Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Diagnostic Imaging Department, Ysbyty Gwynedd, Betsi Cadwaladr 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 Ysbyty Gwynedd, Betsi Cadwaladr University Health Board on 25 and 26 June 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 healthcare inspectors and a two Specialist Clinical Officers from the Medical Exposures Group (MEG) of the United Kingdom Health Security Agency (UKHSA), who acted in an advisory capacity. The inspection was led by a HIW healthcare inspector.

During 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 19 questionnaires were completed by patients or their carers and 24 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.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

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

Staff were seen speaking to patients in a polite, friendly and professional manner, showing dignity and respect to the patients. Efforts were also seen to ensure that patients' privacy was protected. Feedback from patients also supported this. We also found staff provided care in a way that protected and promoted patient rights.

Bilingual information was noted throughout the department including on the risks and benefits of having the treatment, as well as the different types of diagnostic imaging.

The department offered pastoral care to overseas recruits and increased induction length. There were also four active equality staff networks in the health board.

A couple of areas were identified that required attention.

This is what we recommend the service can improve:

- Displaying posters on 'putting things right' and on Llais
- Address some of the less positive comments in the patient feedback.

This is what the service did well:

- Displaying relevant bilingual health promotion material across the waiting areas
- Patients provided positive feedback about the service they had received and the approach of the staff
- The efforts made to promote the Welsh language
- Ensuring that patients' privacy and dignity was protected.

Delivery of Safe and Effective Care

Overall summary:

There was good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. The employer had written procedures and protocols in place as required under IR(ME)R.

Arrangements were in place to promote effective infection prevention and control and decontamination within the department. Staff we spoke with were aware of the health board's policies and procedures in relation to safeguarding. Staff could describe the actions they would take should they have a safeguarding concern.

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

There were some minor issues that needed to be addressed.

This is what we recommend the service can improve:

- Update the written employer's procedure to include the items required in this report
- Standardised approach to audits including learning, actions to be implemented and reaudit
- Mitigate the risk of a single point of failure in relation to the quality assurance testing in X-ray.

This is what the service did well:

- Staff had a good overall understanding of IR(ME)R
- Good level of Medical Physics Expert (MPE) support
- Management and governance of the mini C-arm
- A dose management system which could pull dose data from multiple pieces of equipment
- Advanced practice opportunities for radiographers.

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 training records, competencies, entitlement and scope of practice were clearly documented and linked with the appropriate equipment training records. Staff we spoke with described the knowledge, skills and training required to undertake their respective roles and scope of practice within the department. The compliance with the health board's mandatory training and appraisals was good.

Feedback from staff was generally positive, with staff speaking well about their immediate and senior managers.

This is what the service did well:

- Staff were very positive about the visibility and support from senior managers
- Clear process for ensuring that all staff have the required level of training relevant to their roles
- Staff we spoke with spoke well and answered questions professionally and staff we spoke with in the department were friendly welcoming and positive
- Staff had a good overall understanding of IR(ME)R.

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

HIW issued online and paper questionnaires to obtain patient views on services carried out by Ysbyty Gwynedd to complement the HIW inspection in June 2024. In total, we received 19 responses from patients at this setting.

Responses were mostly positive across all areas, with most who answered rating the service as 'very good' or 'good'. Based on the responses received, some of the responses received may have been affected by the waiting times in the Emergency Department prior to receiving treatment in the Diagnostic Imaging Department. Patients comments about the service are shown below:

> ***"I was referred for x-ray at 5.30pm on Thu 30 May 24 and I was called for an x-ray the same day and had the x-ray at 9am on Fri 31 May 24. Brilliant."***

> ***"The gowns provided in x-ray are not big enough and the ties on the back are often missing which leads to a lack of privacy, comfort or dignity. Referrals from my GP were ignored twice."***

> ***"My elderly father attended for treatment…. As well as the amazing staff who were working under significant pressure, we were very impressed by how proactive every department was in dealing with his needs. Considering his advanced age, we were very pleased and impressed to see how practitioners went above and beyond in terms of investigating possible reasons for his illness and trying different treatments. They were very responsive to the situation as it developed. We have absolutely no doubt that everyone did everything possible to treat him and to care for him. We are grateful for the wonderful service provided."***

Person-centred

Health promotion

There was relevant health promotion material displayed across the waiting areas. Posters were displayed which provided benefit and risk information to patients having an X-ray and posters with information for the patients to inform staff prior

to the exposure, if they may be pregnant or breastfeeding. These posters were displayed in English and Welsh. Relevant information was also made available to patients in leaflet format about the associated benefits and risks of the intended exposure.

We also noted health board specific leaflets in the mammography area which were comprehensive.

Dignified and respectful care

All staff, including porters, receptionists and radiographers were seen to be treating people with kindness and respect as well as being helpful and professional. In addition, there were enough areas for patients to be spoken to in private. There were appropriate changing facilities throughout the unit, where patients were able to change next to imaging rooms. Rooms were available for sensitive conversations between patients and staff.

The waiting area for patients was light, bright, airy and clutter free and doors to examination rooms were noted to be closed when in use.

Many patients in the questionnaire felt they were treated with dignity and respect and felt staff listened to them and answered their questions. In total, 73% of patients agreed that measures were taken to protect their privacy (e.g. private room, curtains drawn, cover-up provided etc.). Almost all patients were able to speak to staff without being overheard by other patients / service users.

All staff respondents in the questionnaire thought patients' privacy and dignity was maintained and agreed patients were informed and involved in decisions about their care. Many respondents felt there were enough staff to allow them to do their job properly and all but one said they had adequate materials, supplies and equipment to do their work.

