Evidence to the NHS Pay Review Body – January 2023

Introduction

The Society of Radiographers is the professional body and trade union for all those practicing in medical imaging and radiography. The Society of Radiographers (SoR) represents over 33,000 members, most of whom work in the NHS across all 4 nations, at all grades across clinical imaging and cancer/radiotherapy pathways of care.

In submitting our evidence to the Pay Review Body (PRB) this year, we recognise some of our partner unions are declining to do so because of a crisis of confidence in the process. We understand and share many of the reservations voiced about the PRB's scope to assert any independence, as well as the constraints bound around the process by pre-set Government spending limits. The annual cycle also creates a pull towards short-term recommendations which is counter-productive, especially against a context of panicked crisis management across the NHS and Government.

The PRB needs to rise above rather than fuel the crisis. Last year, we warned the PRB outcome could "either re-enforce structural barriers to addressing the recruitment and retention crisis or enable a shift towards a healthier, safer, more sustainable workplace culture." Sadly, the below inflation quantum offered, how it was distributed, and the way this was managed all had a wholly negative impact. The latest NHS Vacancy Statistics show a record 132,139 staff vacancies, a 20% rise from March 2022[i]. Vacancy rates for Diagnostic Radiographers have risen from 12% to 13% in the last year. The Sonography workforce, a critical modality for addressing waiting lists, has increased by only 2% since the start of 2020. NHS Mammographer numbers have increased in the same period by just 1 person. If the 2022-23 pay award was hoping to improve recruitment and retention, and boost post-pandemic service recovery, it clearly hasn't worked.

Anyone who cares about the NHS and those it serves must recognise the need for a long-term workforce strategy. The National Imaging Board is tasked with meeting forecast growth in demand for imaging tests and clearing the pandemic backlog. It isn't getting close to its 120% of pre-pandemic scans target because it doesn't have the staff. At the end of September 2022, 1,554,700 patients were waiting for a key diagnostic test, up by 139,741 from the previous September. The number waiting six weeks or more increased in the same period by 94,700[ii]. If the PRB still has a credible role to play, it must speak up and include some clear recommendations to support a sustainable pay and reward strategy aligned to growing the NHS workforce.

We thought long and hard about whether members would benefit from our making a submission. The Society has been championing medical imaging and radiography since 1920 and arguably there has never been a more important time for us to set out the case for investing more in our members.

Radiography is also the clearest lens through which to see the extent of the workforce challenges in the NHS and to measure progress. Looking through the Radiography lens shows the situation is critical. Whilst still not hopeless, urgent action is required. It's in this context that we make our members' case.

Our evidence therefore highlights key priorities for the PRB to consider, framed within the context of the NHS workforce crisis, through the lens of medical imaging and radiography. We will supplement these in our oral evidence to the PRB in February 2023. Our submission also includes some recommendations for reform to the PRB process that could afford greater reassurance to us and others who have chosen not to

participate directly at this time. We would also welcome the opportunity to expand upon these in oral evidence.

Invest More: Making Public Health the new Defence

The SoR recognise current NHS and social care spending have steadily increased year on year throughout this century. However, waiting lists and record staff vacancies highlight how we've not been investing enough. Panicked crisis management amplifies the problem (see below re. rising agency pay) but is a symptom of wider under-investment and poor workforce planning. The PRB should recognise this and challenge the Government to find more now, signpost measures to sustained improvements that patients and staff would support, and thus potentially increase longer-term efficiency.

Confidence in public health and social care systems are essential barometers of confidence in that society. When almost all of the nation's health and social care system is funded directly from general taxation, it's a big part of why people pay their taxes. This also means good health keeps costing us more, something this Government has, since 2010, seemingly failed to recognise. This is not to say health spending hasn't increased; Health economics dictates that demand and costs are always rising. Populations expand and get older. Equipment and treatments get more sophisticated, complex and potentially expensive. Moreover, life gets more expensive, and health isn't immune from wider inflation.

