Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection (Announced)

Diagnostic Imaging, Prince Philip Hospital

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

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced remote Ionising Radiation (Medical Exposure) Regulations inspection of Prince Philip Hospital's Diagnostic Imaging Department on the 23 and 24 February 2021.

Our team, for the remote inspection comprised of two HIW Inspectors and a Senior Clinical Diagnostic Officer from the Medical Exposures Group of Public Health England, who acted in an advisory capacity.

HIW explored how the service:

- Complied with the Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2017
- Complied with the Care Standards Act 2000 and met the Health and Care Standards (2015).

Further details about how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, from the evidence we examined, we found that compliance with IR(ME)R was good. Discussions with staff demonstrated that awareness of their responsibilities in line with IR(ME)R was also generally good.

Both patients and staff who completed the survey were positive about their experiences whilst in the department.

The department was being well managed and comments from staff indicated that they felt supported by senior staff.

Discussions with managers and department staff throughout our inspection provided assurance that arrangements were in place to ensure that examinations were being undertaken safely. However, we highlighted employer's procedures, policies and protocols that were overdue for review and also needed to be updated.

This is what we found the service did well:

- Feedback received from patients indicated that they were very satisfied with the services provided within the department
- The Medical Physics Experts (MPE)[1] involvement was positive both during the inspection and with the hospital in general
- Senior staff were very receptive to our inspection and demonstrated a willingness to make improvements as a result

[1] An MPE is a person having knowledge, training and experience to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine and radiotherapy, whose competence in this respect is recognised by a competent authority. All employers who carry out medical exposures are required in IR(ME)R to appoint a suitable medical physics expert.

- Staff engagement was positive.

This is what we recommend the service could improve:

- Ensuring employer's procedures, policies and protocols are up to date, version controlled and reviewed in a timely manner and reflect actual practises
- The audit programme and associated documentation to include timeframes and frequency for the audits
- Ensure the name of the practitioner justifying the exposure is recorded for all medical and non-medical exposures
- Ensuring that all members of staff within the department are trained in basic life support.

3. What we found

Background of the service

Hywel Dda University Health Board (HDUHB) was established on 1 October 2009 and provides primary, community, hospital and mental health services to the people of the counties of Cardiganshire, Carmarthenshire and Pembrokeshire.

The health board as a whole serves a population of more than 380,000 people. Prince Philip Hospital, Llanelli, is an acute hospital which opened in 1990. There are approximately 225 inpatient beds that support acute and elective services for General Medicine; General Surgery; Orthopaedic; Urology; Acute Stroke and Rehabilitation.

The equipment at the X-ray department at Prince Philip Hospital included:

- General X-ray units
- Mobile general radiography including C-arm fluoroscopy and mini C-arm unit
- General fluoroscopy unit
- Computed tomography (CT) scanner
- Static mammography unit
- Magnetic Resonance Imaging (MRI) and Ultrasound scanners.

The department employed a number of staff including consultant radiologists, reporting radiographers, reporting sonographers, radiographers and assistant practitioners. The department provided an out of hours service staffed by radiographers and a third-party provider. The department also has advice and support from three MPE provided by Radiation Physics in Swansea Bay UHB).

Quality of patient experience

As part of our remote inspection, we reviewed some of the arrangements in place to communicate with and obtain feedback from patients regarding the services provide.

Feedback from patients indicated that they were highly satisfied with the service provided by staff within the radiology department.

Staff feedback was also positive on the standards of care provided.

The department had processes in place to ensure they could communicate effectively with patients.

Arrangements were in place to collate patient feedback on the services being provided. Patient surveys were carried out and there was a clear process for dealing with and responding to concerns received by the service.

Prior to the inspection HIW developed an online patient survey, to allow patients to provide their views and experiences on the services provided within the department. This survey was publicised via a poster displayed within the department in the lead up to our inspection, as well as on the HIW social media pages. A total of 14 questionnaires were completed. Patient comments included the following:

> *"I wish to congratulate each and every one of your colleagues for the truly amazing job you are all doing in such exceptional circumstances"*
>
> *"Service and professionalism excellent"*
>
> *"I'm extremely grateful to the two staff that attended me for the scan in the evening, working long hours to provide care during this pressured time for patient services. I would have felt more secure with female and other staff present in the hospital main areas and radiology department but the staff were reassuringly professional"*

Staff were also invited to complete a staff survey through a similar on-line questionnaire, to find out what working conditions were like and to obtain their views on the standard of care. We received 15 completed questionnaires from a

wide range of staff grades. Respondents said they had been in their current role for between less than 6 months to more than 10 years. Just over half of respondents had been in post more than 10 years.

Most staff who completed the questionnaire agreed the care of patients was the organisation's top priority and most agreed the organisation acted on concerns raised by patients. The overall majority of staff agreed they would recommend the organisation as a place to work and said they would be happy with the standard of care provided by the organisation if a friend or relative needed treatment.

> *"A pleasure to be part of a hard-working and supportive team"*
>
> *"Balancing the budget can sometimes take priority over staff concerns"*
>
> *"I find my place of work a happy and safe environment to work. The management are very supportive to me and always had an open office door"*

Dignified care

All of the patients who completed a questionnaire agreed that they had been treated with dignity and respect by the staff at the hospital. They felt that they were always able to maintain their own privacy, dignity and modesty during their appointments.

All but one of the patients felt that they were listened to by staff during their appointment. They also told us that they were able to speak to staff about their procedure or treatment without being overheard by other people.

The majority of staff that completed a questionnaire also said they were always satisfied with the quality of care they are able to give to patients. Most respondents agreed patients and, or, their relatives were always involved in decisions about their care.