Individualised care

All but two patient respondents felt they were involved as much as they wanted to be in decisions about their treatment and that staff explained what they were doing. Whilst 75% of patients said they were given information on how to care for myself following my procedure / treatment.

Patients we spoke with were also complimentary about their care, one said:

> *"Great to have all the stuff available in one place"*

Timely

Timely care

Staff we spoke with explained the arrangements for communicating waiting times to patients within the department.

Information posters in the waiting room informed patients waiting that a range of imaging procedures were taking place and waiting times varied accordingly. It also indicated that patients were seen at appointment time rather than arrival time.

It was noted that it was difficult at the main reception to inform patients of any significant waiting time due to the number of modalities and sub waiting rooms. However, the inclusion of a sign in the reception areas to remind patients to ask about any delay at reception, if they had been waiting for 15 minutes or more, may assist in this.

The health board is to ensure that there is adequate signage to require patients to ask if there are any delays.

During our inspection, we saw that patients attending the department were seen promptly. However, whilst many respondents agreed that the wait between referral and appointment was reasonable, only 48% of patients said that at the department, they were told how long they would likely have to wait to be seen.

Equitable

Communication and language

Bilingual, Welsh and English, information was noted throughout the department including on the benefits and risks of having the examination, as well as the different types of diagnostic imaging.

We saw posters displayed on how to feedback on care, as well as posters in the waiting rooms on the complaints procedure. We were informed that patients could complain via the “putting things right” process. However, there was not a “putting things right” poster on display in the department. There was a Patient Advice and Liaison Service (PALS) desk at the front of the hospital that offered confidential advice, support and information on health-related matters. We noted a good poster at the entrance to the hospital and bilingual posters advising patients of the methods in which they could provide feedback on their experiences via a number of methods. The department should consider advertising these methods more widely within the department to encourage more feedback.

There was no information noted on Llais, the national, independent body set up to give the people of Wales a stronger voice in their health and social care services.

Additionally, there was not a "you said, we did " type board that informed patients of the results of feedback received and how the setting had learned and improved based on feedback received. We were informed that this was because of the low numbers of feedback received. Evidence was shown to us of individual feedback received. The department should consider displaying this information within the department.

The health board must ensure that the relevant posters are displayed on the following:

- **Llais**
- **“Putting things right”**
- **The results of feedback and the action taken.**

A number of staff were seen wearing a ‘iaith gwaith’ badge, to indicate they spoke Welsh. Patients and staff / staff with staff were heard speaking Welsh to each other.

Only three patients said that Welsh was their preferred language and that they were actively offered the opportunity to speak Welsh throughout your patient journey.

Over 50% of staff who completed the questionnaire said that they were a Welsh speaker but only half of these said they wore a ‘iaith gwaith’ badge or lanyard. Almost all Welsh speaking staff said that they asked patients their preferred language, at least ‘sometimes’.

Rights and equality
There were arrangements in place to make the service accessible to patients such as translation services, wide corridors, large treatment room doors to allow for wheelchair access, with standing hoists and other aids available.

Staff we spoke with had a good awareness of their responsibilities in protecting and promoting patients’ rights when attending the department, as well as staff rights when working in the department.

Senior staff informed us about the weekly radiology newsletters with links reminding staff about the equality procedures in place. There were links to equality pages on the intranet and various wellbeing networks. The department also offered pastoral care to overseas recruits and increased induction length. There were four active equality staff networks in the health board including Celtic Price, for LGBTQ+ staff and BCUnity for ethnic minority and overseas staff.

Equality, diversity and human rights awareness formed part of the health board's mandatory staff training programme and there were relevant policies in place. Information provided confirmed that most staff were up to date with this training.

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), 69% of patients who answered this questionnaire felt they could. Patients commented that:

> *"See comments above stating that despite my father's age and hearing impairment he was treated with immersive courtesy and care."*
>
> *"Apart from accessing GP appointments."*
>
> *"Almost impossible to access any health care services in a timely manner."*

When asked whether they had faced discrimination when accessing or using the service, one patient said they had.

The health board is required to reflect on some of the less favourable responses from patients and inform HIW of the actions it will take to address these.

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
Senior staff we spoke with described the process for reviewing and revising the employer's written procedures and protocols. They spoke about how these changes would be cascaded to staff and how the department would ensure that staff read and understood the procedures. Staff we spoke with knew where to find the written procedures relevant to their practice.

The employer had written employer's procedures and protocols in place as required under IR(ME)R.

There were written protocols in place for standard radiological practice (including non-medical imaging (NMI) procedures where appropriate). The master copies of these documents were available on the radiology SharePoint intranet site for all radiology staff to access. It was noted that the general X-ray protocol appendices were a good support tool for staff. The X-ray protocols could be further improved by using a template similar to the template for computed tomography (CT) written protocols.

Referral guidelines
The clinical referral guidelines, iRefer, were used and were available on the health board intranet for all relevant entitled healthcare professionals to follow. The written employer's procedure on how to make a referral and referral criteria was clear and reflected the detail in the self-assessment form (SAF) and information staff provided on the day.

Non-medically qualified referrers (NMRs) were required to complete a training programme and formally request entitlement, which was then reviewed by a radiology panel before formal entitlement of the applicant was approved. The training was robust with these referrers being required to complete a theory course, a test requiring a 100% pass and then spend time in the modality they wished to refer for before they completed an application to be considered for entitlement. This was considered noteworthy practice.

Diagnostic reference levels (DRLs)

Staff we spoke with knew where to find DRLs in the department and how to record doses. They told us of the action they would take should they identify doses that consistently exceeded the local DRL and this was in accordance with the employer's procedure.

