Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Diagnostic Imaging Department, Withybush Hospital, Hywel Dda University Health Board

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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 Withybush Hospital, Hywel Dda University Health Board on 30 and 31 January 2024. During our inspection we looked at how the department complied with the Regulations and met the Health and Care Quality Standards.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors and a senior clinical 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.

Before the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 104 questionnaires were completed by patients or their carers and 36 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the X-ray Department.

We found staff treated patients with courtesy, respect and kindness. Feedback from patients also supported this. We also found staff provided care in a way that protected and promoted patient rights.

Patients told us they had been provided with sufficient information and had been involved as much as they had wanted to be in their care.

This is what we recommend the service can improve:

- Update patient information material to ensure gender inclusive language
- Ensure that all patient information is appropriately translated into Welsh.

This is what the service did well:

- Patients provided positive feedback and comments about the attitude and approach of the staff looking after them
- Patients told us they didn't have to wait long for their examination or scan.

Delivery of Safe and Effective Care

Overall summary:
We found there were some improvements required to improve compliance with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, across the X-ray Department.

Overall, we found effective arrangements were in place to provide patients with safe and effective care.

This is what we recommend the service can improve:

- Implement an effective document control system for the employer's IR(ME)R procedures and protocols
- Improve the system by which the entitlement of all duty holders is managed
- Improve the procedure for pregnancy enquiry and testing.

This is what the service did well:

- Staff we spoke with had a clear understanding of their IR(ME)R duty holder roles and responsibilities
- An active image optimisation team was in place for Computerised Tomography (CT) demonstrating a proactive approach to optimisation including dose reduction.

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.

Staff demonstrated they had the correct knowledge and skills to undertake their respective roles within the department.

Whilst feedback from staff was generally positive, there were some negative responses and comments from staff that needed to be addressed.

The department's compliance with the health board's face to face mandatory training and appraisals was generally good.

This is what we recommend the service can improve

- Whilst some staff understood the meaning of duty of candour, they had not consistently received the appropriate 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:

- Record keeping was of an appropriate standard
- Training compliance for mandatory and IR(ME)R training was good
- Suitable and effective arrangements were described for seeking patient feedback, for managing concerns and complaints, and for acting on these to 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 issued questionnaires to obtain views and feedback from patients and carers. A total of 104 responses were completed. Responses were positive across all areas, with all rating the service as 'very good' (95/102) or 'good' (7/102).
Patient comments included the following:

> ***"Friendly and helpful staff."***
>
> ***"I was surprisingly impressed by the whole procedure - the timescale and the treatment. Staff were professional and supportive. Overall, a reassuring experience."***
>
> ***"Very pleased with the service – could not fault anything."***
>
> ***"The staff are under a huge amount of pressure to keep up with demand. I hear they are being over-worked and this is not safe nor desirable. Staff relief would be something helpful and would be of great benefit to the people that help care for others."***

Person Centred

Health Promotion
Relevant health promotion material was displayed across the waiting areas.

There were posters displayed that provided information to patients about having an X-ray and to advise staff if they may be pregnant or breastfeeding. These posters were displayed in English and Welsh. Relevant information was made available to patients about the associated benefits and risks of the intended exposure.

Dignified and Respectful Care
We saw staff being polite and treating patients with respect. We saw suitable arrangements in place to promote patient privacy and noted staff made efforts to promote patents' privacy and dignity.

All respondents who answered this question agreed that staff treated them with dignity and respect and that measures were taken to protect their privacy. All respondents also stated they were able to speak to staff about their procedure without being overheard by other patients and all but one said staff listened to them.

When asked whether patients' privacy and dignity were maintained, all but one of the staff who answered the question in the questionnaire agreed. All but two of the staff who answered agreed they were satisfied with the quality of care they gave to patients. Fewer agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (24/36).

Individualised Care

All but two respondents who completed a HIW questionnaire told us they were given information related to their examination or scan. In addition, most of respondents who answered the question in the HIW patient questionnaire also told us they had been given written information on who to contact for advice following their examination or scan.

Most respondents who answered the question in the HIW patient questionnaire told us they had been involved as much as they wanted to be in decisions about their examination or scan. Similarly, all respondents who completed a HIW patient questionnaire told us staff had explained what they were doing, had listened to them and answered their questions.

All staff who completed a HIW questionnaire also told us patients were informed and involved in decisions about their care.

Timely

Timely Care

Patients attending the X-ray department at the hospital were seen to receive timely care. We did not see large numbers of patients waiting for their examination.

