Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Diagnostic Imaging Department, Glangwili General Hospital, Hywel Dda University Health Board

Inspection date: 15 and 16 November 2022

Publication date: 16 February 2023

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80535-481-9

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Diagnostic Imaging Department at Glangwili General Hospital, Hywel Dda University Health Board on 15 and 16 November 2022.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors and a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the Diagnostic Imaging Department at the hospital.

We saw staff being kind and caring to patients and treating them with respect. We also saw suitable arrangements were in place to promote the privacy and dignity of patients when they were having their X-ray.

Relevant information was made available to patients about their procedure and we saw the use of the Welsh language was well promoted within the department.

We found suitable arrangements were in place for patients to provide feedback of their experiences. We also saw information was displayed on how the department had acted on feedback received.

This is what we recommend the service can improve

- Arrangements need to be made to improve the provision of relevant health promotion material in the department for patients to see
- The print quality of appointment letters needs to be improved and consideration should be given to increasing the size of the text used so they can be easily read by patients.

This is what the service did well:

- Patients provided positive feedback about the service they had received from the staff
- The 'Active Offer' was well promoted within the department
- Information on 'Putting Things Right' was available in a range of formats
- High backed chairs were available in the waiting room to promote patient comfort and assist patients with mobility difficulties
- Information was displayed on how the department had acted on patient feedback.

Delivery of Safe and Effective Care

Overall summary:
We identified improvement was needed to comply with the Ionising Radiation (Medical Exposure) Regulations 2017. However, we acknowledge that senior staff

had identified some improvement was needed through their own processes and were taking action to address this.

We saw the environment was clean, and appropriate arrangements were in place to promote effective infection prevention and decontamination within the department.

Staff we spoke to were aware of the health board's policies and procedures in relation to safeguarding. Staff could describe the actions they would take should they have a safeguarding concern.

This is what we recommend the service can improve

- A number of the employer's written procedures need to be revised so they include further details, they reflect national guidance and so they support staff with clear procedures to follow
- IR(ME)R compliance audits need to clearly demonstrate suitable and timely action has been taken in response to findings
- Action needs to be continued to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.

This is what the service did well:

- Image Optimisation Teams were being established and a Computerised Tomography (CT) User Group had been established to optimise and standardise protocols
- Dose audits were being carried out to establish local Diagnostic Reference Levels
- Current patient contact shielding guidance had been implemented.

Quality of Management and Leadership

Overall summary:
The Chief Executive of the health board was the designated employer under IR(ME)R and clear lines of reporting and responsibility were described and demonstrated.

Feedback from staff was generally positive. However, there were negative responses and comments from staff mainly in relation to staffing, the rota/shift pattern, management and staff relations and management not acting on staff concerns reported to them.

Staff we spoke to demonstrated they had the correct knowledge and skills to undertake their respective roles within the department. However, we identified improvement was needed around the completion of the matrix maintained by the department to show the dates when duty holders have completed IR(ME)R related

training and have been assessed as competent, and to show their scope of practice. The department's compliance with the health board's mandatory training also needed to be improved.

We also identified improvement was needed around the ratification process for locally produced documentation to ensure information was consistent with that in the employer's written procedures.

This is what we recommend the service can improve

- Arrangements need to be made to clearly demonstrate when duty holders have attended training and been assessed as competent and to show their scope of practice
- The ratification process for locally produced documentation needs to be improved to ensure information does not conflict with the employer's written procedures
- Arrangements need to be made to ensure staff are aware of the current written examination protocols to be used
- Action needs to continue to improve compliance with mandatory training
- The health board needs to take action to address the less favourable comments highlighted within the 'Quality of Management and Leadership' section of this report.

This is what the service did well:

- Feedback from staff indicated there were opportunities for professional development
- The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements where needed.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 70 were completed, either by patients themselves or by a person on their behalf.

Responses and comments made within the questionnaires indicate patients had a positive experience of using the service. The most positive responses were in relation to the good service provided and friendly, caring staff. The main suggestions for improvement were around waiting times and access to appointments.

When asked in the questionnaire to rate their overall experience of the service, 55 of the 63 patients who gave an opinion rated the service as 'very good', 7 rated it as 'good' and 1 rated it as 'poor'.

Patient comments included the following:

> ***"The service provided was excellent."***
> ***"I think for a busy service all is ok."***
> ***"No recommendations as service already good."***
> ***"Excellent service."***
> ***"… the service I had there [abroad] was appalling, the NHS in Wales was fantastic, I know there are problems but the care I had was wonderful."***

We asked what could be done to improve the service. Comments included the following:

> ***"Waiting times could be improved but everything else was very good."***
> ***"…It would take a lot more time and resources than is available here."***
> ***"Better signposts."***
> ***"Shorter waiting times once checking in for an appointment."***
> ***"Make sure all patients wear a mask."***

Staying Healthy

Health Protection and Improvement

We saw posters clearly displayed in the department advising patients who are pregnant or breastfeeding to inform staff prior to having their X-ray procedure. This was so a decision could be made as to whether to proceed with the medical exposure.

We also saw posters with a QR code displayed in the hospital. This allowed patients with mobile devices to access health promotion advice. However, these were not displayed within the department for patients to see.

Dignified care

Dignified care

We saw staff being kind and caring to patients and treating them with respect.

Individual changing rooms were available providing privacy when patients were required to change out of their clothes for their procedure. We also saw doors to rooms where X-rays were performed were closed when being used.

Senior staff described the department had been subject to considerable investment to improve the facilities within the department. Examples were described of how upgrading work had helped improve the environment to further promote the privacy and dignity of patients.