The employer had a written employer's procedure describing the process for the setting, auditing and reviewing of DRLs, established for imaging examinations performed in the department. We evidenced local DRLs had been established and these were either equivalent to or below national DRLs.

The SAF described how the relevant exposure/dose metrics from all examinations were recorded manually in the radiology information system (RIS) in accordance with the procedure. A number of devices at the hospital were connected to the patient dose management system (PDMS). It was good to see a dose management system which could pull dose data from multiple pieces of equipment to support dose audits.

Medical research
We were told that there were no medical research trials involving the department currently. There was a policy in place for research involving ionising and non-ionising radiation as well as an employer's procedure, which we reviewed. The governance arrangements in place for research trials involving ionising radiation exposures were included in the SAF.

A file was completed for each research trial and we reviewed a sample of these during the inspection and these were in order.

Entitlement
There was a written employer's procedure in place for the entitlement and assuring competency of IR(ME)R 2017 referrers, practitioners and operators. The process was clearly explained in this employer's procedure containing all the detail around delegation, training requirements and the process for entitlement.

All medical and dental referrers completed an induction and were expected to read the appropriate employer's procedures. However, the procedure on entitlement did not include dentists and orthopaedic surgeons in the table for practitioners and operators.

The employer must include all relevant practitioners and operators including dentists and orthopaedic surgeons into the relevant table for practitioners and operators in the procedure for entitlement.

For examinations where radiology did not provide a routine report e.g. dentals and general radiography for orthopaedics, a canned report, (automatically generated reports based on pre-set specifications) was generated reminding the referrer they were required to document the clinical outcome in the patient notes.

The employer must ensure that dentists and orthopaedic surgeons are added to entitlement groups on the relevant employer's procedure.

The radiology service issued an annual letter of entitlement to general practitioners (GPs) and all consultants (for sharing with their team) which included a reminder of good referral practice.

The management and governance of the mini C-arm equipment, for use in theatre, was considered to be good practice. This included completion of relevant training before orthopaedic surgeons were entitled as operators to use the equipment.

Staff we spoke with told us how they were made aware of their duties and scope of entitlement under IR(ME)R.

Patient identification
A suitable written employer's procedure was in place to correctly identify the individual to be exposed to ionising radiation. This also set out the procedure to follow when patients were unable to confirm their identity verbally or in writing such as patients who were unconscious.

Staff we spoke with were able to describe the action taken to correctly identify patients prior to examinations being performed, which was consistent with the relevant employer's procedure.

During discussions with senior staff, we were told that translators would be requested to attend, when the patient was unable to identify themselves due to language barriers. A list of staff who could speak Welsh should there be a need for a Welsh translation was also held by the department. The department were also investing in mobile tablet carts that allowed for translation with video.

Individuals of childbearing potential (pregnancy enquiries)
The evidence provided in the self-assessment form submitted by the setting showed that there was an employer's procedure in place for making enquiries of individuals of childbearing potential. This was to establish whether the individual was, or may be, pregnant or breastfeeding for examinations performed in the department. We identified some improvements could be made to clarify written procedures in relation to pregnancy enquiries.

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

The employer is to ensure that:

- **Clarity is provided in the employer's procedure relating to whether the radiographer is the operator responsible for performing the pregnancy enquiry in settings outside radiology such as theatres**

- **For the pregnancy flowchart an additional step is included as discussed.**

Benefits and risks
The employer's procedure for benefits and risk detailed the process for providing individuals or their representatives with benefit and risk information. The procedure detailed the radiation dose and potential risk associated with different imaging examinations. In addition, the SAF described a working party which had been set up to revise and standardise the patient information across the health board. The revised patient information leaflets had a section on the radiation risk. This leaflet had been approved by the patient communication panel.

Staff were able to describe the information provided to individuals or their representatives relating to the benefits and risks associated with the radiation dose from exposures. This mainly related to comparing the exposure to an equivalent dose of background radiation. We saw posters explaining the benefits and risks clearly displayed within the waiting areas.

In the patient questionnaire, three quarters of respondents said they were provided with enough information to understand the benefits and risks of the procedure or treatment.

The employer's procedure for the use of the mini C-arm included reference to clinical evaluation, the recording of radiation dose and the benefit and risk conversation. However, the procedure did not explicitly state who was responsible for providing benefit and risk information in the theatres.

The employer must ensure that there is a consistent approach to the communication of benefit and risk in the theatres and that this is documented in the relevant procedure.

Clinical evaluation
There was an employer's procedure in place for carrying out and recording an evaluation for medical exposures performed at the department.

The radiology department provided a formal report in RIS for examinations performed by the service. We were told that regular checks were made to ensure all examinations had a report. Performance monitoring was carried out to measure reporting turnaround time in accordance with the guidance form the medical imaging sub-committee (MISC). A monthly check was also carried out to monitor the backlog against the MISC guidance. This monitoring is reported to the radiology senior team and the strategic care clinical effectiveness group.

It was also positive to note that advanced practitioner and reporting radiographers had been trained, signed off as competent and entitled to clinically evaluate axial and appendicular skeleton, chest and abdomen.

Furthermore, a consultant mammographer worked in the department and had been trained, appropriately signed off as competent and entitled. They carried out mammographic reporting in addition to completing several audits, such as image interpretation audit and post-biopsy infection rate.

Non-medical imaging exposures
There was an employer's procedure in place for non-medical imaging (NMI).

However, there were discrepancies between the self-assessment form, the Radiation Protection Policy (RPP) and NMI Procedure. The RPP referred to 'age athlete development. This should be removed as this was not a justified NMI examination. The site confirmed bone assessment as non-medical imaging is not carried out at this site. This should therefore be removed from the RPP and NMI procedure.