Independent OECD data shows we have not been spending enough[iii]. At the start of the century, Britain set itself a target of matching Germany's share of GDP spent on health and social care = 9.8%. By 2018, we'd reached this milestone. However, in the same period, Germany had increased its spending to 11.2% GDP. In the same period, the relative value of British GDP also fell and pre-pandemic we were spending about 20% below the EU15 average spending per person.

During the pandemic, all plans were set aside and whatever monies the NHS needed were found. However, now the Government is resetting the budgets. Closing that 20% pre-pandemic spending gap isn't part of the Government's agenda. The £6.5bn extra NHS funding announced over 3 years fails to recognise current inflation, as if hospitals are immune from rising energy, transport or staffing costs. During the pandemic, the ONS estimate Government spent £47bn on the failed Test and Trace scheme and defective PPE alone. At the planned rate, it will take them almost 22 years to positively re-invest an equivalent amount into the NHS.

Investing ahead of the demand curve staves off a public crisis of confidence in health and social care systems, which in turn helps prevent the wider loss of economic and social confidence that would otherwise generate additional health and social care costs. In this sense, health and social care is like a traditional defence policy, it costs what it reasonably costs to avoid a war, because a war will always be catastrophically expensive and damaging. Sadly, this Government has, as shown by consistently below-inflation pay awards, failed to recognise this and now we are in the midst of the crisis we wanted to avoid. Getting out of it will be expensive. The longer it takes to realise this, the more expensive it will get. Government seems instead to be surrendering to defeat. An independent PRB would call this out.

A Critical Time for the NHS, Medical Imaging and Radiography

The use of medical imaging has soared in recent decades, both in Diagnostic Radiography, with the expansion of screening programmes and greater demand for diagnostic scans; and Therapeutic Radiography, with cancer treatment technologies changing and expanding at a revolutionary speed. 90% of

NHS patients will directly interact with a Diagnostic Radiographer during their NHS treatment pathway; many patients are now as likely to encounter a Radiographer as a Nurse.

Diagnostic and Therapeutic Radiographers are also remarkably cost-effective and efficient so getting Radiography right is at the core of the NHS's ability to meet any and all of its big public targets; cancer survival, stroke, cardiac and respiratory, and others. This was emphasised with the adoption of the Richards Report in November 2020[iv], highlighting how growing the workforce, from Assistant and Support staff to Advanced Radiographers and Reporting Radiographers, would eventually more than pay for itself.

Throughout the Covid-19 pandemic, our members have been on the frontline in all areas of the NHS and as the NHS looks to recover, Radiographers are central to the recovery of elective programmes disrupted by the pandemic and in supporting treatment needs for cancer patients. NHS England's "Priorities and Operational Planning Guidance for 2023-24" (pub. December 2022)[v] requires a 13% increase in cancer treatment capacity and a 25% increase in diagnostics. It highlights how new Community Diagnostic Centres are a strategic keystone, with £2.3bn allocated to 2025 in "capital investment", but the document appears to be silent about where or how to find the staff for the CDCs.

Blocked Pathways and Barriers to growing the Radiography Workforce

Before the pandemic, research from the King's Fund[vi], Cancer Research UK[vii], and wider NHS analysis showed a consensus around growth in annual demand being 6% p/a for Diagnostics and around 7% for Therapeutics through to 2030. The adoption of the Richards Report re-enforced this, requiring a 28% growth in the total diagnostic workforce in England by 2026, including additional staff to support 160 new Community Diagnostic Centres. Between 2014 and 2020, the diagnostic workforce was growing steadily by about 3% p/a, with the therapeutic workforce growing at around 4% p/a. This was around half of the number needed to meet forecast demand and so every year the pressure was increasing as we fell behind the target.

Whilst student and apprentice numbers are now increasing, they're still not increasing by enough. The 2020-21 intake equated to 5.2% of the Diagnostic Radiography workforce, with the Therapeutic equivalent being 7.8%. This merely matched the NHS leaver rate. The latest NHS England data shows 4,422 students and apprentices in training. If all enter the professional radiography workforce this would increase the pool of qualified professionals by 8.6% annually. The latest published leaver rates we have access to, for 2021, are 5.2%. This would only produce a net annual increase of 3.4% to the workforce, still only just above half what we know is needed.