When asked whether staff treated them with dignity and respect, 67 of the 68 patients who answered this question in the questionnaire agreed. When asked whether measures were taken to protect their privacy, 63 of the 65 patients who answered this question agreed and 2 disagreed. Comments included:

> ***"I received an excellent service; staff were fantastic and very nice."***
> ***"Staff were very respectful and friendly. Respected my dignity and privacy."***
> ***"Staff were amazing, kind, caring and friendly."***

When asked whether they were able to speak to staff about their procedure without being overheard by other patients, 60 of the 65 patients who answered this question agreed and 5 disagreed. When asked whether staff listened to them and answered their questions, 64 of the 65 patients who answered this question agreed and 1 disagreed.

During the inspection we used online questionnaires to obtain views and feedback from staff. A total of 48 were completed.

When asked whether patients' privacy and dignity are maintained, 44 of the 47 staff who answered this question agreed and 3 disagreed. When asked whether they are satisfied with the quality of care they give to patients, 40 of the 46 staff who answered this question agreed and 6 disagreed.

Communicating effectively

We saw bilingual signage in both Welsh and English and bilingual posters providing information for patients clearly displayed within the department. We also saw a poster displaying information on the 'Active Offer', advising patients they may communicate in Welsh according to their wishes.

Staff told us there were a number of Welsh speaking staff working in the department and we saw staff wearing badges or lanyards to show they were happy to communicate in Welsh.

When asked about their preferred language, eight patients indicated that Welsh was their preferred language and two who answered told us they were actively offered the opportunity to speak Welsh throughout their patient journey. When asked whether they felt comfortable using Welsh within the hospital environment, seven told us they were, regardless of whether they were asked about their language preference. Four patients told us healthcare information was available in their preferred language.

Staff we spoke to told us they could access a translation service, if required, to assist communication with patients whose first language is not English. Staff also told us patients' language preferences were recorded on the department's booking system so that staff were aware.

When asked whether they are Welsh speakers, 12 of the 39 staff who answered this question in the questionnaire indicated they are. Of these, five staff told us they wore a badge or lanyard showing this. However, they also said these are not worn all the time. In addition, staff told us that patients are not always asked to state their preferred language. Responses within questionnaires, indicated that some staff actively use Welsh in everyday conversations.

We saw examples of appointment letters sent to patients. These were also provided in both Welsh and English. However, these were photocopies and of a poor print quality, making them difficult to read. In addition, we considered the size of the text to be small which may make it difficult to read by some patients.

Patient information

Information for patients on the benefits and risks associated with having an X-ray or Computerised Tomography (CT) scan was prominently displayed within the department.

We also saw examples of leaflets sent to patients with their booking letter. These provided useful information for patients on what to expect when they visited the department for their procedure and where relevant, how to prepare for their procedure.

When asked whether they were given enough information to understand the risks and benefits of the procedure, 59 of the 64 patients who answered this question in the questionnaire agreed and 5 disagreed.

When asked whether staff had explained what they were doing, 63 of the 65 patients who answered this question agreed and 2 disagreed.

Timely care

Timely Access

During the course of our inspection, we saw patients attending the department were seen promptly.

When asked how long they had to wait, 35 of the 68 patients who answered this question said they had to wait less than 15 minutes to have their procedure, 12 waited between 15 and 30 minutes and 21 waited for more than 30 minutes.

We were told when the waiting time at the department was likely to be longer than 15 minutes, a sign would be displayed advising patients of this.

When asked whether they were told at the department how long they would likely have to wait, 46 of the 64 patients who answered this question agreed and 18 disagreed.

Individual care

People's rights

Staff we spoke to demonstrated a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department.

Equality, Diversity and Human Rights awareness formed part of the health board's mandatory staff training programme. We reviewed a sample of training files for five staff and saw all staff were up to date with such training.

When asked whether they are involved as much as they want to be in decisions about their care, 59 of the 61 patients who answered this question told us they were and 2 said they were not.

When asked whether patients are informed and involved in decisions about their care, 37 of the 45 staff who answered this question agreed and 8 disagreed. A staff member commented:

> ***"… allow more time for patients that might be older, have mobility issues, have communication issues … etc. 10-15 minutes isn't always sufficient time for these more complex patients in order to provide a good level of care without rushing."***

When asked whether they could access the right healthcare at the right time (regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) 54 of the 63 patients who answered this questionnaire felt they could, 8 said they felt they could not and 1 preferred not to say.

When asked whether they had faced discrimination when accessing or using the service, 61 of the 64 patients who answered this question said they had not, 2 said they had and 1 preferred not to say.

Listening and learning from feedback

We saw posters were prominently displayed in the department advising patients of how they could make a complaint or provide feedback. Leaflets were also available in a range of formats to help patients with different communication needs to understand the complaints and feedback procedure.

The contact details of other organisations patients can contact for help and advice on making a complaint were also readily available in the department.

We also saw a notice board that had information displayed on feedback that had been received and the action taken by the department in response. We identified this as noteworthy practice as it clearly showed patients the department acted on feedback received.

When asked about patient feedback, 26 of the 46 staff who answered the question agreed patient feedback is collected within the department, 11 disagreed and 9 did not know.

When asked whether they receive updates on patient experience feedback, 15 of the 46 staff who answered this question agreed, 24 disagreed and 7 did not know.

When asked whether feedback from patients is used to make informed decisions within their department, 16 of the 46 staff who answered this question agreed, 7 disagreed and 23 did not know. In addition, 38 of the 46 staff who answered the question, agreed their organisation acts on concerns raised by patients and 8 disagreed. When asked whether the organisation takes swift action to improve when necessary, 25 of the 48 staff who answered this question agreed and 23 disagreed.