The employer must ensure that the relevant employer's procedure and policies for non-medical imaging are updated removing reference to bone age assessment for athlete development.

Employer's duties: clinical audit
The process for clinical audit, including the structure of the programme and which IR(ME)R duty holders were involved, was described. This included that:

- All members of the radiology department including student radiographers participated

- Each department has a lead radiographer and radiologist who oversaw the audits for their site

- All audits were registered with the Head of Quality and Governance

- The joint audit meeting is held quarterly to allow sharing across the health board, which were recorded so that staff unable to attend could view the meeting

- The results were fed back to all staff.

We noted a variety of audit templates were used in the evidence provided and were told that templates depended on the audit and how staff wanted to present the results. Some of the audits provided for inspection, lacked evidence of the dissemination of results, shared learning, implemented changes and plans for reaudit. Whilst we noted the meetings described above, there was a need for a standardised approach to audits including learning, actions to be implemented and reaudit. We were told that an audit tracker had been developed, to establish what needed to be done and that the tracker would be further developed to track the compliance and re-audits.

The employer must ensure that there is a standardised approach to the reporting of audits, the learning actions to be implemented in the audit results and whether there is a need for reaudit.

The department also performed monthly audits on IR(ME)R compliance. Additionally, the MPE, Professional Service Manager Radiography and Head of Quality and Governance also undertook three IR(ME)R and Ionising Radiation Regulations 2017 compliance audits each year.

Employer's duties: accidental or unintended exposures
Staff members we spoke with were able to describe processes for reporting radiation incidents related to accidental or unintended exposures. We were told that any incidents would be logged on DATIX and logged against the department risk register, which was evidence of good practice.

Senior staff also described suitable arrangements for the analysis, recording and reporting of accidental or unintended exposures. Guidance was readily available in the department for staff, should they suspect an accidental or unintended exposure had taken place. This process included involvement of MPEs so that an assessment of the dose could be performed, to identify whether the incident was notifiable to HIW.

We were also provided with examples of where the learning had influenced change in practice. This included additional training to individual staff in relation to specific incidents with new equipment.

There was an employer's procedure in place for reporting and investigating accidental and unintended exposures. However, the definition of clinically significant, accidental and unintended exposures (CSAUE) did not appear to consider psychological harm. This needs to be included in line with professional body guidance.

The employer's procedure for dealing with accidental or unintended radiation exposures of individuals appeared to blend the procedure for probability and magnitude with the procedure for clinically significant accidental and unintended exposures. Separate procedures were required for both.

The employer is the ensure that:

- **The definition of clinically significant, accidental and unintended exposures (CSAUE) includes reference to psychological harm**

- **A procedure is written relating to ensuring that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable as required by Regulation 6, Schedule 2 (1) (k) of IR(ME)R 2017.**

All staff respondents in the questionnaire said their organisation encouraged them to report errors, near misses or incidents, whilst almost all felt staff who were involved were treated fairly. Most who answered said they would feel secure raising concerns about unsafe clinical practice, but fewer, 78%, were confident their concerns would be addressed. All bar two members of staff felt that when errors, near misses or incidents were reported, the organisation took action to ensure that they did not happen again and were given feedback about changes made in response to reported errors, near misses and incidents. Most staff said that if they were concerned about unsafe practice, they knew how to report it.

Duties of practitioner, operator and referrer
There was an employer's procedure which included the entitlement of practitioners, operators and referrers to carry out their duties.

Staff we spoke with were aware of their duty holder roles and responsibilities under IR(ME)R. Duty holders were informed of their entitlement in writing and were included in the entitlement matrix, which also described their scope of practice.

Justification of individual exposures
The processes of how and where justification was recorded was described, with justification being performed prior to the exposure by an IR(ME)R entitled

practitioner. Whilst there was currently no electronic system for justification of referrals, we were told that this would be implemented when the department go live with the new Radiology Information System Procurement (RISP) which will replace both the current RIS and the picture archiving and communication system (PACS).

There was an employer's procedure for the entitlement and ensuring competency of IR(ME)R 2017 referrers, practitioners and operators

The SAF described the process for authorisation and how this would be recorded. Where the practitioner had delegated authorisation to the IR(ME)R operator there was a guideline that detailed the authorisation criteria for the operator. However, it was unclear who was the named individual practitioner responsible for the authorisation guidelines.

The employer is to ensure that the name and role of the practitioner who is responsible for issuing the authorisation guidelines is stated in the authorisation guidelines.

Optimisation
The department has set up a number of radiology image optimisation teams (IOTs) to focus on optimisation of dose and image quality.

We were told that practitioners and operators ensured doses were as low as reasonably practical (ALARP) via a number of factors, these included detailed technique protocols including specific views in general X-ray and detailed scan parameters for CT.

The self-assessment form also described how exposures involving high doses were optimised using the various IOTs.

Paediatrics
Senior staff confirmed X-ray examinations were performed in the department on paediatric patients. They also stated that the CT scanner had specific programmes for imaging children which optimised the dose. Similarly for general X-ray and fluoroscopy the equipment had anatomical programmes set for optimising the imaging of children based on either age or weight.

We were also told that within the general X-ray department a paediatric lead radiographer post had been introduced to support the imaging of paediatrics and ensure exposures were optimised.

Carers or comforters

An employer's procedure was in place to provide advice and guidance on exposers to carers and comforters. The procedure identified dose constraints for these examinations.

Staff we spoke with were able to explain the carers and comforters procedure, which included carrying out the relevant benefit and risk information and pregnancy checks. Carers and comforters would be given a dosimeter badge to hold which measured the amount of radiation exposure.

Senior staff we spoke with described the process for recording the pregnancy records on the holding badge

Expert advice
Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in and provide advice on medical exposures performed at the department. The employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R 2017.