This is already reflected in stubborn and rising waiting times for patients and staff vacancy rates. Between the start of 2020 and the end of 2022, the latest NHS England data shows Diagnostic Radiographer vacancy rates have risen from 12% to 13%. If you add in vacant Sonographer and Mammographer posts, this equates to finding 2,050 more professionals to stand still, meeting none of the forecast extra demand – 46% of the entire existing training cadre.

Retention Sabotage

Vacancy rates are about retention as well as recruitment. This means the NHS needs to look after and nurture those it already has, and work in genuine social partnership with the SoR to develop the radiography workforce, for example, by reviewing clinical workloads and practice across radiography

grades, to assess if AfC bandings still effectively and fairly map across radiography practice, or by agreeing safe staffing levels that accommodate time for professional reflection and development, which will facilitate growth in Advanced and Reporting Radiographer numbers.

Our evidence is that working practices and conditions are instead driving staff away from the NHS. This is fuelled by pay and reward problems, that successive PRB-based awards have re-enforced rather than addressed. This amounts to, consciously or unconsciously, sabotaging retention efforts.

The SoR's 2022 NHS Workforce Conditions Survey[viii] said the NHS was a dangerous, demoralised workplace:

- Only 22% said their workplace was very safe, as opposed to 25% who said it was somewhat or very unsafe.
- 29% said not all possible DATIX reports are completed, and less than ½ (49%) said they were confident they would be acted upon.
- 24% said they lacked confidence their employer would do anything to make their environment safer if they were injured at work.
- 56% said they had witnessed a colleague being abused, bullied, threatened or harassed at work.
- Only 1 in 10 said they were very confident their employer would support them if they were a victim of abuse, bullying or harassment at work.
- Only 4 in 10 said they would recommend working in the NHS to a friend or family member, significantly lower than the 68% who would recommend radiography as a career.

The same survey also found barriers to career development with:

- More members saying they don't have adequate access to professional development and support than do (48% vs 47%).
- Only 1 in 3 said they had protected study time.
- Of those who do, only 32% say the time they have allocated is sufficient.
- 60% are no longer interested in promotion, with 28% of these saying if they applied their manager would block it.
- 20% said promotion wasn't financially viable for them.

Pay on promotion is something the SoR has raised consistently with the PRB. This is especially critical for:

- Support staff considering advancing into a professional role, where the initial reward is limited and the expectation of dangerous Band 5 workloads is prohibitive.
- Anyone moving into first line manager roles, with the difference in take-home pay between the top of Band 7 (excluding any overtime they would earn) and starting rate for 8a now only £26 a week gross or £9 a week net[ix].

Assistant and Support Staff

There is enormous potential to grow from within, by expanding and advancing Assistant and Support grade staff, as recognised by the Richards Report[x]. From a greater base, it is possible to provide both opportunities to develop in work, and incentives to do so. This isn't generally happening yet. Vacancy rates for Assistant Practitioners are 17% and 10% for Imaging Support Workers. The gross hourly rate for someone at the top of Band 4 is only £13.48 p/h . Asking them to take a cut in salary to train isn't unusual. The jump in salary from the top of Band 4 to the start of Band 5 is only 2.9% gross or 2.3% net before hitting the wider challenges facing Band 5 set out below.

Ultrasound and Sonography

The counter-productive nature of the 2021-22 pay award is clearly seen in ultrasound and sonography, a key recovery area for the NHS. Latest NHS data[xi] shows 35.5% of patients waiting more than 6 weeks for a scan are in non-obstetric ultrasound. In 2021-22, fewer of these scans were carried out than in 2018-19 (7.54m vs 8.01m). 29% of the current sonography workforce are near or beyond retirement age. Agency costs have reached 8% of all sonography costs. National outsourcing costs for this type of scan reached £7.4M in 2021-22, averaging £78.33 per scan when the NHS tariff is £40. We have identified 3 regions where the sonography agency rate is £120 p/h. Our evidence shows a majority of Sonographers are likely to be supplementing their NHS work with more lucrative agency work. Much of this is because many are being turned down for flexible working. Opportunities to train inside the NHS in areas such as sonography and mammography are also falling away due to wider workload pressures and people not being released for training.