We saw there was a notice clearly displayed advising patients to inform staff if their wait was longer than 20 minutes. We also noted that there was a sign to indicate how long the wait for results from their X-ray may be.

Most respondents that answered the survey question agreed that the wait between referral and appointment was reasonable. Regarding whether they were told at the department how long they would likely have to wait, most patients who answered this question agreed.

Equitable

Communication and Language
The Welsh language was well promoted within the department. We saw bilingual signage in both Welsh and English. We saw bilingual posters with information for patients clearly displayed within the department.

We saw staff making efforts to deliver the 'Active Offer'. Welsh speaking staff were identified by wearing badges or lanyards. Staff confirmed they would greet patients using the Welsh language and if patients or visitors were Welsh speaking the conversation could be continued in Welsh.

The majority of staff who completed a HIW questionnaire (28/36) told us they were not a Welsh speaker. When asked whether they wear a badge or lanyard to tell patients they are happy to communicate in Welsh, the majority of staff who answered the question (6/8) told us they did, at least sometimes.

We saw appointment letters for CT scans, that were sent to patients, were in Welsh and English, although the Welsh version did not reflect the English. In the same letter, there were outdated comments regarding what to wear “for ladies” and “for men”.

Improvements could be made to the language around clothing and gender. The department should review and update information in leaflets and appointment letters.

Staff we spoke with described some of the arrangements in place to help people with hearing difficulties and with those whose first language was not English. They were aware of the translation service that was available.

Rights and Equality
We found staff working in the X-ray department were working in a way that protected and promoted patient rights. We were told that equality and diversity training for all staff was mandatory. All staff we spoke with confirmed they had completed this course online.

The department was accessible with wide doors, clear corridors and spacious X-ray rooms all on level access.

Staff we spoke with had a good awareness of their responsibilities in protecting and promoting patients’ rights when attending the department. They confirmed the arrangements in place to promote equality and diversity in the organisation.

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) 94/99 of patients who answered this question said they had.

Delivery of Safe and Effective Care

Compliance with The Ionising Radiation (Medical Exposure) Regulations 2017

Employer's Duties: Establishment of General Procedures, Protocols and Quality Assurance Programmes

Procedures and Protocols
HIW requested evidence of an effective and consistent document control system for the employer's written procedures and protocols in place. This was not in place.

The employer must ensure that all documentation including written protocols and policies are part of a QA programme for documentation and include the required level of detail as set out within the employer's procedure for document control.

Referral Guidelines

HIW reviewed documentation and procedures in relation to referrals and referral guidelines. Staff described guidelines. We confirmed with staff members within the department that referrers' practice accurately reflected the employer's written procedures.

Diagnostic Reference Levels
There was a suitable employer's written procedure in place for the use and review of diagnostic reference levels (DRLs).

We confirmed that a broad range of local DRLs had been established. These were equal to or below national DRLs and we identified this as noteworthy practice.

Research Exposures
We were told research involving medical exposures was conducted at the Department. Suitable governance arrangements were described for research trials, with appropriate involvement of Medical Physics Experts (MPEs).

Suitable arrangements were also described for managing research trials, including the correct identification of referrals and the correct selection of the relevant protocol to be used. There was an employer's written procedure in place, describing these governance arrangements.

Entitlement
Staff confirmed the entitlement process described in the employer's written procedure was in place for new referrers, practitioners and operators who join the hospital.

We concluded entitlement of duty holders had been performed according to the employer's written procedure for duty holders who had recently joined the department under the new management team. However, there was a lack of evidence that this process has been robustly performed or maintained for duty holders who joined the hospital as referrers, practitioners, or operators historically. For example, we reviewed evidence of GP medical referrers who have no documented scope of practice, or evidence of entitlement by the Employer.

Senior leaders confirmed there is a historic cohort of staff groups who have not been entitled appropriately as referrer, practitioner, or operator. Staff present described how they had yet to agree, health board wide, how to complete this process. This must be addressed as a priority.

The employer must confirm how they will manage entitlement of all duty holders (medical, non-medical and third-party providers across the Withybush and wider health board sites). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.

Patient Identification
There was an employer's written procedure in place to correctly identify the individual to be exposed to ionising radiation for examinations performed in the department. This included details of the action to be taken by duty holders where patients were unable to identify themselves. In addition, it addressed those situations where more than one operator was involved in the examination.

Staff we spoke with described the action they would take to correctly identify patients prior to examinations being performed. This was consistent with the relevant employer's written procedure.