Medical physics support was good; this was evidenced by their involvement in various groups and committees, as well as advising staff when required. Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in, and provide advice on, medical exposures performed at the department. Examples of this involvement included:

- Being a core standing member of all IOTs
- Regular quality assurance testing incorporating dose measurement
- Carrying out dose estimations for SAUE exposures or as required estimations of foetal dose
- Involved in the procurement and installation design of high dose equipment.

It was also clear during the inspection about the positive support that the MPEs provided to the department.

Equipment: general duties of the employer
The equipment inventory complied with regulatory requirements. However, X-ray room 4 was on the equipment inventory with an installation date of 1997 and the end-of-life notice was 2013. In the evidence provided within the SAF there was a commissioning report for Room 4, which was replaced 12 months ago. The equipment inventory needed to be updated to reflect this.

The employer must ensure that the equipment inventory is kept up to date and this includes reflecting that X-ray room 4 has recently installed.

There were a number of pieces of equipment which have passed the noted replacement year. Currently capital funding was allocated by NHS Wales, each department would score it's proposed equipment replacements and prioritise the list. We were told that the department had been successful in securing a number of pieces of equipment into the top 30 equipment replacement priorities.

There was an employer's procedure in place to ensure a quality assurance (QA) programme of equipment was followed. There was good evidence of QA programme being carried out and documented. Each modality carried out their own quality control (QC) testing. However, it was noted that in general X-ray the QC was being carried out by one individual radiographer. This could be regarded as a potential single point of failure.

The employer must ensure that additional staff are trained and carry out the QC of equipment in general X-ray.

The MPEs we spoke with said that they carried out an audit of quality assurance in CT and the findings were in keeping with what was noted in general X-ray. This concluded that baselines needed to be clear and the process needed to be documented for carrying out and recording test results.

The employer is required to ensure that:

- **Baseline results are documented and available**

- **A system for trend analysis needs to be developed for QC tests.**

The medical physics department also had a programme of testing for each piece of equipment for the more detailed testing. The Institute of Physics and Engineering in Medicine (IPEM) 91 guidance was used to identify the frequency and requirements of the testing programme. We were told that the QA frequency level B was at 75% of what IPEM recommend. This was due to the amount of new equipment being commissioned.

Safe

Risk management
The environment was clean and in a good state of repair, including furniture, fixtures and fittings. Two of the diagnostic imaging rooms had been newly refurbished.

There were no hazards in the environment with corridors clear and no clutter or tripping hazards. The department was a main corridor through the hospital, but this did not affect the privacy and dignity within the department. There were several waiting rooms and waiting areas throughout. The department was relatively quiet throughout the inspection.

The department was well signposted from the main entrance, the diagnostic imaging department was on the main corridor with the reception desk clearly signposted. However, the chairs in the waiting rooms did not have arms nor any chairs at different heights, for less mobile patients.

All bar one patient said they were able to find the department easily, one patient commented:

> *"Reception areas could do with more chairs with arms. Lot of patients have mobility difficulties."*

The health board is required to ensure that seating for less mobile patients is considered, such as chairs with arms, raised chairs and bariatric chairs available in the waiting rooms.

Infection prevention and control (IPC) and decontamination
Staff we spoke with were aware of their responsibilities in relation to IPC and decontamination. This included being told on the morning huddle whether there were any problems with patients on the wards relating to IPC. We were told when speaking with senior staff that one of senior team from the department joined the site safety meeting to gain awareness of site issues relating to IPC.

All areas inspected were visibly clean and tidy and the environment was well maintained. Personal protective equipment (PPE) was readily available for staff to use. Suitable handwashing and drying facilities as well as hand sanitiser were also readily available within the department.

All bar one patient who expressed an opinion in the questionnaire said that infection and prevention control measures were being followed and most who answered felt the setting was clean.

All staff who answered the questionnaire thought there were appropriate IPC procedures in place and that appropriate PPE was supplied and used. All bar one thought there was an effective cleaning schedule in place and most said the environment allowed for effective infection control.

Safeguarding of children and safeguarding adults
Staff we spoke with were aware of their responsibilities around reporting safeguarding concerns and described the process they would follow. They were also aware of where to find the relevant information.

Senior staff described a suitable process for responding to safeguarding concerns.

We examined training information for a sample of five staff and saw that all staff had attended safeguarding training at a level appropriate to their role.

Effective

Patient records
Generally, we found suitable arrangements were in place for the management of records used within the department. The referral records had been completed 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. However, the system was complicated for staff to complete checks across three systems. This should be resolved following the implementation of the RISP.

A sample of five current patient referral documentation and five retrospective patient referral documentation were examined. The sample showed that for the record where a pregnancy check was required, in the current documentation the form was not signed by the operator. Additionally, whilst there was a small section for additional notes on the form, there was not a section relating specifically to when the patient was pregnant and the examination was justified. This needs to be clear on the new system.

Overall, there was a high standard of record keeping evidenced.

The system where canned reports were used still referenced IR(ME)R 2000, this needed to be updated to IR(ME)R 2017.

The employer is to ensure that:

- **Canned reports are amended to include IR(ME)R 2017**

- **The documentation to be used within the new radiology information system (RIS) should include space to capture supportive evidence of appropriate additional checks.**

Efficient

Efficient

Staff and senior staff we spoke with were able to give examples of the arrangements and systems in place to promote an efficient service. This included providing a continuous service 24 hours a day, with a senior member of staff on nights and an on-call second radiographer to provide additional cover.

The department monitored waiting lists at senior staff meetings and all attempted to share and harmonise the workload across the health board.