Delivery of Safe and Effective Care

HIW required senior staff within the department to complete and submit a self-assessment questionnaire prior to our inspection. This was to provide HIW with detailed information about the department and the employer's key policies and procedures in respect of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. This document and the supporting documents submitted were used to inform the inspection approach.

The self-assessment questionnaire was returned to HIW within the agreed timescale and was comprehensive. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly.

Compliance with Ionising Radiation (Medical Exposure) Regulations

Duties of employer

Patient identification

There was an employer's written procedure in place to correctly identify the individual to be exposed to ionising radiation.

The employer's written procedure described alternative means of establishing the correct identity of the individual where verbal communication is difficult or not possible. It did not provide details of checks staff could reasonably perform if discrepancies were identified in relation to identity and laterality.

We examined a sample of nine referral forms. Staff had endorsed the forms to show the identity check had been completed in accordance with the employer's procedure. However, a standardised and consistent approach was not being used to record this check.

Staff we spoke to had a clear understanding of the patient identification procedure.

All patients who completed a questionnaire told us they were asked to confirm their personal details.

Individuals of childbearing potential (pregnancy enquiries)

There was an employer's written procedure in place for making enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding.

The employer's written procedure referred to 'she' and 'female' and so did not accurately reflect the diversity of the gender spectrum in the population. In addition, the appointment letters sent to patients did not reflect current guidance in this regard.

Staff we spoke to described the action they would take to make enquires of individuals, which was consistent with the employer's written procedure.

We examined a sample of nine referral forms. These showed operators had made enquires, in accordance with the employer's written procedure, regarding the pregnancy status of individuals. However, a standardised and consistent approach was not being used to record these enquiries.

Non-medical imaging exposures
Senior staff confirmed non-medical imaging exposures were performed at the department.

There was an employer's written procedure in place for these types of exposures. However, the procedure did not include reference to Tuberculosis (TB) screening which was confirmed as currently being performed.

Referral guidelines
The employer had established referral guidelines for the range of exposures to be performed within the department.

Senior staff confirmed all entitled referrers are sent a leaflet making them aware of how to access these guidelines and also of their responsibilities when referring for X-ray procedures. We were also provided with a copy of the leaflet, which clearly showed this information. We were told referrers were able to access the referral guidelines through arrangements as part of their employment with the NHS in Wales.

Duties of practitioner, operator and referrer
Staff we spoke to demonstrated a good understanding of their duty holder roles and responsibilities under IR(ME)R.

Senior staff described suitable arrangements for how referrals for medical exposures are made to the department.

There was as an employer's written procedure in place providing guidance on making a referral for medical exposures. Senior staff described audit activity had identified acronyms had been written on the referral forms and confirmed that these forms would not be accepted by the department. However, the written procedure did not describe that acronyms are not to be used when completing referral forms. The

employer's written procedures in relation to referrals for non-medical exposures and referrals for research exposures also did not describe acronyms should not be used.

There was also a written non-medical referrers requesting policy for non-medical staff who have been entitled as a referrer. We identified regulations and guidance referenced in this document have been superseded.

We examined a sample of ten referral forms. These showed referrals had been made in accordance with referral guidelines, included sufficient clinical details and had been appropriately completed.

Senior staff described arrangements to audit compliance with the employer's written procedures by those individuals entitled as referrer, practitioner, and operator. While arrangements were in place, the action taken in response to audits was not always clear. We also discussed the timescales for repeating audits and recommended that these are conducted sooner when significant non-compliance with the employer's written procedures is identified.

Senior staff also described audit activity had identified referral forms for exposures performed during surgical theatre cases were not being completed by the referrer. We identified this as poor practice, which was not in keeping with employer's written procedure in this regard. Senior staff described efforts had been made to remind referrers of their responsibilities and a repeat audit was to be conducted. During the inspection we required senior staff to take more timely action in this regard to ensure the employer's written procedure was complied with. Before the end of our inspection, we received written assurance from the employer action was being taken in this regard.

Justification of individual exposures

There was an employer's written procedure for the justification and authorisation of medical exposures. This described the practitioner was responsible for justifying and authorising the exposure. It also described an operator could authorise the exposure under an authorisation guideline issued by the practitioner.

The sample of referral forms we examined showed the above procedure had been followed.

There was also an employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters. This described the practitioner responsible for justifying and authorising the patient exposure is also responsible for the carer and comforter exposure. It also described an operator could authorise the exposure under an authorisation guideline issued by the practitioner. However, the competency records we examined did not record entitlement of practitioners for

the justification of exposures to carers and comforters. Our findings in this regard conflicted with the employer's written procedure.

We were provided with examples of Delegated Authorisation Guidelines (DAG). The DAG for CT referrals did not contain sufficient detail to allow the operator to authorise the exposure and choose the correct protocol, such as the indications for orthopaedic CT and major trauma CT.

Optimisation

Senior staff described the arrangements for the optimisation of medical exposures performed at the department. These included optimising exposures to children, exposures involving high doses, individuals in whom pregnancy cannot be excluded.

It was evident practitioners and operators would give consideration to ensuring doses arising from diagnostic medical exposures performed at the department are kept as low as reasonably practicable (ALARP).

Senior staff confirmed a multi-disciplinary optimisation team had been set up, led by a Medical Physics Expert (MPE), with the aim to improve working practice around the optimisation of exposures. We identified this as noteworthy practice.