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 for examinations performed in the Department. We identified some improvement could be made to clarify written procedures in relation to pregnancy enquiry.

The employer must review the pregnancy enquiry flow chart and employer's procedure so it reflects gender diversity and inclusivity of language.

How pregnancy tests for radiology examinations were used was discussed with staff members. Staff gave assurance pregnancy tests were not performed by radiology staff. If there was any question arising from the pregnancy enquiry flow chart, a pregnancy test would be performed by Emergency Department (ED) staff. Assurance was given that this was routinely now a blood test as this was more sensitive (updated following an incident). It suggested the process was to be agreed with ED and a robust method of communicating the test result instigated. This additional process check should be documented in the employer's procedure for pregnancy enquiries for staff to follow.

The employer's procedure for pregnancy enquiries must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered, who performs the test and how the result will be effectively communicated.

Benefits and Risks

Suitable arrangements were described for providing patients with adequate information on the benefits of having the examination (exposure) and the risks associated with the radiation dose. We saw posters explaining the risk and benefits clearly displayed within the waiting areas.

We reviewed a patient information leaflet that was given to patients with their appointment, prior to a CT scan, information on benefits and risks was included within the leaflet. We were also told staff would reiterate this information to patients verbally when they attended for their examination.

All respondents who completed a HIW patient questionnaire told us they had been given enough information about the benefits and risks of their examination or scan.

Clinical Evaluation

We reviewed evidence and processes relating to clinical evaluation. This included the effective monitoring of third parties, training, development and monitoring of effective clinical evaluation for staff. We were not assured that training, competency and entitlement records were adequate or monitored for some non-medical referrers who were documented as entitled to clinically evaluate and act upon their evaluation to treat patients.

The health board must review and update the process and records for all non-medical referrers who are clinically evaluating chest, fluoroscopy, and musculoskeletal general radiography. The health board must also ensure they are appropriately trained, competent and entitled by the Employer to carry out these functions.

Non-medical Imaging Exposures
The employer process for referral and management of non-medical exposures was reviewed. Staff confirmed that radiographers authorise non-medical exposures under guidelines and CT non-medical referrals are justified and authorised by radiologists.

Employer's Duties - Clinical Audit
A range of clinical audits were reviewed as part of this inspection. We saw evidence of effective mechanisms for sharing radiographer audit feedback as part of morning huddles and team briefings. The newly implemented audit report template used for incident analysis was noted as good practice.

We reviewed several radiologist audits and saw that the presentations shared did not effectively capture actions, learning or timeframes for future audits.

The employer must ensure that outcomes and changes to practice following clinical audits are clearly documented for multidisciplinary teams through the department to ensure that audits sufficiently demonstrate action plans, re-audit and learning points. The use of a consistent audit report template should be implemented for all clinical audits performed by radiology across the health board.

Employer's Duties - Accidental or Unintended exposures
There was a clear and well-structured employer's written procedure in place for the reporting, recording, investigating and the analysis of significant accidental or unintended exposures involving radiation. This included all relevant processes required by the health board and HIW.

Staff members we spoke with were able to describe processes for reporting incidents related to accidental or unintended exposures.

Clear governance processes were in place for staff to follow for the recording and analysis of accidental or unintended exposures or near misses.

Duties of Practitioner, Operator and Referrer
We reviewed a clear and well-structured employer's written procedure in place providing guidance on making a referral for medical exposures. Staff we spoke with

demonstrated a good understanding of their duty holder roles and responsibilities under IR(ME)R.

The Employer provided evidence of appropriate IR(ME)R audits, to demonstrate duty holders were following the employer's written procedures.

Justification of Individual Exposures
There were clear and well-structured authorisation guidelines with clear criteria described in place for CT scanning and an employer's procedure for the justification and authorisation processes to follow.

Optimisation
Arrangements were described in relation to how practitioners and operators ensured exposures performed at the X-ray Department were as low as reasonably practicable (ALARP). These arrangements included how practitioners and operators paid particular attention in relation to individuals in whom pregnancy could not be excluded and exposures involving high doses to the individual.

We noted the work of the active image optimisation team (IOT) for CT. Whilst it was pleasing to note that work was underway on standardising cross health board CT protocols, we also noted that this standardisation is not yet in place. HIW suggested there should be multidisciplinary input into IOT and support for taking this optimisation work forward to gain radiologist agreement and approval across the health board. It was good to note that there was radiologist engagement to take this work forward.