We also noted good practice in the monthly quality and governance in radiology newsletter sent to all staff that included alerts, shared learning and professional guidance from the National Institute for Health and Care Excellence (NICE) amongst the topics.

Quality of Management and Leadership

Staff feedback

HIW issued an online questionnaire to obtain staff views on services carried out at the diagnostic imaging department at Ysbyty Gwynedd and their experience of working there. The questionnaire complements the HIW inspection in June 2024. In total, we received 24 responses from staff. Not all respondents completed the questionnaire to the end and questions were skipped throughout.

Responses from staff were generally positive. All respondents were satisfied with the quality of care and support they gave to patients. Most staff agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family and would recommend their organisation as a place to work. We received several comments on the service, some are shown below:

> *"I am proud to work in my department. Our Patients receive a high standard of care, kindness and respect. We work well as a large team and with our smaller teams. We care for our patients and each other."*

> *"The organisation is under severe pressure with workload. The funding from government doesn't appear to get to where it is needed on the front line of care delivery. This must be rectified to stop the decline in the quality of the NHS for its users and those delivering the care directly to them."*

> *"All of the moisturiser dispensers were removed recently which means that there is no way of moisturising hands after cleaning them. I find my hands become extremely dry and cracked and used to rely on the moisturiser dispensers. This has infection control implications because staff are less likely to use the sanitiser as a result of dried hands."*

> *"The department has tried hard the recruit staff and any staff shortages are due to a countrywide shortage. Management have done an excellent job and have kept us safe during Covid and beyond. We have good communication with senior managers who are compassionate in their approach."*

Leadership

Governance and leadership

The Chief Executive of the health board was the designated employer under IR(ME)R and 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.

We were provided with details of the organisational structure. Clear lines of reporting and responsibilities under IR(ME)R were described and demonstrated. The SAF, required before the inspection started, was completed comprehensively and was clear, as well as being provided within the timescale required. The management team had clearly demonstrated a commitment to correct the issues raised during this inspection and make improvements where identified.

Staff we spoke with were very positive about the visibility and support from senior managers. It was also clear from speaking with managers and staff in the department that the daily huddles provided staff with relevant information and was good practice.

There were also clear lines of leadership and responsibility noted in the department, this was supported by staff comments in the questionnaires. Percentages agreeing with the comments of the organisation were as follows:

- My organisation was supportive --91%
- My organisation supported staff to identify and solve problems - 91%
- My organisation took swift action to improve when necessary - 70%.

Similarly, the percentage agreement with the questions below relating to staff's immediate and senior manager were as follows:

- My immediate manager can be counted on to help me with a difficult task at work - 83%
- My immediate manager gave me clear feedback on my work - 83%
- My immediate manager asked for my opinion before making decisions that affected my work - 79%
- Senior managers were visible - 88%
- Communication between senior management and staff was effective – 79%
- Senior managers were committed to patient care – 92%.

Senior staff described the various ways they ensured that they engaged with staff on a regular basis. This included the annual appraisal, pay progression meeting and development days every two months where the department engaged in focussed pieces of work away from the department.

The process for the review and amendment of general policies relevant to the department was also described by senior staff. Where the procedure was owned by the department this would be agreed by the quality safety and experience group.

Workforce

Skilled and enabled workforce
Overall staff had a good understanding of IR(ME)R.

The arrangements in place to enable staff to report issues or concerns were discussed with staff. Staff we spoke with referred to the health board speak out safely as well as access to staff wellbeing and staff could self-refer to the occupational health service.

In the staff questionnaire, regarding their health and wellbeing at work, most staff agreed that, in general, their job was not detrimental to their health and that their organisation took positive action on health and wellbeing. A similar number stated that their current working pattern and off duty allowed for a good work-life balance and almost all were aware of the occupational health support available to them.

We reviewed a sample of five IR(ME)R competency training records for a range of staff and found these to be in good order, generally. The induction form for an interventional radiographer lacked signatures and dates and the entries were ticked instead of being signed. If this was a format issue with the form, then this should be amended. There were clear processes to ensure that all staff had the required level of training relevant to their roles.

Generally, staff we spoke with were positive about their workload and that there were enough radiography staff at the site. Staff we spoke with, spoke well and answered our questions professionally and staff we spoke with in the department were friendly, welcoming and positive.

There were a number of student radiographers working at the department, which was positive to note, this had led to five qualifying radiographers starting at the department in September 2024. We discussed the levels of supervision for students and how staff manage such high numbers with senior staff. They commented that

students were not all on site at the same time and that there was student education support from the University. No more than one student was assigned to any one radiographer.

It was also positive to note that sickness levels in the department were low at 3.1%.

Overall compliance with training was good, with over 90% compliance with the majority of courses. Training records were clear and there was an appropriate system to identify when training was due as senior staff maintained a full matrix of mandatory courses. Our check of the staff records for five members of staff confirmed that they had 100% compliance with safeguarding, IPC, health and safety and relevant resuscitation training or basic life support.

Most staff in the questionnaire felt they had appropriate training to undertake their role.

For the questions asked about the duty of candour in the questionnaire, all staff agreed that they knew and understand the Duty of Candour and understood their role in meeting the Duty of Candour standards. All bar one member of staff said that their organisation encouraged them to raise concerns when something had gone wrong and to share this with the patient. After speaking to management about the lack of training on duty of candour, they immediately worked on organising formal training for staff. They stated that there was a 'soft' launch with a brief video on the duty when it was introduced, but this was not linked to the electronic staff record (ESR).

In total 92% of staff were able to confirm in the questionnaire that in the last 12 months, they had an appraisal, annual review or development review of their work. Senior staff confirmed that the compliance with appraisals was over 90%.

