with regular updates is important.
- Having a well-respected SME was extremely beneficial to help steer the project and gain peer engagement
- Providing multiple communication methods for participants and offering flexibility to meet will engage more participants.
- The importance of listening to staff and the positive impact this can have on morale and feeling valued.

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 imaging network and GM Cancer alliance and discussions will ensue with the GM Imaging workforce Group to agree priority areas of focus over the next 12 months. There will be a recommendation for the imaging network to provide a response and action plan relative to the findings in this report.

9 Appendices

Appendix 9.1- Clinical Support Workers and Assistant practitioners

Appendix-9.1-Assistant-Practitioners.pdf (gmcancer.org.uk)

Appendix 9.2 – Radiographers & Clinical Technologists

Appendix-9.2-Radiographers-and-Clinical-Technologist.pdf (gmcancer.org.uk)

Appendix 9.3 – Radiologists, Clinical Fellows & Specialist Registrars

Appendix-9.3-Radiologists-Clinical-Fellows-Specialist-Registrars.pdf (gmcancer.org.uk)

Appendix 9.4– Student Radiographers

Appendix-9.4-Student-Radiographers.pdf (gmcancer.org.uk)