Paediatrics
Senior staff confirmed X-ray examinations were performed in the department on paediatric patients. There were written protocols available for paediatric imaging. Staff described the protocols would be reviewed annually or if any change in practice was made. We were told that radiographers would use the digital radiography equipment whenever possible when imaging paediatric patients, to ensure doses were ALARP.

We saw an appropriate waiting area specifically for children. We were informed that some staff within the department had an interest in improving the experience for children that needed diagnostic imaging. We reviewed a children's book that had been written for children by a department staff member. This picture book was available to support and inform children attending for an X-ray / scan. This was seen as notable good practice.

Carers or Comforters
There was a suitable employer's written procedure in place to establish dose constraints and guidance for the exposure to carers or comforters for the X-ray Department.

Expert Advice
We confirmed the employer for the X-ray department had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R 2017.

Equipment: General Duties of the Employer
We reviewed the equipment inventory which was comprehensively completed to include all information required under IR(ME)R 2017.

Safe

Risk Management
Whilst there was some building work being carried out in parts of the department, the environment appeared well maintained and in a good state of repair. 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.

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

We were told that safety notices, alerts and other communications were shared by emails to modality leads to cascade down to their teams. Methods included using team huddles, notices and instant electronic messages.

Infection Prevention and Control (IPC) and Decontamination
We found suitable infection prevention and control and decontamination arrangements were in place. All areas accessible by patients were visibly clean and free of clutter.

The equipment was also visibly clean and staff described suitable cleaning and decontamination procedures.

Personal protective equipment (PPE) was available within the examination rooms and staff we spoke with confirmed they had access to suitable PPE and this was readily available. We also saw cleaning wipes to decontaminate shared equipment and staff demonstrated a good understanding of their role in this regard.

Regarding PPE, all but one member of staff agreed there had been a sufficient supply of PPE. All but three staff who answered agreed there were decontamination arrangements for equipment and relevant areas.

There was clear evidence that staff had completed IPC training, with overall compliance at over 85%. Staff we spoke with were aware of their responsibilities in relation to infection prevention and control and decontamination.

All but two patients who completed the questionnaire said that, in their opinion, the department was clean.

Safeguarding of Children and Safeguarding Adults
Most staff we spoke with 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.

All five staff records that we reviewed confirmed that the appropriate level of safeguarding training had been completed.

Effective

Record Keeping
There were arrangements in place for the management of records used within the department.

A sample of five current patient referral documentation and five retrospective patient referral documentation were examined. The sample showed that the referral records had been completed fully to demonstrate appropriate patient checks had been performed. This included patient identification, sufficient clinical details, enquiries made of pregnancy status where applicable, justification had been carried out and the referral appropriately signed by an entitled referrer.

Quality of Management and Leadership

Staff Feedback

Responses from staff were positive, with all but two being satisfied with the quality of care and support they give to patients. However, fewer agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (24/36). Three-quarters of respondents recommended their organisation as a place to work.

Staff comments included the following:

> ***"Over the last few years this setting has made some positive changes. We still need more space and funding but the things that have been put into place so far have made a positive difference."***

> "***Xray pads / support aids are old and could be replaced***"

Leadership

Governance and Leadership
The Chief Executive was designated as the 'employer' as required under IR(ME)R 2017. Whilst they had overall responsibility for ensuring the regulations were complied with, where appropriate the employer had delegated tasks to other professionals working in the health board to implement IR(ME)R.

There was also a clear governance and management structure demonstrated within the self-assessment, which was completed comprehensively and was clear, as well as being provided within the timescale required. The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements where identified.

Staff comments were mixed regarding management and leadership. However, many staff that we spoke with spoke of improvements in culture in recent months.

Results from the staff questionnaire, was as follows:

- Three quarters of staff who completed a HIW questionnaire told us they would recommend their organisation as a good place to work.
- In addition, two thirds told us their organisation was supportive and supported staff to identify and solve problems.
- Fewer told us that the organisation took swift action to improve when necessary (21/36).

The remainder disagreed.

The health board must consider the feedback percentages from staff and make a plan to address the issues.

When asked about their immediate managers, two thirds of staff who completed a HIW questionnaire stated their manager could be counted upon to help them with a difficult task at work. When asked whether their manager gave them clear feedback about their work, 26/36 agreed. In addition, 25/36 told us their immediate manager asked for their opinion before making decisions that affected their work. The remainder disagreed.

Most staff who completed a HIW questionnaire felt senior managers were committed to patient care (29/36).