Patient information

We were provided with a copy of the poster detailing the benefits and risks of an X-ray examination for patients, which we were told was displayed in the waiting room areas. This poster had been developed by one of the MPEs. All but one of the patients who completed a questionnaire told us that they felt involved as much as they wanted to be in any decisions made about their treatment. Every patient said that they had received clear information to understand the benefits and risks of their treatment options.

The majority of patients who completed a questionnaire told us that they had been given information on how to care for themselves following their treatment. However, half of the patients said that they had not been given written information on who to contact for advice regarding possible after effects from treatments they had received. The health board should consider addressing this issue.

Communicating effectively

We were informed by staff that there was a hearing loop installed within the main reception area, to assist patients wearing hearing aids, when communicating with staff.

Staff informed us that access was available to telephone translation services, should a patient attend the unit who was unable to communicate in English. We were also informed that there were Welsh speaking staff available in the department, should a patient prefer to communicate in Welsh.

Half of the patients who completed a questionnaire told us that staff asked them which language they preferred to communicate in and where applicable the majority said they were comfortable to communicate in Welsh. All but one of the patients preferred to communicate in English. We were told that bilingual letters were sent to patients and there was bilingual signage throughout the department. We were also told that staff who were able to speak Welsh, wore an appropriate lanyard to identify them as a Welsh speaker.

Timely care

All of the patients who completed a questionnaire told us that they were able to arrange an appointment at a time that suited them. 35 percent of patients had last visited the setting within the last two months.

Staff we spoke with, said that patients were told of any delays to waiting times when they were in the department, particularly in areas such as CT or Ultrasound where the delay was over 20 minutes. In these cases, patients were given the offer of leaving the department and returning within a specified time.

Whilst, we were told that waiting times were communicated to patients within the department on arrival, the reception desk was not always aware of any short delays. Additionally, the majority of the patients who completed a questionnaire told us they had waited less than 15 minutes to have their procedure or treatment. However, just over half of the patients stated that they were not told on arrival how long they would likely have to wait before having their procedure or treatment. The department should identify further ways of ensuring patients were aware of any delays.

Improvement needed

The health board is required to provide HIW with details of the action taken to better inform patients visiting the department of current waiting times.

Individual Care

Listening and learning from feedback

The process of obtaining feedback from patients was described, with Quick Response (QR)[2] codes visible in every room, for patients to scan. This process, we were told, was instigated by the new Superintendent Radiographer. However, patients were not informed of the results of the feedback. The health board should provide information to patients of their replies to surveys, with actions taken on feedback.

All but one of the staff respondents told us patient experience feedback (e.g. patient surveys) were collected. The majority said they received regular updates on the patient experience feedback. All but one of the respondents said it was used to make informed decisions within their directorate or department.

Staff told us that on the occasions where verbal concerns were raised by patients, attempts were made, where possible, to speak with the patient immediately, to try to help resolve any issues or concerns quickly and efficiently. Where this was not possible, we were told that patients were signposted to the Patient Support Service[3] of the Health Board, who managed these concerns.

[2] A QR code is a type of matrix barcode (or two-dimensional barcode). A barcode is a machine-readable optical label that contains information about the item to which it is attached. In practice, QR codes often contain data for a locator, identifier, or tracker that points to a website or application.

[3] https://hduhb.nhs.wales/healthcare/services-and-teams/patient-support-services-complaints-feedback/

Improvement needed

The health board is required to inform HIW of the action taken to provide information to patients of their replies to surveys, with actions taken on feedback.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We found that compliance with IR(ME)R overall was good, from the evidence available and discussions undertaken with staff.

Staff awareness of their IR(ME)R responsibilities was generally good.

Policies and written employer's procedures required under IR(ME)R were available. These helped the department to comply with the requirements of the regulations as they applied to radiology. However, these were now overdue for review.

Areas for improvement were highlighted in regard to recording the names of out-of-hours practitioners who justify exposures for CT examinations.

Compliance with Ionising Radiation (Medical Exposure) Regulations

Duties of Employer

Patient identification

The employer's procedure for identification of individuals undergoing a medical exposure procedure clearly identified those staff responsible for correctly identifying patients. Staff were expected to ask patients to confirm their name, date of birth and address. This was in keeping with current UK guidance[4]. The

[4] Department of Health and Social Care (2018); Guidance to the Ionising Radiation (Medical Exposure) Regulations 2017

procedure also described alternative approaches that staff must use should patients be unable to verbally confirm their identity themselves. The procedure also set out the process staff should follow when undertaking identification checks for paediatric patients.

Staff we spoke with were able to describe the correct procedure to identify patients. Also, all patients who completed our questionnaire told us that they were asked to confirm their personal details by staff before starting their examination.

Individuals of childbearing potential (pregnancy enquiries)

There was an employer's procedure in place in relation to the process for carrying out pregnancy enquiries for individuals of childbearing potential, prior to any exposures. This procedure aimed to ensure that such enquiries were made in a standard and consistent manner. The procedure identified the staff responsible for making the relevant enquiries and set out the process to follow depending on the individual's response. The procedure also included the age range of patients who should be asked about pregnancy, in accordance with UK guidance.

We identified areas within the procedure which would benefit from additional detail for staff. These included clarity needed on the enquiry made to those under 16 years of age and to ensure staff were clear on the procedure and include details around gender diversity.

We were told that there were posters displayed within the department advising patients to speak with staff if they either were, or thought they may be pregnant. This was important to minimise potential harm to an unborn child from the exposure to ionising radiation.

Improvement needed

The employer must ensure that a review of the employer's written procedure relating to pregnancy enquires is undertaken. This is to ensure that there is sufficient detail on the process to be followed by staff, for all types of patients they may encounter. Additionally, this review should include how gender diversity is considered and managed.

Non-medical imaging exposures

The employer had a written procedure in place which set out the criteria for carrying out non-medical imaging exposures[5]. Referrals for non-medical imaging examinations would only be accepted from registered healthcare professionals.

