Lancashire & South Cumbria Diagnostic Programme Board

Title of Paper	**5-year Diagnostic Imaging Additional Staff recruitment plan for Lancashire & South Cumbria**		
Date of Meeting		Agenda Item	XX

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Paper endorsed by	Jack Smith, Director, L&SC Diagnostic Imaging Network	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X
Executive Summary	This paper presents a 5-year plan for NHS Diagnostic Imaging additional staff across Lancashire and South Cumbria (L&SC). Application of an agreed set of imaging workforce assumptions utilising the latest L&SC demand and capacity modelling has informed this plan. No direct revenue request is detailed within this paper, rather a commitment to support the plan via individual trust business plans. This paper has been reviewed and endorsed by both the L&SC Radiology Working Group and the L&SC Diagnostic Imaging Network Workforce workstream.	
Recommendations	L&SC Diagnostics Programme Board is requested to: 1. Note the content of this report 2. Support the request for the revenue funding to secure the recruitment 3. Advise on potential funding source(s) for the revenue required. 4. Support engagement with the Trust Directors of Finance and Directors of HR to support progression of the proposed approach	

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1. Background

1.1 The endorsement by L&SC Diagnostic Programme Board (DPB) of the 5 year recruitment plans for Radiographers, Radiologists, Assistant Practitioners and Support Workers, and Band 2/3 Admin and Clerical staff will result in the registered clinical and non registered workforce expanding over the coming years. This paper sets out the requirement to consider additional staff groups. These staff groups are not necessarily employed directly by our Radiology Departments, but are essential as part of business plans and service expansion as well as facilitation of new service delivery.

1.2 The Prof Mike Richards Report, Diagnostics: Recovery and Renewal (Oct 2020) was an independent review commissioned by NHS England because '*The need for radical investment and reform of diagnostic services was recognised at the time the NHS Long Term Plan was published in 2019*'.

1.3 Recommendations from the report were categorised under five key pillars; New service delivery models; Equipment and facilities; Workforce; Digitisation and connectivity; Delivery the change. Clear and unambiguous recommendations from the report for workforce include

Recommendation 12: There should be a major expansion in the imaging workforce – an additional 2,000 radiologists and 4,000 radiographers (including advanced practitioner radiographers, who undertake reporting) as well as other support staff and key 'navigator' roles. Additional training places should be provided for radiologists and radiographers and initiatives will be needed to meet demand, as well as expansion in assistant practitioner and support staff roles.

1.4 Current modelling for the Radiographer and Radiologist 5-year recruitment plan shows a need to expand the workforce by 20% and 30-35% respectively.

2. Case for recruiting in readiness

2.1 With an expansion of the Imaging Workforce, alongside expansion of assets within the Community Diagnostic Centres it is imperative that the funding for the relevant workforce required for implementation, commissioning, servicing, and governance needs to also expand in proportion to service expansion.

2.2 Appendix 1 provides data extrapolated from the Prof Mike Richards report recommendation 12 as it relates to L&SC ICS based on population size. The report data suggest the L&SC physicist workforce needs to expand by 6. Currently within L&SC Diagnostic Imaging there are no Physicists directly employed. Current services are commissioned from the Christie (LTH, BTH and UHMB) or IRS (ELHT). Careful consideration needs to be given as to whether this group of staff needs to be employed within L&SC in the future, particularly with regards to 'on-site' support and any potential changes to regional radiopharmacy provisions or expansion of PET imaging, alongside increased assets at the CDCs. Any changes would need to be modelled on a regional rather than L&SC basis due to the relatively small workforce required and the wide range of workforce seen within the 'physicist' workforce, including Healthcare Science Assistant, Healthcare Science Practitioners, Healthcare Scientists, Consultant Healthcare Scientists, Radiation Protection Advisers (RPA), Radioactive Waste Advisers (RWA), Medical Physics Expert (MPE) as well as those specialising in ultrasound and MRI.