Culture

People engagement, feedback and learning
When asked as to whether staff had fair and equal access to workplace opportunities, regardless of any protected characteristics, 96% agreed. The comments received were:

> ***"I have a background in equality work, and I believe my department, BCUHB and the NHS more broadly perform very well in this regard."***

"Yes, but not always made aware to all members of staff it's sometimes heard off the back of a conversation with other colleagues and some members of staff are not involved."

All bar two members of staff agreed that the workplace was supportive of equality and diversity. Two staff respondents told us that they had faced discrimination at work.

Staff were not as positive in their responses regarding patient experience measures, with 42% agreeing that patient / service user experience feedback was collected within the department. However, 38% said they didn't know. Only 63% said they received regular updates on patient /service user experience feedback. Half the staff said that feedback from patients / service users used to make informed decisions within the department, with 37.5% saying they did not know.

Only 58% of patients said they would you know how to complain about poor service, if they wanted to.

The health board is required to reflect on some of the less favourable responses from staff and inform HIW of the actions it will take to address these.

Other responses in the staff questionnaire were as follows:

- Care of patients was my organisation's top priority - 96%
- Overall, I am content with the efforts of my organisation to keep me / patients safe - 96%
- I would recommend my organisation as a good place to work - 91%
- I would be happy with the standard of care provided by this organisation for myself or friends / family - 83%
- I am involved in deciding on changes introduced that affect my work area - 75%
- I am able to meet the conflicting demands on my time at work - 92%
- I am able to access ICT systems I need to provide good care and support for patients - 92%

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 Department, Ysbyty Gwynedd

Date of inspection: 25 and 26 June 2024

The table below includes any immediate non-compliance 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
1.	No immediate assurance issues.					
2.						

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 Department, Ysbyty Gwynedd

Date of inspection: 25 and 26 June 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
1.	It was noted that it was difficult on the main reception to inform patients of any significant waiting time due to the number of modalities and sub waiting rooms. However, the inclusion of a sign in the reception areas to remind patients to ask about any delay at	The health board is to ensure that there is adequate signage to require patients to ask if there were any delays.	Timely	Put up signs	Radiology service Manager West	Completed

	reception if they had been waiting for 15 minutes or more, may assist in this.					
2.	There was not • A “putting things right” poster on display in the department • Information noted on Llais • A "you said, we did " type board that informed patients of the results of feedback received.	The health board must ensure that the relevant posters are displayed on the following: • Llais • “Putting things right” • The results of feedback and the action taken.	Communication and language	Put up appropriate signs	For Radiology Radiology Service Manger (West)	Complete

3.	When asked whether they had faced discrimination when accessing or using the service, one patient said they had.	The health board is required to reflect on some of the less favourable responses from patients and inform HIW of the actions it will take to address these.	Rights and equality	Review procedures with equality team to support patients to ensure they do not face discrimination	Head of Quality & Governance Radiology	October 2024
4.	All medical and dental referrers completed an induction and were expected to read the appropriate employer's procedures. However, the procedure on entitlement did not include dentists and orthopaedic surgeons in the table for practitioners and operators.	The employer must include all relevant practitioners and operators including dentists and orthopaedic surgeons into the relevant table for practitioners and operators in the procedure for entitlement.	IR(ME)R 2017, Regulation 6 (1) (a) Schedule 2 1 (b)	Update procedure RAD 004	Professional Service Manager Radiography	On going – for October 2024 This date allows for all meeting dates required for approval

5.	We identified some improvements could be made to clarify written procedures in relation to pregnancy enquiries.	The employer is to ensure that: • Clarity is provided in the employer's procedure relating to the operator responsible for performing the pregnancy enquiry in settings such as theatres • For the pregnancy flowchart an additional step is included to ensure the flowcharts reflect the processes described in the procedure as discussed.	IR(ME)R 2017, Regulation 6 (1) (a) Regulation 12 (8) (d) and Schedule 2 1 (c)	Pregnancy procedure updated	Head of Quality & Governance	On going – for October 2024 This date allows for all meeting dates required for approval.
6.	The employer's written procedure	The employer must ensure that there is a	IR(ME)R 2017,	Mini C-arm Procedure to be	Professional Service Manager Radiography	

	for the use of the mini C-arm included reference to clinical evaluation, the recording of radiation dose and the benefit and risk conversation. However, the procedure does not explicitly state who is responsible for carrying out these tasks in the theatres.	consistent approach to the communication of benefit and risk, carrying out clinical evaluation and dose recording in the theatres and that this is documented in the relevant procedure.	Regulation 6 (1) (a) Schedule 2 1 (i)	updated to provide the required clarity that it is the doctor carrying out the procedure that is responsible for the communication of benefit and risk		On going – for December 2024 This date allows for all meeting dates required for approval
7.	Examinations where radiology did not provide a routine report e.g. dentals and general radiography for orthopaedics, a canned report was generated	The employer must ensure that dentists and orthopaedic surgeons are added to entitlement groups on the relevant employer's procedure.	IR(ME)R 2017, Regulation 6 (1) (a) Regulation 10 (3) Schedule 2 1 (b)	Update employer procedures cover entitlement where a referrer is documenting in the patient notes	Professional Service Manager Radiography	October 2024

	reminding the referrer they were required to document the clinical outcome in the patient notes.					
8.	Conflict of information on non-medical imaging undertaken at site was found in the employer's procedures and Radiation Protection Policy (RPP).	The employer must ensure that the: • Relevant employer's procedure for non-medical imaging is updated removing reference to bone age as a non-medical imaging exposure • RPP is updated to remove the section on athlete development.	IR(ME)R 2017 Regulation 6 (4)	Radiology procedure RAD 002 updated to reflect comments Update Radiation Protection Policy	Professional Service manager radiographer MPE (Medical Physics Ecpert)	Completed December 2024 to allow for approval process
9.	We noted a variety of audit templates	The employer must ensure that there is a	IR(ME)R 2017 Regulation 7	The audits are reported to	Head of Quality & Governance Radiology	Completed August 2024