Our 2022 NHS Workplace Conditions Survey[xii] also found:

- 89% of all responses saying there were not enough staff to meet their department roster without requiring regular overtime.
- 60% saying there were fewer rostered staff now than before the pandemic.
- 4 in 10 believe colleagues leaving in the next 12 months would not be replaced.

Most experienced Sonographers are paid at the top of Band 7. Our research (see table 1[xiii]) shows their basic hourly rate is £24.45 gross and £16.51 net. One traditional route used to attract and retain Sonographers has been to utilise their training and clinical expertise to re-band them to 8a. Last year's Band 8a pay rise was less than 3% and less in actual terms than someone at the top of Band 5.

New Professionals

In our 2022 PRB evidence[xiv], we raised particular concern about the barriers to retention facing New Professionals, entering radiography at Band 5. This concern was ignored and the 2022-23 award has evidently made things even more challenging.

Band 5 starting salaries are increasingly uncompetitive, with at or above £30,000 a common benchmark for graduate entry roles even in other parts of the public sector like teaching, social work or probation. Retail management traineeships would pay higher still.

However, there are structural barriers designed into the Band 5 pay that neutralise pay progression. The progression increase at the end of a Band 5's first year is now £1,525 gross. If they've remained in the NHS Pension Scheme, their contributions will increase by £777p/a , swallowing 51% of this increase. This leaves their net increase as only £797 or £15p/w[xv].

Our analysis before last year's pay award showed a second year Band 5 paying student loans with £393 net take home pay p/w. The same analysis in December 2022 (set out in Table 2[xvi]) shows this increasing to £409 net p/w – plus £16 p/w. However, because the award was less than half the average inflation rate, our analysis of the same notional Band 5 living in average shared rental accommodation in Salford shows their real disposable income (after basics like rent, transport, utilities, etc) is now only £148p/w – a fall of £30p/w as a direct result of last year's pay award.

Evidence from Nightingale et al[xvii] looking at radiography retention supports what we said to the PRB in 2022, and repeat now. New Professionals have a stark choice of either:

- working excessive amounts of overtime to feel they are progressing financially, at which point they become time poor and start to burn out, or
- looking to leave, for more lucrative locum/agency roles that hinder their professional development or leaving radiography altogether.

The need to feel valued and professionally supported is identified by Nightingale et al, as being especially important for New Professionals, in particular in Therapeutic Radiography who conversely suffer most from having limited support and career development.

We recognise that a significant pay increase for all Band 5s will require equally significant adjustment across the other AfC grades but this is inevitable and should start now. This is a big part of why the **SoR accepts and calls for a long-term funded plan for above inflation pay awards mapped against independently audited, credible workforce planning data. The PRB should signal support for this principle. It should also signpost recognition of the problem by highlighting the need to remove the New Professionals Pension Penalty.**

Managers and Leaders

In our 2022 evidence, we highlighted the importance of growing the number of radiographers in leadership positions. If medical imaging and radiography are a keystone in national health strategy then having senior leaders who understand radiography would be positive; for example, it could prompt local Trusts to prioritise how to make efficiencies from developing more Advanced or Reporting radiographers. However, our own research and ESR data[xviii] showed that whilst the number of NHS radiographers has grown as a whole since 2014, the number of radiographers in post at or above Band 8b remained static, and so has fallen as a percentage of the radiographic workforce as a whole. We believe this remains the case.

In 2022, we launched a Manager Members' Survey[xix] which illustrates why. It found:

- A relatively low 54% said they'd been in their post for 3 years or more, suggesting high turnover.
- 52% said they manage 20 or more staff.
- 39% said they manage 30 or more staff.
- 45% said they had received no specific training from their organisation in managing their team.