We were told exposures as part of a health screening programme were not performed at the department. Therefore, the arrangements for performing these exposures were not considered at this inspection.

Senior staff confirmed current guidance around the use of contact shielding for patients had been implemented at the department. We identified this as noteworthy practice.

Diagnostic reference levels
There was an employer's written procedure in place for the use and review of diagnostic reference levels (DRLs) established for X-ray procedures.

We confirmed local DRLs had been established and these were below national DRLs. We identified this as noteworthy practice. Both local and national DRLs were clearly displayed in the work areas of the department for staff to refer to.

Staff we spoke to confirmed they were aware of the employer's written procedure. They described the action they would take should they identify a DRL has been exceeded and this was in accordance with the employer's procedure. When a DRL had been exceeded, we were told this would be recorded in a logbook and reviewed regularly. The employer's procedure did not specify the frequency of review of the

logbooks. Senior staff confirmed this was every three months. Not all staff with responsibility for checking the logbooks were aware of this frequency.

Paediatrics
Senior staff confirmed X-ray procedures on children were performed in the department.

There was an employer's written procedure in place for performing medical exposures on paediatrics.

Written protocols were in place for standard examinations. However, the arrangements specific to paediatric patients were not always described.

Clinical evaluation
There was an employer's written procedure in place for the carrying out and the recording of an evaluation for each medical exposure performed at the department. This also included the procedure for clinical evaluation carried out by a clinician when in theatres and in the Outpatients Department.

The sample of referral forms we examined included four retrospective referral forms. These all showed evidence of a clinical evaluation being completed.

Equipment: general duties of the employer
There was an employer's written procedure in place to ensure a quality assurance programme in respect of equipment was followed.

We found there had been significant investment in new equipment, with six pieces of new equipment having been installed at the department during 2022.

We confirmed the employer had suitable arrangements in place for the acceptance testing of new equipment, performance testing at regular intervals and performance testing following equipment maintenance. However, information provided by senior staff showed the frequency of regular testing had not been in accordance with the agreed testing schedule. Senior staff provided an assurance that this had since been addressed.

There was an employer's written procedure in place for the assessment of patient dose and administered activity. This included details of the procedure for recording dose indicators for equipment used within the department. This information was available to MPEs for audit when recommending and reviewing DRLs. However, details were not included for recording dose indicators for exposures performed in surgical theatres or for interventional radiography.

We confirmed the employer had suitable arrangements in place to improve inadequate or defective equipment. This involved processes for identifying, reporting and escalating equipment faults to senior staff and taking corrective action, including removing equipment from service.

An inventory of equipment installed at the department was available. This included the information required under the regulations.

Safe Care

Managing risk and promoting health and safety
We saw the environment appeared well maintained and in a good state of repair. Senior staff described upgrading works had recently been completed and explained this had resulted in improved facilities for patients visiting the department.

We did not identify any obvious hazards to the health and safety of staff working in the department or to patients and other individuals visiting the department.

The department was signposted from the main entrance of the hospital and we found the signs generally easy to follow. There was level access to the hospital and the department was located on the ground floor making it accessible to patients using wheelchairs or with mobility difficulties.

We saw waiting areas were of a sufficient size for the numbers of patients attending the department. We also saw a number of high-backed chairs located in the waiting room. We identified this as noteworthy practice as it meant these may provide a higher level of comfort to patients and also make it easier for patients with mobility difficulties to sit down and get up from a seated position.

When asked whether they were able to find the department easily at the hospital, 63 of the 65 who answered this question agreed and 2 disagreed.

We saw signage clearly displayed to alert patients and visitors not to enter controlled areas where ionising radiation was being used.

Infection prevention and control (IPC) and Decontamination
All areas of the department we saw were visibly clean and tidy and the equipment we saw was also clean.

We saw staff cleaning equipment between patients to help reduce cross infection.

Suitable handwashing and drying facilities were available and hand sanitising stations were located throughout the department. Personal protective equipment (PPE) was readily available for staff to use.

Staff we spoke to were aware of their responsibilities in relation to infection prevention and control and decontamination.

We saw screens were installed between chairs in the waiting room. These had been installed to reduce the spread of COVID-19 and senior staff confirmed a decision had been made to keep these in place.

When asked how clean the department was, 49 of the 69 patients who answered this question said it was 'very clean', 9 said it was 'fairly clean' and 1 said it was 'not very clean'. When asked whether COVID-19 infection control measures were being followed, where appropriate, 51 of the 67 patients who answered this question said they were, 4 said they were not and 12 said they either didn't know or did not notice.

When asked about infection prevention and control measures, 44 of the 48 staff who completed a questionnaire agreed appropriate measures were in place and 4 disagreed. When asked about COVID-19, 38 of the 40 staff who answered this question agreed the organisation had implemented the necessary environmental issues to become COVID-19 compliant and 2 disagreed. In addition, 40 of the 41 staff who answered the question agreed the organisation has implemented the necessary practice changes and 1 disagreed.

Of the 41 staff who answered the question, 39 agreed there has been a sufficient supply of PPE and 2 disagreed. In addition, 38 of the 40 staff who answered the question agreed there are decontamination arrangements for equipment and relevant areas and 2 disagreed.

Safeguarding children and safeguarding adults at risk

Staff we spoke to were aware of the health board's safeguarding policies and procedures and where to access these. Staff were also able to describe the actions they would take should they have a safeguarding concern.

We were told safeguarding training was mandatory for staff. The sample of training records we examined showed most of the staff were up to date with training, which had been completed at an appropriate level according to their role within the department.