2.3 PACS/IT specialists, Data analysts, performance managers and other specific workforce are either currently employed or may need to be considered in business cases and service expansion. This may be for support for specific projects, or as part of an expanding teams. As activity increases, the emerging roles of Image Navigators and Senior Imaging Navigators to assist the patient journey in a

timely and appropriate manner should be explored, thus ensuring diagnostics are delivered at the right time, endeavouring to provide innovative solutions to reducing such inefficiencies as DNA, cancellations or repeat diagnostics in line with GIRFT principles. This needs to be viewed as a separate modality.

2.4 Whilst not entirely being under the remit of the Diagnostic Imaging Network, Nurses and Healthcare assistants are employed across all trusts to support patients through all aspects of care within Radiology, including angiography and other interventions, drainages, biopsy, a wide range of fluoroscopy services, or through supporting the delivery of services within the Radiology Departments such as endoscopy. Service expansions and re-designs need to ensure this group of staffing is included.

2.5 As we recruit and train more staff in reporting including consultant and career grade radiologists, specialist registrars in training and reporting radiographers, we need to be mindful that there will be an increase in workstations, which will need the support of IT. With the increase in remote reporting, including at home or within the CDCs, there is a potential that this IT support needs to be off site and out of hours, potentially via managed services.

2.6 Service expansions and activity increases will increase demands on portering colleagues. Of the four provider trusts, three use central portering teams, with one trust (BTH) directly employing their own staff. Whichever model fits best for the trust, it is imperative we understand the effect that good portering can have in improving our productivity by maximising room occupancy. As we develop quicker scan times through improved technology, for example Accelerated Acquisition Technology for MRI which is being implemented across the ICS, or as we separate our in-patient and out-patient we will fail to realise the benefits if we cannot get patients transferred into our departments and rooms in co-ordinated and timely manner.

2.7 There are a number of risks contributing to the case for recruiting

- Workforce expansion for increased imaging acquisition and reporting without consideration of these specialised and niche roles will lead to inefficiencies
- Recruitment of appropriate non-clinical staff will allow clinical staff to work to the top of their skill sets

3. Proposed approach to recruiting

3.1 New roles of Band 4 and Band 6 Imaging Navigators/Senior Image Navigators should be considered across each trust. These roles would have an increased overview of patient pathways, working across clinical and admin. staff and in support of PACS and Bookings teams to understand and unlock barriers for patients accessing the service, audit and implement service improvements (eg reducing DNA rates, ensuring all imaging was completed before MDT dates to optimise pathways and reduce delays for treatment).

3.2 Multi-disciplinary PACS, IT, Performance Management, Clinical Educators teams should be scoped within each trust, ensuring they have sufficient revenue and resources to deliver the system support, as well as delivering increasing PACS needs in line with Digital Transformation projects.

3.3 The increased requirement for Physics workforce should be costed and resourced according to service expansion. Future requirements to bring some of these roles ‘in house’ should be consider. This work would fall under the Healthcare Sciences Diagnostic Network

3.4 Nursing and healthcare assistant roles should be scoped to ensure appropriate nursing support is available within all departments.

3.5 Portering services should reflect the impact on increased activity and increased throughput.

3.6 Recruitment timeframes should be aligned to increased demand/service expansion both within the acute sites and at the CDCs.

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3.7 In summary, there are a number of benefits to increasing recruitment

- To support elective recovery
- To provide safe patient-centred pathways
- To deliver required reforms in diagnostic imaging services including delivery of CDCs with sufficient suitably qualified and skilled staff to deliver in these out of hospitals settings

4. Costs and additional terms to consider

4.1 The indicative additional revenue will need to be determined according to business cases.

4.2 Increasing the substantive posts allows delegation of tasks for registered professionals, enabling them to work to the top of their scale.

4.3 Consideration needs to be given to the requirement for role development across the network, such as PACS teams to support a single instance PACS system, Performance Managers and Image Navigators to support network wide bookings, and Clinical Educators to support local and inform co-ordinated network educational needs.

4.4 Accreditation via the Quality Standard for Imaging, an accreditation system supported by the professional bodies of the Royal College of Radiologists and Society and College of Radiographers has been achieved at BTH. As the Diagnostic Imaging Network strive to reach thriving status, this should be a standard for the network. Revenue is essential to develop and maintain accreditation.