Referral guidelines

The employer's procedure for referral and referral criteria was documented to give guidance on making a referral for a medical exposure.

We were informed that the clinical referral guidelines from the Royal College of Radiologists (RCR) iRefer[6] were freely available to all healthcare professionals via the health board intranet. Staff we spoke with as part of our inspection were clear on the referral guidelines and process in place.

Currently, all referrals submitted to the department for imaging were paper based, using the radiology referral form. Once received, all referrals were registered onto the electronic radiology information system (RadIS)[7] and the referral form was scanned onto the RadIS system so that a permanent record existed.

The self-assessment form stated that, prioritisation was based on clinical need, area of referral and timeliness of referrals. Patients from Minor Injuries Unit (MIU) and outpatients tended to be seen within an hour. The hospital currently operated a "walk in" service for general practice patients for general X-ray, so these patients were also seen in a timely manner. Referrals of patients with suspected cancer were made using a separate form and were undertaken within 10 days whenever possible.

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[5] Non-medical imaging is defined as any deliberate exposure of an individual for imaging where the primary intention of the exposure is not to bring a health benefit to the individual being exposed. Such exposures include those performed for insurance or legal purposes without a medical indication, or exposures for suspected concealed drugs.

[6] https://www.irefer.org.uk/

[7] The Welsh Radiology Information System (WRIS), also known as RadIS2, performs functions such as patient scheduling and clinical reporting involving medical images such as x-rays, CT and MRI scans and ultrasound.

Staff stated that for patients who required specifically timed future examinations, the referral was entered onto RadIS and the form kept on file, which was monitored by administrative staff. These patients would then be sent appointment letters at the correct time, for their examination.

We were provided with evidence of the clinical audit of the quality of the completion of referral forms, dated July 2020. This audit reviewed a sample of referral forms to establish evidence of authorisation, identity checks, pregnancy questions and recording of dose information. The audit also aimed to establish whether a clinical evaluation of each exposure has been recorded. There was a 100 percent compliance noted on this audit.

Duties of practitioner, operator and referrer

There was a system in place to identify the different types and roles of the professionals involved in referring and performing radiology examinations for patients. The employer's procedure on how IR(ME)R 2017 was implemented within the department identified, by individual or staff group, who were entitled to be referrer[8], practitioner[9] and operator[10] (known as duty holders).

Information was included within the Ionising Radiation Protection Policy in relation to the minimum competency / training requirements for each duty holder role. Entitlement was linked to successful completion of the relevant training and competency checks for specific equipment and examinations. Training records were provided for a range of staff. All had been recently completed. However, it was noted that they were not signed. We were told that the duty site lead was in the process of reviewing all training records and had not completed the process

[8] Under IR(ME)R a referrer is a registered healthcare professional who is entitled, in accordance with the employer's procedures, to refer individuals for medical exposures.

[9] Under IR(ME)R a practitioner is registered healthcare professional who is entitled, in accordance with the employer's procedures, to take responsibility for an individual medical exposure. The primary role of the practitioner is to justify medical exposures.

[10] Under IR(ME)R an operator is any person who is entitled, in accordance with the employer's procedures, to carry out the practical aspects of a medical exposure.

of signoff as yet. Staff training was recorded on a training matrix and accessible to staff to update.

The policy outlined the Medical Director's responsibility for ensuring that entitlement structures for referrers, practitioners and operators were in place at the health board. The Medical Exposure Committee (MEC) devise the entitlement structures on behalf of the Medical Director and ensure that provisions for regular evaluation of the scope of entitlement of practitioners and operators were being maintained. The MEC reported findings to the Clinical Quality Forum or the Medical Director directly. However, staff did not have evidence of their individual entitlement.

Staff we spoke to had a clear understanding of their relevant duty holder roles and scope of entitlement under IR(ME)R. Staff confirmed that they were able to access up to date electronic versions of policies and employer's procedures via the health board intranet. We were told that all staff had computer access within the department.

Senior staff described the system for notifying department staff of any changes to policies and procedures within the department. This involved individual staff members being provided with details of any reviewed and updated documents. Staff were then asked to confirm that they had reviewed and understood the relevant changes, a record of which was subsequently made and retained. Staff we spoke with confirmed they were aware of the system in place.

There was a contract in place between all health boards in Wales with Everlight Radiology[11]. The contract provided a radiology reporting service which included, out of hours justification of specified examinations and associated clinical evaluation. The radiologists working under this contract received group entitlement as practitioners and operators to justify, authorise and clinically evaluate CT scans, out of hours. During the course of the inspection it was noted that the department did not hold an up to date list of the Everlight Radiologists. A list of Everlight practitioners was subsequently obtained and senior staff stated

[11] Everlight Radiology is a substantial provider of teleradiology services based in London and Australia.

they would look into a process to record the name of the practitioner justifying the CT referral on RadIS, to comply with IR(ME)R requirements.

The self-assessment form stated that an administrator from Everlight phoned the on-call CT radiographers with the name of the patient and the examination to be performed. The radiographer could speak to Everlight if clarification was needed or further detail. The name of the practitioner was not routinely recorded or taken. The radiologist justifying the exposure was not always the same as the radiologist clinically evaluating the exposure.

Improvement needed

The employer must ensure that the name of the Everlight practitioner is listed on the referral form and subsequently on RadIS. This ensures that all medical and non-medical exposures are justified and that the individual practitioner justifying and authorising each exposure can be identified.

Justification of Individual Medical Exposures

The employer had a written employer's procedure in place for the justification and authorisation of medical exposures. Staff we spoke with had a clear understanding of the justification process. Justification of individual medical exposures was recorded on the radiology referral forms, with the date and signature of the practitioner.