Additionally, many managers tell us they retain some direct clinical responsibility or often step in as cover. Our own pay research[xx] shows leadership grades in the grip of a long-hours culture. There is no significant difference between the number of extra additional hours worked regularly by members in different pay Bands until 8b and above, averaging between 4 and 6 for Bands 5 to 8a, before rising to an average 11 additional hours a week for 8d. All bands had members working significantly longer than this at least occasionally, with the Working Time Regulation limits regularly passed in all Bands.

As referenced above (re: Sonographers), the "reward" for stepping up into a first line management role is likely to be a cut in salary. Band 8 is excluded from overtime and the difference in pay between the top of Band 7 and the start of Band 8a is now only £61 p/m gross or £42 p/m net. Additionally Band 8 have a 4

year wait for any pay progression, during which time recent experience suggests this gap will be eroded even further.

The situation isn't much better between Band 8a and 8b, with the second smallest percentage net pay gap (1.8 %) of any AfC Bands on promotion. (See table 3[xxi])

The PRB must acknowledge this problem and **at least start to rectify the counter-productive erosion of the relativities afforded to the key clinical leaders in radiography and across the NHS**.

Overseas Recruits

NHSE figures[xxii] show 56% of the 3% growth in diagnostic radiographer recruitment into the NHS between 2016 and the end of 2020 was due to international recruitment. Whilst the number of UK-based FTE radiographers in the NHS grew by 9%, the number of internationally trained FTE working in the NHS grew by 147%.

In the medium and likely longer-term, the NHS will continue to be heavily reliant on international recruitment and even more so in areas like non-obstetric ultrasound where you need additional training and experience. It is important to note that Medical Radiographers remain on the Home Office Shortage Occupation list.[xxiii]

However, our analysis of NHS and HCPC data shows that 2 in 3 diagnostic radiographers being recruited into the UK workforce from overseas are being recruited directly into the private sector. Data showed that between 2016 and 2020, almost 4 in 10 of those recruited from overseas had already left the NHS. Our anecdotal evidence suggests this may be accelerating, with examples of racism and a hostile environment towards overseas radiographers emerging. For example, in 2022 we discovered an NHS Trust notifying an overseas recruit looking to move after 3 years that they would seek to recover training costs, relocation support and even the money for a travel pass to help orientate themselves in their new city from when they were recruited. Some of this poor practice may be because some senior NHS leaders are racist. It could also be a symptom of the chronic underfunding culture and unthinking panic. Either way we and **the PRB need to champion measures that would allow the NHS to compete for and retain overseas recruits**. In 2023, we will be publishing a Charter for Recruiting Overseas professionals to support this end.

Agency Pay – a symptom not a cause

In our 2022 evidence we highlighted NHS and HCPC[xxiv] data that showed 8,952 radiographers joined the NHS from within the UK between 2016 and 2020, either as new starters, re-joiners or those who had qualified from within the NHS. However, in the same period 6,894 (77% of the joining figure) left. The age profile of radiography strongly suggests the majority of these did not retire but went elsewhere.

Nightingale et al's[xxv] research backs-up our own research and anecdotal evidence, showing that whilst some are leaving UK radiography altogether (especially overseas recruits), a growing number are going either into the private sector or to work through private agencies who then hire them back to the NHS at a grossly inflated mark-up.

The latest data from the NHS Imaging Board[xxvi] shows that in 2021-22, the NHS spent almost £136M on agency and bank pay for imaging service. This is already equivalent to 13.4% of the total substantive pay bill for all imaging services. Approximately 60% of the increased overall spend on pay, from £2.7bn to

2.8bn in 2021-22, comes from increased agency and bank costs. The competition are outspending the NHS and using the NHS's money to do so.