Workforce

Skilled and Enabled Workforce

We reviewed the mandatory training records of five staff members and the IR(ME)R training records of two staff members. These records contained the relevant and expected details of training.

We saw clear evidence that staff had completed relevant mandatory training to the required level, this included safeguarding training, safe moving and handling, and IPC training. Training records were clear and there was an appropriate system to identify when training is due.

The health board's target for mandatory training compliance was 80%. Actual performance was 90% at the time of the inspection.

The target for appraisals (value-based appraisals) was 80%. The actual compliance was 85%. We were told that further appraisals were in progress.

Staff shortages were described by many staff members and referenced in the staff questionnaire feedback. Challenges around the recruitment of staff to Withybush were noted. Senior staff described positive innovative processes to manage vacancies and increase the number of appropriately trained staff in the future.

Culture

People Engagement, Feedback and Learning

We saw information clearly displayed for patients on how they could provide feedback or make a compliant on their experiences of visiting the department. The NHS Wales complaints process 'Putting Things Right' was displayed in a number of locations, including in the main reception. There was a QR code for a "Big Thank You" displayed if patients were pleased with their treatment in the department. A board detailing "You Said, We Did" information on how patient feedback has been used to improve services / experience was also displayed in the department.

Management were aware of the complaints completed and outstanding through a dashboard.

Most staff (31/34) who completed a HIW questionnaire told us they knew and understood the Duty of Candour, understood their roles in meeting the Duty, and their organisation encourages them to raise concerns and to tell patients when something has gone wrong. When we spoke with some individual staff members during the inspection, they could not recall training on Duty of Candour and some were not able to confirm their understanding verbally.

The health board must ensure that staff members in the department are trained in the Duty of Candour.

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 were identified on this inspection			

Appendix B - Immediate improvement plan

Service: Diagnostic Imaging, X-ray Department, Withybush Hospital

Date of inspection: 30 and 31 January 2024

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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance were identified on this inspection					

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: Diagnostic Imaging, X-ray Department, Withybush Hospital

Date of inspection: 30 and 31 January 2024

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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
We found the employer's written procedure for making pregnancy enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding would benefit from being clearer.	The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure and flow chart for pregnancy enquiries for staff must be updated to ensure it includes reference to the circumstances when a pregnancy test should be considered and how the result will be effectively communicated	IR(ME)R 2017 Regulation 6(1)(a) Schedule 2(1)(c)	Employers Procedure 8 to be reviewed and updated to reflect the circumstances when a pregnancy test should be considered, recorded and communicated. Mitigation – not accepting verbal confirmation of pregnancy status, it must be written on the request form or checked via Welsh Clinical Portal during	Site Superintendent Radiographer / Head of Radiology / Deputy Head of Radiology / Consultant Clinical Scientist	31st May 2024

			the review period. This will be communicated across all sites.		
We found the employer's written procedure for making pregnancy enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding would benefit from being updated to include gender inclusive language.	The Employer is required to provide HIW with details of the action taken to revise and update the employer's written procedure for pregnancy enquiries to include gender inclusive language.	IR(ME)R 2017 Regulation 6(1)(a) Schedule 2(1)(c)	Employers Procedure 8 to be reviewed and amended to include gender inclusive language.	Site Superintendent Radiographer / Head of Radiology / Deputy Head of Radiology / Consultant Clinical Scientist	31st May 2024
We found further details needed to be recorded around the process of clinical audit.	The employer must ensure that outcomes and changes to practice following clinical audits are clearly documented for multidisciplinary teams through the department to ensure that audits sufficiently demonstrate	IR(ME)R 2017 Regulation 7	1. Disseminate audit template widely across Radiology sites within the Health Board and at the	Clinical Director of Radiology	31st August 2024

	action plans, re-audit and leaning points. The use of a consistent audit report template should be instigated for all clinical audits performed by radiology across the health board.		Clinical Audit Meeting. 2. Review compliance of audit template after Clinical Audit Meeting in July 2024.		
We did not review sufficient evidence of an effective consistent document control system for documentation including written policies procedures and protocols.	The Employer is required to provide HIW with details of action taken to ensure that all written documentation in place include the required level of detail as set out within the employer's procedure for Quality Assurance programme document control.	IR(ME)R 2017 Regulation 6 (5) (b)	1. A document control system needs to be sourced. 2. Interim solution – current paper and electronic shared policies and procedures (both local and health board wide) will be reviewed and amended with version control to the same standard as	1. Head of Radiology/ Deputy Head of Radiology 2. Site Superintendent Radiographer	31st December 2024 Immediate effect – 31/12/24