We discussed with senior managers the aspect of carers and comforters[12] within the service delivery. There was an employer's procedure in place relating to the exposures of carers and comforters. We were told that the practitioner justifying the patient exposure would also act as the practitioner for the carer and comforter exposure. In justifying the exposure of the carer and comforter, the practitioner had to satisfy themselves that the patient truly required the close support of another individual for the examination to take place successfully.

[12] carers and comforters means individuals knowingly and willingly incurring an exposure to ionising radiation by helping, other than as part of their occupation, in the support and comfort of individuals undergoing or having undergone an exposure.

As described above, during discussions with staff it was highlighted that justification for out of hours CT referrals was being provided by Everlight Radiology. This was in line with the out-of-hours contract agreement in place. However, the name of the individual practitioner justifying the exposure was not being recorded on the relevant documentation. For any medical or non-medical exposure, the individual practitioner justifying the exposure, needs to be identified.

Optimisation

Optimisation is the process of keeping exposures as low as reasonably practicable while achieving the best image quality to answer the clinical question. The employer had arrangements in place for the optimisation of exposures.

The self-assessment form described how practitioners and operators ensured doses were kept as low as reasonably practicable. This included ensuring that the correct modality[13] had been requested for the justification of the examination and the correct protocol was followed. Additionally, the operator would ensure pre-set exposure factors were optimised to account for the physical characteristics of the individual patient. We were told that the Health Board had convened a multidisciplinary image optimisation team (CT User Group), led by an MPE, to reduce the variation in the patient dose through the development of consensus imaging protocols and sharing of best practice.

Diagnostic reference levels[14] *(DRLs)*

The DRLs for the general X-ray rooms dated 2016, were overdue for review and referenced IR(ME)R 2000. The MPE was aware of this and we were told that a new member of the medical physics team had been appointed to address this issue. The employer's procedures for DRLs needs to include details on how local DRLs are ratified.

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[13] Modality is the term used in radiology to refer to one form of imaging e.g. CT scanning.

[14] Diagnostic reference levels means dose levels in medical radiodiagnostic or interventional radiology practices, or, in the case of radio-pharmaceuticals, levels of activity, for typical examinations for groups of standard-sized individuals or standard phantoms for broadly defined types of equipment

Paediatrics

The self-assessment form stated, for paediatrics, that specific examination protocols were available and displayed in a prominent position behind the control panel with exposures for all age ranges. The pre-set exposure factors are optimised to account for the age and weight of the patient. Practitioners balanced the benefits and risks when justifying a referral. This also included the availability of low dose procedures balanced with the clinical urgency of the diagnosis. For example, for paediatric general radiology examinations, the operator set the required dose, and where required adjusts the parameters to the appropriate age or weight of the patient. We were also told that whilst the number of paediatric exposures undertaken was low, a number of radiographers had an interest in paediatric radiography.

Clinical evaluation

The purpose of the procedure for carrying out and recording clinical evaluation for each exposure was to ensure that a radiological report was available to the referrer and to other relevant staff involved in the patient's care. Clinical evaluation would only be performed by a suitably entitled operator.

The self-assessment form described how the clinical evaluation was undertaken and evidenced for each type of exposure. Images were reviewed by the operator who undertook the procedure. The hospital operated a red dot system (the radiographer abnormality detection system) for general X-rays. A formal report would follow from a reporting radiologist or radiographer. A quality assurance (QA) program was in place that highlighted any unreported images which were then brought to the attention of a reporting radiographer or radiologist.

We were provided with the IR(ME)R audit relating to the recording of patient dose information on RadIS that showed a 100 percent compliance. The audit reviewed a sample of patient records on RadIS to ensure the operator had recorded the patient dose, units of exposure, examination room / equipment used and examination name.

Improvement needed

The employer must ensure the review of DRLs is carried out within the timeframe specified in the employer's procedure.

Equipment: general duties of the employer

The employer had an up-to-date inventory (list) of the equipment used within the radiology department. The self-assessment form stated that all equipment within radiology was installed and maintained by qualified service engineers. Acceptance testing was undertaken by the MPE prior to clinical use and supported by a scheduled QA programme. This is supplemented by a local QA programme operated in all areas of radiology using a QA handbook provided by the MPE. X-ray QA issues were reported to the health board Medical Exposure Group. X-ray equipment performance was assessed in accordance with recommended national standards supported by local work instructions.

We were told that any defective equipment was taken out of action immediately when it became apparent that it was faulty. Staff were informed not to use the unit and notices were put on the equipment. The engineer providing the service was called to repair the unit. On completion of the repairs, hand over documentation was completed prior to the unit being returned to clinical use. We were told that each diagnostic room had a faults book and issues would also be communicated to other parties via email and Datix[15].

Staff were also able to describe the process where equipment was not working and the handover process of equipment from maintenance back into service.

Safe care

Managing risk and promoting health and safety

Staff who responded to the questionnaire said they had not reported any accidental or unattended exposure incidents within the last month. The vast majority who completed the questionnaire said they had not seen patient safety errors, near misses or incidents in the last month. The majority of respondents agreed the last time they saw an error, near miss or incident, it was reported.

The majority of respondents agreed staff who are involved in an error, near miss or incident were treated fairly. Most agreed that their organisation encourages them to report errors, near misses or incidents and few disagreed. All but one of

[15] Datix is the incident reporting system used by all health boards in Wales.

the respondents agreed the organisation would treat reports of an error, near miss or incident confidentially. The vast majority agreed that the organisation would not blame or punish the people who are involved in such incidents and action would be taken on incidents identified so they did not happen again.

All but one of the respondents who completed the questionnaire agreed they were informed about errors, near misses and incidents that happened in the organisation and were given feedback about changes made in response to reported errors, near misses and incidents.

Infection prevention and control (IPC)

There were no concerns given by patients over the cleanliness of the department and all of the patients who completed a questionnaire felt that, in their opinion, the department was clean. All but one of the patients said COVID-19 compliant procedures were evident during their time at the setting.