This could very easily get out of control in 2023-24, with no as yet evident adjustment to cost plans to accommodate workforce growth for the 160 Community Diagnostic Centres. As these CDCs come into operation over the next 2 years, the NHS will become a hostage to agencies in medical imaging and radiography unless something is done to acknowledge and address this risk now.

It is important to recognise that radiographers aren't opting to work for an agency just because of higher short term pay, although continued below inflation pay awards and above inflation pension hikes for most radiographers inevitably makes the NHS increasingly uncompetitive.

Evidence shows it's also the way people are treated at work, the lack of flexibility and control over their work, demands to work increasingly excessive hours, the implied criticism for failing to meet impossible waiting list targets, lack of career development and training opportunities, and working with over-stressed managers who can't protect them. These are all triggers that prompt towards leaving an NHS they still care for.

Another clear example of this is **mammography**. Nightingale et al cites Mammographers and Sonographers are the two of the groups most likely to leave in later career due to burnout and injury in the NHS. This is supported by SoR evidence in successful personal injury claims, the vast majority of which involve these two groups of members despite their making up about 1 in 10 of our overall membership. These are experienced professionals in areas of high and increasing demand. Sonography and mammography services are both areas where growing amounts of NHS work is being outsourced because the NHS can't insource demand. The latest NHS workforce data shows the number of mammographers directly employed by the NHS in England between 2019-20 and 2021-22 has increased by 1 person.

Reporting Radiographers serve as another example. A combination of poor recognition and an inability to support flexible hours are amongst the key drivers for Reporting Radiographers leaving the NHS. The NHS then pays a huge additional premium to re-access their services, as Richards also noted.

The SoR does not believe that the drain of staff and money to agencies is not yet inevitable. There is an immediate opportunity to put a break on this, provided by the need to staff CDCs. The SoR has been seeking national partnership discussions that would address a phased introduction of CDCs so as not to compromise existing acute provision. Inevitably, this will require additional funded incentives for those either moving between the two settings or working in one or the other to secure a stable transition. Constructive, nationally co-ordinated discussion would also help develop a consensus about the level of long-term additional investment needed for the NHS to remain competitive as an employer, including improving the quality of work. A positive, honest, partnership approach now could still redress the negative supply and demand cycle which will otherwise spin out of control.

Conclusion

The evidence above sets out the challenges facing the NHS through the medical imaging and radiography lens, a keystone in the Government's health strategies. If it fails to meet these challenges those health strategies also fail.

We also believe we show that failure isn't inevitable, and it is not too late to win the staffing battle but Government, and therefore the PRB in its delegated role, must recognise that a change of direction and a new approach is essential.

The cost of the staffing crisis isn't just financial; we evidence how it is impacting on patients by causing longer waiting times for scans and therefore delays in treatment. This in turn lowers national morale and confidence in our NHS which damages the country's collective health and confidence.

However, the financial costs are also evident, whether that's the rising agency costs or the lost efficiencies from, for example, outsourcing imaging reports because we are not finding space and capacity to grow more Reporting Radiographers from within the existing workforce.

The financial impact on staff is equally evident, whether that is new professionals seeing their real disposable income falling by £30 p/w to the point where paying for basics such as food, rent and clothes becomes a genuine struggle, or potential leaders calculating that career development is unaffordable.

Critically, our evidence highlights that much of this is because the NHS has not had, and still does not have, a credible strategic workforce plan. This has created the space that is being filled by panic and chaos.

The Government need help to overcome the workforce crisis. It has made great play in recent weeks that the PRB are independent and that they will follow the PRB's recommendations. We don't believe there is credible evidence that the PRB has been able to operate independently at any stage since it was created. However, there is now very clear political permission from the highest ranks of Government for the PRB to offer genuine leadership. It could well be the PRB's last chance.

Therefore, the SoR urges the PRB to find this independent voice and recommend:

- **A significant, above inflation pay award for 2023 for all AfC grade staff at all grades**.
    - This should be paid **as close to 1st April as is possible**. Making people wait when the cost of living crisis fuels the retention crisis undermines the impact of any award requiring publication of a recommendation before then. Members waiting for an award also increases the risk of unforeseen consequences when it is paid (e.g. members losing back pay due to owed additional pension contributions which could continue for part of a year if pension rates are only realigned from the point the award is paid).