Effective care

Quality improvement, research and innovation

Clinical audit

There was an employer's written procedure in place for carrying out clinical audit.

Senior staff provided examples of clinical audits that had been completed. We saw these were not presented in a consistent format to describe the aims and objectives of the audit, analysis of the findings, the action required and the date for review. This means it was not always clear what action needed to be taken as a result of the audit and whether any action implemented had resulted in improvement.

Expert advice

We confirmed the employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R.

Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in, and provide advice on, medical exposures performed at the department.

Medical Research

Senior staff confirmed the department did participate in research programmes. We were told that this was mainly to perform routine exposures as part of patients' follow up care.

There was an employer's written procedure in place for medical exposures performed for research.

Record keeping

Generally, we found suitable arrangements were in place for the management of records used within the department.

The sample of referral records we examined had been completed fully to demonstrate checks had been conducted to promote patient safety. However, we identified the system for recording certain information was inconsistent, such as identity checking and pregnancy enquiries.

Quality of Management and Leadership

Staff Feedback

During the inspection we used online questionnaires to obtain feedback and views from staff working in the department. A total of 48 were completed. Not all staff answered all the questions in the questionnaire.

Responses from staff were generally positive, with most respondents being satisfied with the quality of care they give to patients, and just under two-thirds being happy with the standard of care provided by this organisation for themselves, friends or relatives. Two-thirds of respondents recommended the service as a place to work.

The most positive responses were in relation to opportunities for professional development, and the team spirit amongst colleagues.

However, there were negative responses and comments from staff. The main issues raised were staffing, the rota/shift pattern, management and staff relations and management not acting on staff concerns reported to them.

Staff comments included the following:

> ***"The team of band 5s and 6s are all lovely and this department has the potential to be a great place to work."***
> ***"Absolutely unhappy place and would not recommend to anyone to come here."***
> ***"The department has struggled over the last two years with staffing. At times the staffing levels have been unsafe."***
> ***"The team … rose to the challenge, however difficult the climate has been, they have managed to provide a good service to patients."***
> ***"Manage Rota's better to enable adequate numbers of staffing at all times so workload is shared across the team…"***
> ***"The situation has improved recently with the addition of overseas staff. There is a shortage of UK radiographers which is especially felt in the west of Wales with our rurality."***
> ***"There is not enough open communication/regular feedback or face to face team updates to allow staff to feel appreciated and heard."***
> ***"weekly feedback has improved communication"***

We asked staff what could be done to improve the service. Staff suggestions included the following:

"Perhaps more communication would help across all areas of the NHS - it feels like everyone is working hard, but there needs to be smarter thinking to try and make things more efficient. Departments do not necessarily talk to each other about what goes on in their own departments and therefore they do not know how best to help each other or indeed for the patient."
"More available x-ray rooms to lessen patient waiting times and workload on staff."
"Longer appointment slots to allow for good patient care and best clinical practice, also less stressful for staff"

Governance, Leadership and Accountability

The Chief Executive of the health board was the designated employer under IR(ME)R and had overall responsibility for ensuring the regulations are complied with. Where appropriate the employer had delegated tasks to other professionals working in the health board to implement IR(ME)R.

Senior staff submitted details of the organisational structure. Clear lines of reporting and responsibilities under IR(ME)R were described and demonstrated.

Senior staff confirmed arrangements were in place to monitor the quality and safety of services provided in the department and to provide assurance to the health board as part of the governance arrangements.

Senior staff provided examples of work to improve services provided to patients. These included an initiative to fast track patients, who had fallen while residing in care homes, directly to the department to have a CT head scan to prevent them from waiting unnecessarily in the hospital's Emergency Unit.

When asked whether they were content with the efforts of the organisation to keep them and patients safe, 37 of the 48 staff who answered this question agreed and 11 disagreed. In addition, 41 of the 48 staff agreed care of patients is their organisation's top priority and 7 disagreed.

When asked whether they know who senior managers are, 44 of the 46 staff who answered this question agreed and 2 disagreed. In addition, 30 of the 45 staff who answered the question agreed that senior managers are visible and 15 disagreed. Comments included:

"… it's been nigh on impossible to see a manager, with a sign being placed on the door stating, 'video conference do not enter' when our manager has said in the past 'I just put that on the door to keep people away'. You cannot feel supported by management like this."

> ***"[We need] More support from management and management to work within the team during the day to day running of the service."***

When asked whether communication between senior management and staff is effective, 23 of the 45 staff who answered this question agreed and 22 disagreed. Of the 46 staff who answered the question, 35 agreed that senior managers are committed to patient care and 11 disagreed.

Most staff agreed their immediate manager can be counted on to help with a difficult task at work, however, 13 of the 45 staff who answered this question disagreed. Similarly, most staff agreed their immediate manager gives them clear feedback, however 15 disagreed. Additionally, 24 of the 46 staff who answered the question agreed their immediate manager asks for their opinion before making decisions that affect their work and 22 disagreed. We received the following comment:

> ***"My line manager [anonymised] and her manager [anonymised] always listened and supports. They take on board my concerns and escalate to the next level. They have an open-door policy, and I can gain advice whenever I need."***

When asked whether their organisation encourages teamwork 37 staff who completed a questionnaire agreed and 11 disagreed. In addition, 33 staff agreed their organisation is supportive while 15 disagreed.

Duties of the employer

Entitlement

There was a written employer's procedure in place to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice.