Every staff respondent said IPC procedures were followed and patients' privacy and dignity was maintained. Staff we spoke with confirmed that they had received IPC training and demonstrated a good awareness of their responsibilities in regards to infection control within the department.

Information provided by staff indicated that there were arrangements in place for effective infection prevention and decontamination within the department. We were informed that these arrangements had been strengthened as a result of COVID-19. Staff stated that they were confident and competent at using personal protective equipment (PPE) and there was sufficient supplies of this equipment. Staff had also been fit tested to use the FFP3[16] mask. All but one of the staff who completed the questionnaire felt there was enough staff at the organisation to enable them to do their job properly.

Staff we spoke with described the specific arrangements in place for COVID-19 symptomatic patients or patients with confirmed infections attending the unit. This included closing the department to other patients and making sure any doors on

[16] FFP3 masks provide the highest level of respiratory protection that a disposable mask can offer. A well-fitting FFP3 mask can protect users against fine toxic particulates including asbestos, bacteria, viruses and radioactive particles.

the pathway to the department were secured so that other patients and staff were prevented from entering these areas. Staff also wore additional PPE and the relevant areas were deep cleaned after use.

Safeguarding children and adults at risk

Discussions with staff within the department demonstrated that there was an awareness of current safeguarding procedures in place. Staff we spoke with also informed us that they had completed online training to help them keep up to date with the relevant safeguarding issues.

Effective care

Quality improvement, research and innovation

Clinical audit

We were provided with a copy of the Radiology Clinical Audit Programme for 2020/21. Additionally, there was an employer's procedure for clinical audit of radiological procedures relating to IR(ME)R. However, the programme and procedures did not give timeframes and frequency for the audits, how the findings were shared and how recommendations were actioned. In addition, there is no reference to when re-audit was required following the implementation of change. The health board need to amend the documentation and the process in place to ensure that these omissions are corrected.

Expert advice

The health board had expert advice provided by three Medical Physics Experts (MPE) employed by Swansea Bay UHB. The health board were complimentary about the engagement and advice provided by the MPE. This involvement included:

- Providing a QA workshops and a QA workbook for radiography staff
- Provision of an end of year summary of progress report to each site lead to close off any outstanding actions
- Being a member of the CT Image Optimisation Team and CT user group. The aim of the meetings was to standardise CT protocols and doses

- New equipment installation and acceptance, matters relating to optimisation including establishment of diagnostic reference levels, setting up of the automatic exposure control (AEC)[17]
- Provision of advice on accidental or unintended incidents / exposures
- Aiming to establish QA teams for each site
- The setting of protocols and input into procedure writing
- MPEs being available as required by the health board.

Medical research

There was an employer's procedure in place with regard to medical research exposures. However, we were informed by senior managers that research involving medical exposures was not currently being performed at the hospital.

Improvement needed

The employer must ensure that the audit programme and associated documentation includes timeframes and frequency for the audits, how the findings were shared and how recommendations were actioned. In addition, there must be reference to when re-audit was required following the implementation of change.

[17] An automatic exposure control (AEC) system is a tool available on most modern radiographic units to assist the radiographer. AEC is a system used to consistently control the amount of radiation reaching the image receptor by terminating the length of exposure.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

A management structure with clear lines of reporting and accountability was described and demonstrated.

The department was being well managed and comments from staff indicated that they felt supported by senior staff within the department. It was clear from our inspection that there was a good rapport between department staff and senior managers.

There were written procedures and management arrangements were in place to support the radiology department's compliance with IR(ME)R 2017. However, these were overdue for review and need to be updated.

Governance, leadership and accountability

Senior staff described their regular engagement with staff, including setting up a site lead Microsoft teams group, to discuss issues. These issues were cascaded down to staff as well as staff being copied into relevant e-mails.

Staff we interviewed stated that there had been a positive change in management style recently. This included monthly team meetings and the information that was cascaded in these meetings, which were described as an open forum, where staff could also bring concerns to management’s attention.

All staff members who completed a questionnaire said that if they were concerned about unsafe clinical practice, they would know how to report it. All but one respondent said they would feel secure raising concerns about unsafe clinical practice. The vast majority felt confident their organisation would address their concerns once reported.

There was a management structure in place, with clear lines of reporting, which was described by senior staff and demonstrated through an organisational chart.

We found that governance arrangements were in place to support the effective operation of the department.

Prior to our inspection, HIW required senior staff within the department to complete and submit a self-assessment form. This was to provide HIW with detailed information about the department and the employer's key policies and procedures in place, in respect of IR(ME)R 2017. This document was used to inform the inspection approach.

The self-assessment form 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.

On the days of our inspection, senior management staff made themselves available and facilitated the inspection process. They were receptive to our feedback and demonstrated a willingness to make improvements as a result of the issues highlighted.

Duties of the employer

Entitlement

The procedure for the entitlement of duty holders for medical exposures was evidenced in Appendix One to the Ionising Radiations Safety Policy. This described how staff were entitled to be referrers, practitioners or operators (including medical physics experts) in accordance with Regulation 17(1) and Schedule 2 (b) of IR(ME)R.

The Medical Director is responsible for ensuring that entitlement structures for referrers, practitioners and operators are in place within the health board. The Medical Exposure Committee (MEC) devise the entitlement structures on behalf of the Medical Director and ensure that provisions for regular evaluation of the scope of entitlement of referrers, practitioners and operators were being maintained. The MEC report findings to the Clinical Quality Forum or the Medical Director directly.

Non-medical referrers followed a protocol and were entitled to refer by the Radiology Clinical Director. A register was held by the Radiation Services Manager (RSM) and available to all staff within radiology.