- **Frame any recommendations so as to limit the risk of burnout from excessive hours.**

- **Allow Trusts to use money currently being given to agencies for recruitment and retention payments.**

- **Ensure banding outcomes reflect job content in 2023, for all grades and job profiles.**

- **Further immediate recommendations that address obvious barriers to retention and progression, including:**
    - **Framing recommendations so they support progression and career development, rather than re-enforcing existing barriers to career progression.**

- **Specifically recommending changes to the pension thresholds to remove the New Professional's Pension Penalty**, as part of pension contribution adjustments scheduled for October 2023.

- **Government commit to a longer-term programme of guaranteed above inflation pay awards until the erosion of the value of NHS AfC grade pay since 2010 has been redressed** and the recruitment and retention crisis resolved.

- **The introduction of independent, published analysis of NHS workforce data** with the scope to adjust pay and reward measures against progress in recruitment and retention, factoring in identified areas of long-term growth in service demand such as medical imaging and radiography. This is similar to the recommendation from the Health and Social Care Select Committee in 2022, when under the Chairmanship of the current Chancellor and former Health Secretary, Jeremy Hunt MP. Analysis of such public data would inform future evidence to and from the PRB.

- **Resource be found to better support genuine national partnership working and a tripartite approach to sustaining a safe, fair and credible pay and reward framework. This will include**:
  - **Establishing real vacancy rates and providing the right level of staffing to meet Safe Staffing levels -** establishing and then adjusting to honest real vacancy rates.
  - **Strengthening central accountability with clear lines of responsibility into Government** so employers and unions can go to a responsible national lead on keystone projects, such as the introduction of CDCs.

We also recommend the PRB strengthen its independence and credibility by:

- **Publishing its recommendations to all parties at the point they are ready to forward them to Government** in the way that the ONS would publish data and any other genuinely independent body would expect to.

- **Explicitly stating where the PRB feels it cannot meet the above proposals because of limits placed upon it by the Government funding remits**, going on the record to allow the public insight into how genuinely independent the PRB process is in reality.

References & Further reading

NIB NIDC slides - Dec 2022.pdf

[i] NIB NIDC Slides – Dec 2022

[ii] OECD Health Statistics 2022 - OECD

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

[iv] Priorities-and-operational-planning-guidance-december-2022.pdf (england.nhs.uk)

[v] https://www.kingsfund.org.uk/reports

[vi] Cancer Research UK Report (Dec 2017): Microsoft Word - Full report FINAL (cancerresearchuk.org)

[vii] SoR NHS Workforce Conditions Survey 2022 (Details available upon request)

[viii] PRB Research Analysis 2023 – Table 1

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

[x] Data from Diagnostic Imaging Advisory Group (DIAG) presentation 01/12/2022

[xi] SoR NHS Workforce Conditions Survey 2022 (Details available upon request)

PRB Research Analysis 2023.xlsx

[xii] SoR PRB Submission January 2022

[xiii] PRB Research Analysis 2023 – Table 1

[xiv] PRB Research Analysis 2023 – Table 2

[xv] Retention of radiographers in the NHS: Influencing factors across the career trajectory - Radiography (radiographyonline.com)

[xvi] NHSI data - SoR PRB Submission January 2022

[xvii] SoR Members Pay Survey 2022 (Details available upon request)

[xviii] PRB Research Analysis 2023 – Table 1

[xix] PRB Research Analysis 2023 – Table 3

[xx] Data from NHSE drawn from various presentations and sources during 2022

[xxi] Skilled Worker visa: shortage occupations for healthcare and education - GOV.UK (www.gov.uk)

[xxii] SoR PRB Submission January 2022

[xxiii] Retention of radiographers in the NHS: Influencing factors across the career trajectory - Radiography (radiographyonline.com)

[xxiv] NIB NIDC Slides – Dec 2022