We identified anaesthesia associates had been entitled as referrers. However, as this group of staff are not currently registered as healthcare professionals, they would not be permitted to be referrers. Senior staff confirmed these individuals held a current registration as another healthcare professional. The employer's written procedure needed to be revised to make this position clear. We also recommended that individual staff contact their relevant regulatory body to ensure they could satisfy the requirements for continued registration and also to check they had suitable indemnity insurance in place, if not already done so.

Senior staff confirmed that an individual's entitlement and scope of practice was reviewed every two years to identify any changes. We viewed a sample of competency records for five staff and the training and entitlement matrix maintained by the department. While the scope of practice for practitioners and operators was recorded on the competency forms, there were gaps on the matrix

and the current scope of practice of the listed duty holders was not always recorded. In addition, it was not always recorded when individuals had been entitled as a duty holder.

In relation to non-medical referrers, it was not always clear when these duty holders had completed training and when they had been assessed as competent. Senior staff described they had identified this through their own process and were taking action to address this. In addition, there was no agreed frequency for non-medical referrers to complete refresher training.

Procedures and protocols
The employer had written procedures as required under IR(ME)R. We saw these were well written, however, we identified some could include more detail as highlighted in this report.

There was an employer's written procedure in place for the quality assurance of written procedures and protocols. The sample of written procedures we examined followed a consistent format and reflected the written procedure. However, the ratification process for locally produced documentation, such as the CT referral form, required improvement to ensure information such as ID checking and dose recording boxes are included on the form and therefore does not conflict with the requirement of the employer's written procedures.

We also examined a sample of written examination protocols. We identified these did not include version numbers or review dates and it was not always clear who had written the protocols. Therefore, we could not be assured staff would be aware of the current version to use.

Some protocols were available in electronic form only. We recommended that arrangements be made to ensure staff can access these protocols in the event of a system failure.

Significant accidental or unintended exposures
There was an employer's written procedure in place for reporting and investigating accidental and unintended exposures. Senior staff were aware of the requirement to notify HIW of such incidents.

Senior staff described a suitable process for undertaking preliminary and detailed investigations into accidental or unintended exposures. This process included the involvement of MPEs so that an assessment of the dose can be performed to identify whether the incident is notifiable to HIW.

Senior staff also described suitable arrangements for informing the referrer, the practitioner and the patient or their representative of clinically significant incidents together with the outcome of the analysis of the incident.

Suitable arrangements were also described for sharing learning from incidents with staff in the department and those working in departments at other hospitals within the health board.

When asked about the organisation's approach to handling incidents, 35 of the 42 staff who answered the question agreed the organisation encourages them to report errors, near misses or incidents and 7 disagreed. In addition, 36 of the 41 staff who answered the question agreed the organisation treats staff involved fairly and 5 disagreed.

Most staff who answered the question agreed when errors, near misses or incidents are reported, the organisation takes action to ensure that they do not happen again. However, 9 of the 42 staff who answered this question disagreed. We received the following comment:

> ***"There's doesn't seem to be any accountability when staff have incidents or near misses. A lot of things are swept under the carpet even when things have been dangerous"***

When asked whether they are given feedback about changes made in response to reported errors, near misses or incidents 27 of the 42 staff who answered this question agreed and 15 disagreed. We received the following comment:

> ***"Issues or concerns that are raised to management don't always seem to be actioned. Maybe they are but because there aren't good channels of communication and feedback to staff, or any changes made - staff assume nothing is being done."***

When asked whether they would know how to report a concern about unsafe practice, 38 of the 40 staff who answered this question agreed they would know how to report it and 2 disagreed. Of the 41 staff who answered the question, 20 felt confident their concerns would be addressed, 12 did not and 9 did not know.

When asked about whether they feel secure raising concerns about unsafe practice, 29 of the 41 staff who answered this question said they would, 9 said they would not and 3 did not know. Comments received included:

"Management should listen to the concerns of staff and act upon them - not threaten staff with disciplinary for raising concerns about a member of staff."
"There is a general lack of support if staff raise concerns about staff inappropriate behaviour or unsafe practice."
"Things have to change, for patient safety and care to improve, the incompetence of some professional staff to do the simple of tasks is shocking and the managers need to act on concerns…"

Workforce

Senior staff provided details of the number and skill mix of staff working for the department. It was evident from our discussions with senior staff the department was experiencing challenges around staffing. We found considerable efforts were being made to try and address the staffing issues and maintain services for patients.

When asked whether they agreed there are enough staff to enable them to do their job properly, 26 of the 48 staff who completed a questionnaire agreed and 22 disagreed.

A matrix was maintained to show each duty holder's training and entitlement. We were told individuals held their own training records in relation to IR(ME)R.

Generally, we saw information within the matrix was incomplete, with dates of training and dates when duty holders had been assessed as competent missing. We were told that competency was re-assessed as part of staff appraisals and saw evidence of this within the sample of competency records we examined. However, competency was not recorded for practitioners who had been entitled to justify exposures to carers and comforters or for staff performing operator tasks in surgical theatres.

We reviewed staff training records in relation to the health board's mandatory training programme. These showed staff were expected to complete training on a range of topics relevant to their role. Generally, the records showed these staff were up to date with mandatory training. We saw that overall staff compliance with training was at 68%. Senior staff had identified improvement was needed to improve compliance and described strategies to address this.

While senior staff were able to access individual training records to monitor training compliance, consideration should be given to developing a suitable matrix to make this task easier.