There was an employer's procedure in place for the process of entitlement, as described above. However, we were not assured that training and competency and scope of practice was checked prior to entitlement to ensure this reflected

the duty holder's role. This included staff external to radiology. Additionally, duty holders were not informed of their entitlement as there was not a current process for the duty holders to show entitlement for example letter or certificate

Furthermore, it was unclear if the medical director was aware of their role of entitler within the hospital theatres. This needed to be clarified and added to the theatre employer's procedure

We were told that the scope of practice was reviewed at the performance appraisal and development review (PADR) or when new tasks were added such as a CT competency. Where a staff member lost their competency, additional training was provided. From speaking to staff, the entitlement process and scope of practice was well understood. We also noted that the entitlement for MPE matrix provided was clear and included relevant dates.

The entitlement tables in the employer's procedure EP1 were well presented and these tables would also benefit from being included, or linked, in the Ionising Radiation Safety Policy, which was also overdue for review.

Procedures and protocols

The Ionising Radiations Safety Policy dated October 2018 outlined the processes employed by the health board to manage the safety of its patients, employees, visitors and public from the use of ionising radiations on its premises. The policy identified the Chief Executive Officer as the officer with overall responsibility for compliance with the duties of the employer required by all legislation concerning radiation safety. The Chief Executive could delegate tasks, but not responsibility, for ionising radiation safety appropriately through the organisational arrangements in order to effectively manage and control the risks from ionising radiation.

As part of the self-assessment the health board provided HIW with an extensive list of procedures and protocols. However, it was noted that a number of these procedures and protocols were overdue for review and in some instances lacked version control. These included, the employer's procedures, the Ionising Radiations Safety Policy and the written protocols for both general radiography (dated 2013) and CT and general X-ray DRLs. We were told by senior management that the Medical Exposure Group, where procedures were reviewed, was cancelled in November 2020. This was due to COVID-19 and winter pressures and documentation will be reviewed in April 2021.

Staff we spoke with, as part of our inspection, confirmed that they had access to current versions of the policies and procedures in place. Also, senior staff

confirmed that when any changes to documents occur, notifications were circulated to department staff, who were subsequently asked to confirm that they had read and understood the relevant changes.

A number of suggestions were provided during our conversations with senior managers with regard to the current detail included within the documents to assist the ongoing revision of the document. These included:

- EP1 did not state when individual scope of practice would be reviewed, for example at appraisal or yearly. The health board should consider including frequency of review to this procedure
- The induction pack provided was generic and lacked any detail on IR(ME)R requirements or compliance. This should include for example, the need to read employer's procedures and radiation safety policy, how to accept a referral, the use of authorisation guidelines and process of entitlement etc. Senior staff we spoke with said that they were in the process of reviewing and updating this document
- EP 6, there is a need to consider including how authorisation guidelines were used by operators to authorise referrals as this was currently not included
- EP 10, the dose recording needs to include detail of dose units to be recorded for theatre screening
- EP 11, the addition of how DRLs were ratified prior to being put into clinical practice
- The employer's procedures in theatres should also be amended to included Schedule 2 (i), relating to the communication of benefits and risks information. The health board agreed to add this to the procedure and confirm if this was part of World Health Organisation (WHO) surgical check list[18]. Additionally, the need to complete the X-ray safety

[18] The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The

and performance assessment (equipment QA) at regular intervals as recommended by the MPE (currently this is not checked by the MPE). In the future it was agreed that the Radiation Protection Supervisor[19] from theatres would be invited to the MEG to discuss the annual audits on the mini C-arm[20].

Significant accidental or unintended exposures

The employer had a written employer's procedure for reporting and investigating accidental or unintended exposures within the department. The employer's procedure set out the process staff should follow if they suspect that a significant accidental or unintended exposure (SAUE) had occurred. The procedure guided staff of the process to follow and subsequently resulted in HIW being informed of such incidents in a timely manner. However, the procedure needs to be reviewed and updated to include, links to SAUE guidance, definition on accidental and unintended and consideration to the physiological effects of a clinically significant unintended or accidental exposure on the individual. Additionally, when reviewing, the references to "Equipment used in connection with medical exposure. Guidance Note PM77 (third edition). HSE. 2006" and "Guidance on investigation and notification of medical exposures much greater than intended. DoH. 2017" should be updated to reflect current guidance.

Staff interviewed were aware of the procedure for reporting accidental or unintended exposures. Senior management stated that the procedure for reporting and investigating would also involve speaking to the MPE to establish whether the incident was notifiable to the regulatory authority, HIW. We were told that staff were informed through e-mails and staff meetings, of any additional risks or safety notices, alerts and other communications. Staff stated that they were made aware of incidents and of the lessons learned to avoid a repetition of any event. There was also a log for each area / modality, to record any of these

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19-item checklist has gone on to show significant reduction in both morbidity and mortality and is now used by a majority of surgical providers around the world.

[19] A Radiation Protection Supervisor (RPS) is appointed for the purpose of securing compliance with the Ionising.

[20] A mini C-Arm is an X-Ray machine that scans a specific body area, usually the upper body, while allowing clinicians to view the results in real time, live on the monitor screen during surgery.

instances and the lessons learned, which staff had to sign to show they were aware of the issues.

We were informed that any incidents or near misses were recording via Datix. Radiation incidents were brought to the attention of the specific modality lead radiographer for any lessons learned from the incident to be disseminated and discussed. The reports were reviewed at the site lead group meeting and then subsequently with the executive team. The analysis of incidents information provided was only numeric, there was no detail in the information reviewed in regard to the specifics of the incidents or a detailed analysis of radiation incidents and near misses. This analysis should highlight trends, report on the whether the incidents were closed, and what action had been taken to enable shared learning and identify changes in practice to improve patient safety.