4.5 Procurement of increased diagnostic equipment will impact on the Medical Engineer colleagues for purposes of installation and maintenance contracts

5. Recommendations

5.1 The L&SC Diagnostics Programme Board is requested to:

- Note the content of this report
- Support the principle for the revenue funding via business cases to secure the recruitment
- Advise on potential funding source(s) for the revenue required.
- Support engagement with Trust Directors of Finance and Directors of HR to support progression of the proposed approach.

Appendix 1 – Data for Workforce extrapolated from the Prof Mike Richards Report based on population for the North West

	Over next 5 years					Yearly Additional Requirement			
Imaging workforce	**Additional requirement**	**North West**	**GM**	**CM**	**L&SC**	**North West**	**GM**	**CM**	**L&SC**
Radiologists	2,000	268	112	100	57	54	22	20	11
Advanced practitioner/reporting radiographers	500	67	28	25	14	13	6	5	3
Radiographers	3,500	469	195	174	100	94	39	35	20
Assistant practitioners	2,500	335	140	125	71	67	28	25	14
Admin and support staff	2,670	358	149	133	76	72	30	27	15
Physicists	220	29	12	11	6	6	2	2	1
	11,390	**1527**	**636**	**567**	**324**	**305**	**127**	**113**	**65**

Weighted pop proportions :

North - West	7,964,158	13.41%
Lancashire and South Cumbria	1,689,821	21.22%
Greater Manchester	3,315,292	41.63%
Cheshire and Merseyside	2,959,044	37.15%
England	59,402,338	**100.00%**

Lancashire and South Cumbria Health and Care Partnership

Appendix 2 – Community Diagnostic Centres Modelling Staffing Assumptions (7 day/12 hour)

MRI x 1	Staff Per Scanner 2022/23 WTE	Equipment per CDH	WTE per CDH	Estimated Staff Cost per WTE	Staffing Cost per CDH
Band 7 Radiographer WTE	2.73	1	2.73	£55,000	£150,304
Band 6 Radiographer	2.73	1	2.73	£48,000	£131,174
Imaging Support Worker	2.73	1	2.73	£28,000	£76,518
Band 8a Service Management	0.55	1	0.55	£65,000	£35,526
Admin Support	1.37	1	1.37	£28,000	£38,259
Assistant Practitioner	0.00	1	0.00	£32,000	£0
Consultant Radiologist - Reporting	3.02	1	3.02	£130,000	£392,796
Total MRI Workforce	13.13		**13.13**		**£824,578**

X-Ray x 2	Staff Per Scanner	Equipment per CDH	WTE per CDH	Estimated per WTE	Staffing Cost per CDH
Band 5 Radiographer	1.37	2	2.73	£40,000	£109,312
Band 6 Radiographer	1.37	2	2.73	£48,000	£131,174
Assistant Practitioner	2.73	2	5.47	£32,000	£174,899
Reporting Radiographers	1.39	2	2.78	£55,000	£153,172
Total Xray Workforce	6.86		**13.72**		**£568,558**

CT x 2	Staff Per Scanner	Equipment per CDH	WTE per CDH	Estimated per WTE	Staffing Cost per CDH
Band 7 Radiographer	2.73	2	5.47	£55,000	£300,608
Band 6 Radiographer	2.73	2	5.47	£48,000	£262,349
Imaging Support Worker	2.73	2	5.47	£28,000	£153,037
Band 8a Service Management	0.55	2	1.09	£65,000	£71,053
Admin Support	1.37	2	2.73	£28,000	£76,518
Assistant Practitioner	0.00	2	0.00	£32,000	£0
Consultant Radiologist - Reporting	4.53	2	9.05	£130,000	£1,176,989
Total CT Workforce	14.64		**29.28**		**£2,040,554**

Ultrasound x 2	Staff Per Scanner	Equipment per CDH	WTE per CDH	Estimated per WTE	Staffing Cost per CDH
Band 7 Ultrasonographer	0.55	2	1.09	£55,000	£60,122
Band 8A Ultrasonographer	2.19	2	4.37	£65,000	£284,211
Support Worker	2.73	2	5.47	£28,000	£153,037
Total US Workforce	5.47		**10.93**		**£497,370**