When asked whether they have received appropriate training to undertake their role, 32 of the 48 staff who completed a questionnaire felt they have, 11 felt they

partially have and 5 felt they have not. We asked if there was any other training staff would find useful. Staff comments included:

> ***"Demonstration of the crash trolley"***
> ***"British sign language"***
> ***"BLS [basic life support]"***
> ***"More courses and apprenticeship-based learning needs to be accessible for employees who live as far West in Wales as Pembrokeshire and in more rural areas in order to allow people to further their careers."***

When asked whether they are Welsh speakers, 12 of the 39 staff who answered this question indicated they are. When asked whether they are given the opportunity to complete training in Welsh, 3 indicated they are and 9 indicated they are not.

When asked whether they their training, learning and development helped them do their job more effectively and helped them deliver a better patient experience, 43 staff who completed a questionnaire agreed and 5 disagreed. Most staff who completed a questionnaire agreed their training, learning and development helped them to stay up to date with professional requirements, however 7 disagreed. The following comment was made:

> ***"Staff … are encouraged to undertake postgraduate training and we have a large number of staff working as advanced practitioner or in training. The role development opportunities in GGH [Glangwili General Hospital] for radiographers is high compared to other health boards."***

We also reviewed compliance with conducting staff appraisals and identified compliance was at 58%. Senior staff had identified improvement was needed to improve compliance and described strategies to address this.

When asked whether they had an annual review or appraisal within the last 12 months, 29 staff who completed a questionnaire indicated they had, 16 indicated they had not and 3 could not remember.

Of the 29 who had an annual review or appraisal, 21 stated that training, learning, or development needs were identified and 8 stated they were not. Responses generally indicated that their manager supported them to receive this training, learning or development.

Of the 38 staff who answered the question, 31 agreed staff have fair and equal access to workplace opportunities, 5 disagreed and 2 preferred not to say. In addition, 30 agreed the workplace is supportive of equality and diversity, 4 disagreed and 4 preferred not to say. We received the following comments:

"Some are favoured by management."
"No real initiatives to support staff equality and diversity"

Whilst 27 of the 43 staff who answered the question agreed their job is not detrimental to their health, 16 disagreed. We received the following comment:

"Staff are all exhausted including myself due to the demands being placed on them."

When asked whether the organisation takes positive action on health and wellbeing, 32 of the 44 staff who answered this question agreed and 12 disagreed. In addition, 32 staff who completed a questionnaire agreed they would recommend their organisation as a place to work and 16 disagreed.

When asked whether they agreed their current working pattern/off duty allows for a good work-life balance, 35 of the 44 staff who answered this question did agree and 9 did not. We received the following comment:

"Everyone is burning out by the unsuitable shift pattern. Most staff that are on the on-call rota only have days off after an on-call shift. This is causing these members of staff to be ill, tired and make mistakes because they're exhausted."

Of the 44 staff who answered the question, 27 agreed they are offered full support in the event of challenging situations and 17 disagreed.

Most staff who answered the question were aware of the Occupational Health support available to them, 39 of the 44 staff indicated they are and 5 indicated they are not.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns relating to patient safety were identified.			

Appendix B - Immediate improvement plan

Service: Glangwili General Hospital, Diagnostic Imaging Dept

Date of inspection: 15 and 16 November 2022

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
No immediate improvement plan required.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Glangwili General Hospital, Diagnostic Imaging Dept

Date of inspection: 15 and 16 November 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide HIW with details of the action taken to improve the provision of relevant health promotion information within the Diagnostic Imaging Dept.	Standard 1.2 Health Promotion, Protection and Improvement	Health promotional material has been ordered and will be in place as soon as it has been delivered. Introduce a process whereby the content will be reviewed / updated regularly.	Site Lead Superintendent Radiographer	28th February 2023
The health board is required to provide HIW with details of the action taken to improve the print quality of appointment letters sent to patients.	Standard 3.2 Communicating Effectively	Instigate a process whereby the service will only send printed copies of letters and not photocopy any letters with immediate action.	Site Lead Superintendent Radiographer	Complete

		Create a working group to standardise the letter format for radiology using the HB guidelines.		30th September 2023
The health board is required to provide HIW with details of the action taken to improve the system of providing staff with updates on patient experience feedback.	Standard 6.3 Listening and Learning from Feedback	Process introduced whereby any feedback is displayed in work areas and emailed to the staff involved. Instigate a monthly feedback memo displaying all feedback from patients. Patient experience is also shared at the Radiology Quality Safety and Patient Experience Meeting	Site Lead Superintendent Radiographer	Completed Completed Completed
The employer is required to provide HIW with details of the action taken to promote an effective and consistent approach to staff recording patient identity checks, pregnancy enquiries and exposure doses.	Regulation 6 1(a), 2 Schedule 2 1(a), (c), (e)	A review of the procedure for patient identify checks will be undertaken to update the Employer's Procedure (EP). Introduce an audit to be performed on compliance with identity checks.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th April 2023

The employer is required to provide HIW with details of the action taken to: • review and revise the employer's written procedure for making enquiries of individuals of childbearing potential so that it reflects the diversity of the gender spectrum in the population • review and revise appointment letters so they reflect the diversity of the gender spectrum in the population	Regulation 6 1(a) Schedule 2 1(c)	A review of the enquiries of individuals of child bearing potential Employer's Procedure will be undertaken and updated with any gender specific reference to be removed. A review of all service documentation including letters and posters will be undertaken with any gender specific reference to be removed.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th April 2023 30th April 2023
The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for non-medical imaging exposures so that it includes reference to Tuberculosis (TB) screening.	Regulation 6 1(a) Schedule 2 1(m)	Introduce a process whereby all Employer's Procedures will be reviewed in February 23 and updated to include all examinations currently performed.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	April 23 to allow for sign off after the meeting