			Employers Procedure 14.		
HIW confirmed that entitlement is performed according to the employer's procedure for duty holders who have recently joined the radiology department under the new radiology management team. We did not review sufficient evidence that this process has been robustly performed or maintained for duty holders who joined the hospital as referrers practitioners or operators historically.	Employer must provide HIW with details of action taken to manage entitlement of all duty holders (medical, non-medical and third party across the site). They must provide an action plan detailing when this process will be completed and the mitigation in place in the meantime to promote patient safety.	IR(ME)R 2017 Regulation 6, Schedule 2 (1) (b)	1. Non-medical referrers (NMRs) to have ongoing bi-annual review. Historic NMRs to be identified and to undergo same process. 2. All Medical/third party referrers to be identified by implementation of the new PACS and RIS system which will move entirely to electronic referrals. 3. <u>Mitigation</u> Whilst awaiting the new RISP system we have	Deputy Head of Radiology Deputy Head of Radiology Medical Director/Executive Director of Therapies and Health	1st September 2024 31st December 2025 31st May 2024

				been implementing an electronic requesting system which is recording all grades of referrers and referrers cannot be added to the system unless they have GMC/GDC/Non-medical referrer entitlement. A list of foundation doctors are flagged to us via medical staffing which is checked by radiographers prior to accepting requests. Six monthly Health Board wide	Science/Executive Director of Nursing, Quality and Patient Experience	

			communication from Medical Director/ Executive Director of Therapies and Health Science/ Executive Director of Nursing, Quality and Patient Experience to all medical and non-medical referrers working within their teams, to ensure they are aware of their referrer responsibilities and required training under IR(ME)R 2017. This will also be disseminated via “quick guide for e-IRMER support		

			for Radiology" and global intranet communication.		
There was not sufficient assurance that appropriate and up to date training and competency information was being recorded, performed and monitored for some non-medical referrers and particularly when this evaluation was acted upon to treat patients.	The employer must provide HIW with details of action taken to review and update the process of non-medical referrer clinical evaluation to ensure appropriate up to date training on how to clinically evaluate chest and musculoskeletal general radiography is being performed.	IR(ME)R 2017 Regulation 17(1) Regulation 17 (4) Regulation 6, Schedule 2 (1) (b)	All non-medical referrers who have indicated that they can clinically evaluate images will be reviewed and the matrix will be updated to reflect this. Staff training records will be obtained, appraised and reviewed bi-annually. Audits will be required to ensure competencies are maintained and continuation of referral rights. Failure to supply these documents will be escalated to the Executive Director of Therapies and Health Science/ Executive	Head of Radiology/ Deputy Head of Radiology	31st August 2024

			Director of Nursing, Quality and Patient Experience. An action plan will be developed to ensure that an ongoing process is undertaken, whereby all non-medical referrers are aware of their responsibilities under IR(ME)R 2017.This is to ensure that all non-medical referrers undertake up to date training and provide assurance to the employer that this has been completed in line with Ionising Safety Policy.		
Whilst some staff understood the meaning of duty of candour, they had not consistently received the appropriate training.	The health board must provide HIW with details of action taken to ensure that all staff are aware of the duty of candour and the implications for their role.	Effective	Training provision has been identified via the Health Board lead for training and in addition staff will attend online training to ensure	Site Superintendent Radiographers / Head of Radiology / Deputy Head of Radiology / Consultant Clinical Scientist	31st December 2024

			compliance with Duty of Candour.		
We saw that Improvements could be made to the language around clothing and gender in some letters. Some patient letters reviewed did not contain the same information in English and Welsh	The department should review and update information in leaflets and appointment letters to improve inclusivity.	Equitable	Patient information will be reviewed and amended to remove gender specific language and improve inclusivity. This will be translated. This will also be replicated across all radiology departments within the Health Board.	Site Superintendent Radiographers / Head of Radiology / Deputy Head of Radiology / Consultant Clinical Scientist	31st August 2024
The staff questionnaire results indicated that some staff were not happy with the standard of care provided.	**The health board must consider the feedback percentages from staff and make a plan to address the issues.**	Effective	Ongoing support from the Organisational Development Department to continue work to improve departmental relationships and communication. Staff will be encouraged to provide feedback around any concerns regarding the standard of care provided and forums	Site Superintendent Radiographers / Head of Radiology / Deputy Head of Radiology / OD Relationship Manager	31st August 2024

			are available to allow staff to communicate suggestions for improvement.		

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: 10th April 2024