Improvement needed

The health board must ensure that:

- Training, competency and scope of practice is checked prior to entitlement to ensure this reflects the duty holder's role, including staff external to radiology
- Duty holders are informed of their entitlement by for example a letter or certificate
- The medical director is aware of their role of entitler within theatres and this is further clarified and added to the theatre employer's procedure
- All employer's procedures, policies and protocols that are overdue for review be reviewed and updated. This must ensure they are up to date, reviewed in a timely manner and reflect practices and arrangements in place, including addressing the issues highlighted in the procedures and protocols section of this report
- A detailed analysis including themes and trends of accidental or unintended exposures including near misses is carried out. This should include what actions had been taken to enable shared learning and identify what changes were implemented in practice to improve patient safety

- The relevant written procedures relating to accidental or unintended exposures are updated to accurately reflect current guidance and HIW incident reporting process requirements
- The employer's procedures for theatres are updated to include how benefit and risk information is communicated to patients prior to the exposure.

Staff and resources

Workforce

All staff interviewed stated that the number and skill mix of staff in the department was appropriate and safe. We were told that the service was considering moving to a shift system, which would require more staff and a review of current roles. The Head of Radiology for the health board also believed there was a need for more support staff for example assistant practitioners.

Staff stated that they had regular supervision and appraisals. New members of staff were allocated a mentor to provide advice and training within the department. The Head of Radiology monitored annual staff compliance with the PADR process.

All but one of the staff who completed a questionnaire told us they had an appraisal, annual review or development review of their work in the last 12 months. The vast majority who had received an appraisal said their learning or development needs were identified, and they told us that their manager always supported them to achieve these needs.

Senior staff told us that staff had access to relevant training and development opportunities to support them in their role. All staff had access to electronic learning resources, they were encouraged to use these and were allocated time to complete this training. Any member of staff that wished to complete additional training needed to discuss this with their line manager. This also had to be included on their PADR and requests would be considered and agreed if they were in the interest of the service.

Most staff indicated in the questionnaires that they had undertaken learning and development, in areas such as health and safety, fire safety and infection control. In addition, staff said that they had received training in IR(ME)R relevant to their functions as practitioner or operator, relating to specialist area of practice and other training in the last 12 months.

The majority of those who completed a questionnaire said training or learning and development helped them to do their job more effectively. Most respondents said it helped them to stay up to date with professional requirements and deliver a better experience for patients.

Staff were asked to write on the questionnaire what training they would wish to attend, some of the responses are copied below:

"Basic Life Support"

"Viewing images with reporters"

Senior staff also told us that there was only one member of staff in the department who was up to date with their Basic Life Support training, but they had been trying to source a training provider.

The new well-being initiatives introduced to support staff due to COVID-19, were described that included additional intranet pages and well-being resources on line. In addition, mindfulness resources had been increased and staff were encouraged to use them. Staff who were shielding were also made aware of these resources.

The majority of staff who completed the questionnaire agreed that their immediate manager took a positive interest in their health and well-being and agreed their organisation takes positive action on health and well-being. Just over half of staff agreed their current working pattern allowed for a good work life balance. All staff said they were aware of the occupational health support available. The majority of staff said they were offered full support in the event of challenging situations.

Staff were asked in the questionnaires to rate how often a number of statements relating to their organisation applied in their experience. The majority who completed a questionnaire said the organisation encouraged teamwork and felt the organisation was supportive. Every staff member agreed front line professionals, who deal with patients, were empowered to speak up and take action when issues arise.

All but two of the staff said there was a culture of openness and learning within the organisation that supported staff to identify and solve problems. The majority who responded thought the organisation had access to the right information to monitor the quality of care across all clinical interventions and take swift action when there are shortcomings. Every respondent said they were content with the efforts of the organisation to keep them and the patients safe.

Staff were asked in the questionnaire about their immediate manager, and the feedback received was generally positive. Staff members provided the following comments:

> "*My immediate manager involves me in all decisions affecting my area of work. She helps when I am unsure of something and encourages me in all areas of my job role"*
>
> *"Our new management team have completely turned morale around in PPH. We now feel we are valued and respected members of a team that strive to do our best for patient care"*
>
> *"We have an excellent and proactive Radiology Site Lead and Deputy Site Lead. Both relatively new in post but making a big and positive impact."*

Nearly all staff who completed a questionnaire said that they knew who the senior managers were in the organisation. They also said senior managers tried to involve staff in important decisions and act on staff feedback. The majority said senior managers were committed to patient care. All but one of the respondents said their organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age. Every staff member said they had not personally experienced discrimination at work in the last 12 months.

In the questionnaires, staff were given a number of statements relating to how well the organisation has adapted to become COVID-19 compliant. All but one of the staff members agreed the organisation had implemented the necessary environmental, practise changes and decontamination arrangements for equipment and relevant areas.

Improvement needed

The health board must ensure that all members of staff within the department are trained in basic life support and source the necessary training provider without delay.

4. What next?

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.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- 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.

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.

5. How we inspect services that use ionising radiation

HIW are responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 and its subsequent amendment (2018).

The regulations are designed to ensure that:

- Patients are protected from unintended, excessive or incorrect exposure to medical radiation and that, in each case, the risk from exposure is assessed against the clinical benefit
- Patients receive no more exposure than necessary to achieve the desired benefit within the limits of current technology
- Volunteers in medical research programmes are protected

We look at how services:

- Comply with the Ionising Radiation (Medical Exposure) Regulations
- Comply with the Care Standards Act 2000
- Comply with the Health and Care Standards 2015
- Meet any other relevant professional standards and guidance where applicable

Our inspections of healthcare services using ionising radiation are usually announced. Services receive up to seven weeks' notice of an inspection.

The inspections are conducted by at least one HIW inspector and are supported by a Senior Clinical Officer from Public Health England (PHE), acting in an advisory capacity.

Prior to the inspection, the service is required to complete a self-assessment form and provide supporting documentation as evidence. The two day remote inspection consists of discussions with senior managers and operational staff working within the department, in relation to the policies and procedures in place.