The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedures providing guidance on making a referral so that they reflect the need to avoid using acronyms and include reference to current guidance where applicable.	Regulation 6 1(b), 5(a)	All Employer's Procedures will be reviewed in February 23 and updated to include that we do not accept referral forms with acronyms. We will also ensure that all referrers receive a copy of the Employers Procedures for referrers.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th April 2023
The employer is required to provide an update on the action taken to ensure the employer's written procedure is adhered to by entitled referrers making a referral prior to exposures performed during surgical theatre cases.	Regulation 6 2	Reinforcement of referral process with all appropriate staff being reminded of the process. Introduction of an audit to check compliance with the referral process.	Site Lead Superintendent Radiographer Site Lead Superintendent Radiographer	Complete Complete
The employer is required to provide HIW with details of the action taken to review and revise the DAG for CT referrals so that it includes more detail for the indications for orthopaedic CT and major trauma CT.	Regulation 6 4	Introduction of a process to review the DAG to ensure more detail is included for CT referrals.	Site Lead Superintendent Radiographer / Head of Radiology / Clinical Director Radiology	30th April 2023

The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the use and review of diagnostic reference levels so that it provides details of the frequency for reviewing logbooks.	Regulation 6 1(a) Schedule 2 1(f)	Introduction of a procedure to review EP's to include the logbook checking frequency. Instigate an audit to check compliance as part of the audit schedule.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th April 2023
The employer is required to provide HIW with details of the action taken to review and revise the employer's written procedure for the assessment of patient dose and administered activity so that it includes details of the procedure for exposures performed in surgical theatres and interventional radiography.	Regulation 6 1(a) Schedule 2 1(e)	Introduction of a procedure to review all Employer's Procedures to include theatre procedures and interventional radiography.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th April 2023
The employer is required to provide HIW with details of the action taken to promote a	Regulation 7	Instigate a procedure to promote a consistent approach for process and presentation of clinical audits.	Site Lead Superintendent Radiographer / Head of Radiology / Clinical Director Radiology	30th March 23

consistent approach for the process and presentation of clinical audits.				
The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to identify individuals entitled to act as referrer, practitioner or operator so that it clearly sets out the position in relation to anaesthesia associates.	Regulation 6 1(a) Schedule 2 1(b)	Introduce a procedure to review all Employer's Procedures to include the position on anaesthesia associate. The policy will be clearly reworded to reflect that only registered professionals are able to refer.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th March 2023
The employer is required to provide HIW with details of the action taken to maintain a complete and up to date record of the training, entitlement and scope of practice for entitled duty holders, including non-medical referrers	Regulation 6 1(a) Schedule 2 1(b) Regulation 17 4	A review of the entitled duty holder matrix will be undertaken with the suggested change being made to provide a more thorough record.	Site Lead Superintendent Radiographer	30th June 2023
The employer is required to provide HIW with details of the action taken to demonstrate competency has been assessed:	Regulation 6 1(a) Schedule 2 1(b), (n)	Instigate the development of a training document which will provide assurance and information to staff about the specific roles. These	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th May 23

• for those practitioners entitled to justify exposures to carers and comforters • for staff performing operator roles in surgical theatres. The employer's written procedure to establish dose constraints and guidance for the exposure of carers and comforters must also be reviewed and revised to clarify the arrangements for the justification of such exposures by the practitioner.		competencies will be added to matrix. The Employer's Procedure will be updated to include the justification process. Introduce a process to establish dose constraints and add to Employer Procedures.	Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist Site Lead Superintendent Radiographer / Head of Radiology / Consultant Clinical Scientist	30th May 2023 30th May 2023
The employer is required to provide HIW with details of the action taken to develop and implement written protocols, where appropriate, for paediatric patients.	Regulation 6 4	A process has been introduced to review all adult protocols. The review will inform the development and implementation of paediatric protocols.	Site Lead Superintendent Radiographer / Head of Radiology / Clinical Director Radiology	30th July 2023
The employer is required to provide HIW with details of the action taken to improve the	Regulation 6 1(a)	A process has been introduced whereby the Lead Radiographer coordinates all written	Head of Radiology	30th April 23

ratification process for locally produced documentation so that information does not conflict with the employer's written procedures.	Schedule 2 1(d)	documentation to ensure no conflict with the employers written procedures. To source a document control system.	 Head of Radiology	 30th September 2023
The employer is required to provide HIW with details of the action taken to: • ensure staff are aware of the current written examination protocols to use • ensure the written protocols clearly identify the author • ensure staff can access protocols in the event of a system failure.	Regulation 6 2	Hard copies of the protocols are available at all times in the department. A process will be undertaken to ensure any remaining old copies of protocols are removed and that the author is identified. Staff have been briefed on protocols and any changes to protocols as they are made via team meetings. Written examination protocols will be made available to all staff in electronic and paper formats for all areas.	Site Lead Superintendent Radiographer Site Lead Superintendent Radiographer Site Lead Superintendent Radiographer	30th March 23 Complete 28th February 2023

The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	Standard 7.1 Workforce	The management team have approached the Health Board's values and culture team for expert advice on how to ensure the staff's voices are heard and action taken.	Site Lead Superintendent Radiographer	30th May 2023
		A series of staff engagement events are planned to instigate 'culture change' within the department and empower staff's confidence in the management.	Site Lead Superintendent Radiographer	30th May 2023
		Staff meetings are being strengthened and a regular schedule of meetings are being arranged in advance and circulated to staff.	Site Lead Superintendent Radiographer	30th May 2023

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Gail Roberts-Davies

Job role: Head of Radiology

Date: 17/01/2023