	were used in the evidence provided and were told that templates depend on the audit and how people want to present the results. Some of the audits provided for inspection lacked evidence of the dissemination of results, shared learning, implemented changes and plans for reaudit.	standardised approach to the reporting of audits, the learning actions to be implemented in the audit results and whether there is a need for reaudit.		Strategic Clinical Effectiveness Group Radiology to use a standard reporting outcome template for clinical audits There is also a radiology audit tracker that lists when re audits are required.		
10.	The definition of clinically significant, accidental and unintended exposures (CSAUE) did not appear to	The employer is the ensure that the definition of clinically significant, accidental and unintended exposures (CSAUE) includes reference to psychological harm.	IR(ME)R Regulation 8 (1) Schedule 2 1 (l)	Reflect this requirement in the revised employers procedure	Professional Service Manager Radiography	31st October 2024 This date allows for all meeting dates required for approval

	consider psychological harm.					
11.	The employer's procedure for dealing with accidental or unintended radiation exposures of patients appeared to blend the procedure for probability and magnitude with the procedure for clinically significant accidental and unintended exposures. Separate procedures were required for both.	A procedure is written relating to ensuring that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable as required by Schedule 2 of IR(ME)R 2017.	Schedule 2 1 (k)	Separate current procedure into two separate procedures	Professional Service Manager Radiography	31st October 2024 This date allows for all meeting dates required for approval
12.	It was unclear who was the named	The employer is to ensure that the name	Regulation 11 (5) Schedule 2 1 (b)	All delegated authorisation	Head of Quality & Governance	Completed

	individual practitioner responsible for the authorisation guidelines.	and role of the practitioner who is responsible for issuing the authorisation guidelines is stated in the authorisation guidelines.		guidelines updated to be clear that the responsible practitioner is the clinical director and their name added		
13.	The equipment inventory complied with regulatory requirements. However, X-ray room 4 was on the equipment inventory with an installation date of 1997 and the end-of-life notice was 2013. In the evidence provided within the self-assessment form there was a commissioning report for Room 4,	The employer must ensure that the equipment inventory is kept up to date and this includes reflecting that X-ray room 4 has recently installed.	IR(ME)R 2017, Regulation 15 (1) (b) & (2)	Correct the entry for room 4 in the IR(ME)R equipment inventory	Professional Service manager Radiography	Completed (on the day of the inspection)

	which was replace 12 months ago. The equipment inventory needs to be updated to reflect this.					
14.	It was noted that in general X-ray that the QA was being carried out by one individual radiographer. This could be regarded as a potential single point of failure. Each modality carried out their own QA testing.	The employer must ensure that additional staff are trained and carry out the QC of equipment in general X-ray.	IR(ME)R 2017, Regulation 15 (1) (a)	Identify additional staff to support with QA Ensure the new radiology workforce model has sufficient staff with QA skills	Radiology Service Manger (West) Professional Service Manager Radiography	Completed August 2024 December 2024
15.	The MPEs we spoke with said that they carried out an audit of quality	The employer is required to ensure that:	IR(ME)R 2017, Regulation 15 (1) (a)	Review QA procedures to ensure appropriate documentation is	Principal CT Radiographer	October 2024

	assurance in CT and the finding were in keeping with what was noted in general X-ray. This concluded that baselines need to be clear and the process needs to be documented for carrying out and recording test results.	• Baseline results are documented and available • A system for trend analysis needs to be developed for QC tests.		available and trend analysis is performed.		
16.	The chairs in the waiting rooms did not have arms nor any chairs at different heights, for less mobile patients.	The health board is required to ensure that seating for less mobile patients is considered, such as with chairs with arms, raised chairs and bariatric chairs available in the waiting rooms.	Risk	Arrange department chairs across waiting rooms to ensure there are a variety available	Professional Service Manager (West)	Completed
17.	Pregnancy checking forms did not have	The employer is to ensure that:		Ensure RISP can capture require	Professional Service Manager	April 2025 when new

	a section for recording additional relevant information or where an exposure has been justified when there is a known pregnancy. The system where canned reports, automatically generated reports based on pre-set specifications, referenced IR(ME)R 2000, this needs to be updated to IR(ME)R 2017.	• The documentation to be used within the new radiology information system (RIS) should include space to capture supportive evidence of appropriate additional checks and justification where pregnancy is known • Canned reports are amended to include IR(ME)R 2017.	IR(ME)R 2017, Regulation 1 and 11 (1) (f)	pregnancy information Correct canned date in all RAD systems	Radiography/Head of Systems and performance Radiology Professional Service Manager Radiography/Head of Systems and performance Radiology	system goes live Completed August 2024
18.	All bar two members of staff	The health board is required to reflect on	Equitable	Radiology work very closely with	Professional Service Manager	Complete

	agreed that the workplace was supportive of equality and diversity. Two staff respondents told us that they had faced discrimination at work.	some of the less favourable responses from staff and inform HIW of the actions it will take to address these.		workforce to ensure staff are supported. Staff are signed posted to support within the health board in relation to wellbeing and also the speak out safely team. Staff are encouraged to raise concerns with line managers. As part of the back to basics month in September a reminder of behaviours expected will be included.	Radiography/Radiology Service Manager (West)	

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): **Helen Hughes**

Job role: **Professional Service Manager Radiography/ADoTH**

Date: **26 August 2024**