To allow us to collate additional views, relevant patient and staff surveys are conducted in the weeks leading up to our inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

These inspections capture a snapshot of the standards of care relating to ionising radiation.

Further detail about how HIW inspects the NHS can be found on our 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 were identified on this inspection			

Appendix B – Immediate improvement plan

Hospital: Prince Philip Hospital

Ward/department: Diagnostic Imaging

Date of inspection: 23 and 24 February 2021

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.

Immediate improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues noted				

Appendix C – Improvement plan

Hospital: Prince Philip Hospital

Ward/department: Diagnostic Imaging

Date of inspection: 23 and 24 February 2021

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
Quality of the patient experience				
The health board is required to provide HIW with details of the action taken to better inform patients visiting the department of current waiting times.	5.1 Timely access	Information board to be installed in reception area. Approximate wait times to be updated regularly for each modality.	Head of Radiology	30 June 2021
The health board is required to inform HIW of the action taken to provide information to patients of their replies to surveys, with actions taken on feedback.	6.3 Listening and Learning from Feedback	As above. Information board to include a 'you said, we did' section updated monthly This will be rolled out in radiology departments across all four acute sites	Head of Radiology	30 June 2021

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The employer must ensure that a review of the employer's written procedure relating to pregnancy enquires is undertaken. This is to ensure that there is sufficient detail on the process to be followed by staff, for all types of patients they may encounter. Additionally, this review should include how gender diversity is considered and managed.	Regulation6 Schedule 2 1(c) Regulation 11(1)(f)	All written procedures to be reviewed, updated and presented for approval to the next Radiation Protection Group (RPG). This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	Head of Radiology	31 May 2021
The employer must ensure that the name of the Everlight practitioner is listed on the referral form and subsequently on RadIS. This ensures that all medical and non-medical exposures are justified and that the individual practitioner justifying and authorising each exposure can be identified.	Regulation 6 Schedule 2 1 (b)	Staff have already instigated the process of adding the Everlight practitioner to on the referral form and subsequently on RadIS./ PACS. To be reviewed and audited after a period of 3 months	Head of Radiology	Complete 30 June 2021
The employer must ensure the review of DRLs is carried out within the timeframe specified in the employer's procedure.	Regulation 6(5)(c) Schedule 2 1(f)	Contact to be made with Medical Physics for an update. DRL Review Programme to be revisited at RPG to ensure compliance	Consultant Clinical Scientist (Medical Physical & Clinical Engineering)	Complete 31 May 2021

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The employer must ensure that the audit programme and associated documentation includes timeframes and frequency for the audits, how the findings were shared and how recommendations were actioned. In addition, there must be reference to when re-audit was required following the implementation of change.	3.3 Quality Improvement, Research and Innovation Regulation 7	To be discussed and updated at the RPG in April 2021 All findings will be shared at the RPG and Radiology Quality Safety and patient Experience group	Head of Radiology	31 May 2021
Quality of management and leadership				
The employer must ensure that: • Training, competency and scope of practice is checked prior to entitlement to ensure this reflects the duty holder's role, including staff external to radiology	Regulation 6(3)(b)	To be discussed and approved at RPG April 2021 following which it will be cascaded to relevant staff	Head of Radiology	31 May 2021
• Duty holders are informed of their entitlement and are aware of their specified scope of practice by for example a letter or certificate	Regulation 6 Schedule 2 1(b)	Letter / certificate to be drafted and reviewed at the RPG for use after approval	Head of Radiology / Clinical Director Radiology	31 May 2021

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
• The medical director is aware of their entitler role within theatres and this is further clarified and added to the theatre employer's procedure	Regulation 6 Schedule 2 1(b)	Procedure to be reviewed, updated and presented for approval at RPG in April 2021, and then disseminated to appropriate staff.	Head of Radiology	31 May 2021
• All employer's procedures, policies and protocols that are overdue for review be reviewed and updated. This must ensure they are up to date, version controlled, reviewed in a timely manner and reflect practices and arrangements in place, including addressing the issues highlighted in the procedures and protocols section of this report	Regulation 6(5)(b) Schedule 2 1(d)	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic.	Head of Radiology	31 May 2021
• A detailed analysis is completed, including themes and trends of accidental or unintended exposures including near misses. This should include what actions had been taken to enable shared learning and identify what changes	Regulation 8(3)	Annual review and analysis of all relevant incident submissions to be undertaken and presented to the RPG (the new Once for Wales Concerns Management System (OfWCMS) has improved concerns codes which will allow for	Head of Radiology with assistance from the Quality Assurance and Safety Team	30 April 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
were implemented in practice to improve patient safety		capturing of radiology related incidents and theming of the learning). Quarterly reports of (relevant) incidents reported to be provided to the RPG	Quality Assurance and Safety Team	31 July 2021
• The relevant written procedures relating to accidental or unintended exposures are updated to accurately reflect current guidance and HIW incident reporting process requirements	Regulation 8(4)(b)(iv)	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	Head of Radiology	31 May 2021
• The employers procedures for theatres are updated to include how benefit and risk information is communicated to patients prior to the exposure.	Regulation 6 Schedule 2 1(i)	All written procedures to be reviewed, updated and presented for approval to the next RPG. This is scheduled for April 20th 2021 after being stood down in 2020 in response to pressures from the pandemic	Head of Radiology	31 May 2021
The health board must ensure that all members of staff within the department are trained in basic life support and source the necessary training provider without delay.	7.1 Workforce	The Resuscitation training department to be provided with a list of all outstanding staff requiring training.	Head of Radiology	23 April 2021

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		Training to be scheduled to accommodate all outstanding staff	Head of Radiology / Resuscitation Department	30 June 2021

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): **Amanda Evans**

Job role: **RSM**

Date: **8.4.2021**