Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Diagnostic Imaging Department, Prince Charles Hospital, Cwm Taf 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 Prince Charles Hospital, Cwm Taf Morgannwg University Health Board on 20 and 21 May 2025. 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 two Senior Clinical Diagnostic Officers from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity.

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 22 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:
The department actively promoted health through bilingual materials in waiting areas, focusing on healthy lifestyles and smoking cessation. Posters also informed patients about X-ray procedures, including benefits and risks information, and pregnancy-related precautions.

Patient comments in the questionnaire were mostly positive across all areas, with most respondents rating the service as ‘very good’ or ‘good’ and that they were involved as much as they wanted to be in decisions about their treatment.

Staff interactions were consistently polite, professional and respectful. Efforts to maintain patient privacy and dignity were evident, with private changing rooms and closed doors during procedures. Although the open-plan reception posed some privacy concerns, a quiet room was available. Most patients felt respected, listened to and involved in their care.

Despite ongoing refurbishment, the department remained clean and functional. Equipment for dental and intraoral imaging was also available. Diagnostic reference levels (DRLs) and informative posters were displayed throughout.

Patients were seen promptly, with clear communication about waiting times. The majority of patients thought the wait reasonable and appreciated being informed about delays.

Communication and accessibility were supported through bilingual signage, translation services and British Sign Language tools. However, some materials, like the NHS ‘Putting Things Right’ leaflet, were only available in English. There was no visible evidence of feedback-driven improvements, such as a ‘you said, we did’ board.

The department promoted equality and accessibility, with wheelchair access, adjustable beds, and hoists. Staff were trained in equality and diversity. Welsh-speaking staff were available, though not always visibly identified.

Overall, the department demonstrated a strong commitment to dignified, timely and individualised care, with areas for improvement in communication visibility and feedback integration.

This is what we recommend the service can improve:

- A bilingual NHS ‘Putting Things Right’ leaflet
- Evidence of feedback, such as a ‘You said, we did’ board.

This is what the service did well:

- The department actively promoted health through bilingual materials
- Patients feedback to the questionnaire was positive
- Efforts to maintain patient privacy and dignity were evident
- Patients were seen promptly, with clear communication about waiting times
- The department promoted equality and accessibility.

Delivery of Safe and Effective Care

Overall summary:
The inspection found that the department generally had comprehensive written procedures and protocols in place, aligned with IR(ME)R regulations. Staff were aware of these procedures and updates were communicated effectively. Referral processes followed national guidelines and audits were underway to address duplicate referrals. However, inconsistencies in diagnostic reference levels (DRLs) and unclear ratification responsibilities were noted, requiring review and clarification.

Entitlement processes for practitioners, operators, and referrers were in place but lacked consistency and clarity, especially for staff outside radiology. The need for clearer documentation of training, competency and scope of practice was emphasised. Procedures for patient identification, pregnancy enquiries and communication of benefits and risks were well established, though some updates were recommended.

Clinical evaluation processes were in place within radiology, but entitlement and audit mechanisms for clinical evaluations outside radiology were insufficient. The audit program was robust but inconsistently applied, with recommendations to improve documentation, set 100% compliance targets and broaden audit scope.

Accidental or unintended exposures were managed through detailed procedures, with learning shared across sites. Most staff felt supported in reporting incidents and but few believed their concerns would be addressed.

Quality control (QC) programs were in place for equipment, though gaps in computerised tomography (CT) QC testing and inconsistencies in baseline values were identified. Infection prevention and control measures were effective and safeguarding protocols were well understood by staff.

Patient records were well maintained, with appropriate documentation of referrals, justification, and clinical evaluations. Efficiency was supported through initiatives like same-day CT scans for suspected malignancies and national pilot programs such as the lung health check.

Immediate assurances:
There was a failure to provide evidence of a robust process in place for the ratification of DRLs or that appropriate actions were taken following advice in the report prepared by the MPEs. There was a need to:

- Establish a robust process to assign and carrying out the actions recommended in the MPE reports and feedback mechanism to ensure the actions have had the desired effect
- Review the process for the establishment and ratification of DRLs and ensure the employer's procedure clearly outlines the agreed process
- Staff should be informed of any changes to DRLs and must read and comply with the employer's procedure.

This is what we recommend the service can improve:

- Review and document the process for the ratification and implementation of DRLs
- Review the entitlement processes, especially for staff outside radiology
- Review the QC programme for equipment and ensure all areas are meeting the level of QC testing and frequency required

This is what the service did well:

- Staff were aware of procedures and updates communicated effectively
- Accidental or unintended exposures were managed through detailed procedures, with learning shared across sites
- Patient records were well maintained, with appropriate documentation of referrals, justification, and clinical evaluations.

Quality of Management and Leadership

Overall summary:
The inspection highlighted a clear governance structure within the radiology department, with the Chief Executive designated as the IR(ME)R employer. While responsibilities were appropriately delegated, senior management presence in the department had been limited, partly due to building works. Plans were in place to improve visibility, communication, and staff engagement through initiatives such as newsletters, safety huddles, and regular staff meetings.

Staff demonstrated awareness of their roles and responsibilities under IR(ME)R and relevant procedures. However, concerns were raised about night shift staffing levels, with only two radiographers scheduled, potentially leaving one alone. A business case for a third night staff member had been submitted. Training compliance was generally good, with clear systems in place to track and notify staff of training needs. However, gaps were found in infection prevention training. Inconsistencies in competency and entitlement records, particularly for radiographers acting as non-medical referrers and operators in fluoroscopy were also identified.

The entitlement process lacked alignment with the employer's procedures and some records were outdated or incomplete. The department was advised to ensure entitlement reviews were clearly evidenced at regular intervals, such as during personal development reviews (PDRs) and that all staff involved in fluoroscopy were appropriately entitled.

Appraisal completion stood at 75%, with plans to improve this. Responses from staff in the survey were mixed, with most of the negative responses relating to management and staffing issues. Most respondents were satisfied with the quality of care and support they gave to patients.

In terms of culture, patient complaints were well managed and analysed for themes. Staff were aware of the complaints process and learning was shared across the department. Patient feedback mechanisms were in place and the department considered appointing patient experience champions. While staff understood the duty of candour, not all had received formal training.

This is what we recommend the service can improve:

- Improve the entitlement process
- Enhance staff engagement and communication
- Night shift staffing levels.

This is what the service did well:

- A clear governance structure
- Training compliance was generally good, with clear systems in place to track and notify staff of training needs
- Complaints were well managed and analysed for themes.

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 at Prince Charles Hospital to complement the HIW inspection in May 2025.

In total, we received 22 responses from patients at this setting., with all but one of the respondents who answered rating the service as 'very good' or 'good' and felt they were involved as much as they wanted to be in decisions about their treatment. The three comments we received about the service were:

> ***"Very friendly and treated my daughter kindly as was nervous."***
>
> ***"The staff are very rude; the environment is untidy."***
>
> ***"Dementia patients no support for patient or family."***

Person-centred

Health promotion
Health promotion material was displayed in the waiting areas within the department. This included information on the benefits of adopting a healthy lifestyle and smoking cessation.

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

Dignified and respectful care
Reception and clinical staff were observed speaking to patients in a polite, friendly and professional manner. Staff were seen explaining information patiently to some patients despite difficulties with the noise from building refurbishments.

Suitable arrangements were in place to promote patient privacy and we noted staff made efforts to promote patents' privacy and dignity.

The reception area was well lit open and could be busy, with wipeable seating in a good condition. This open plan reception area meant patients could hear other patients names and addresses when checking in. We were told that a quiet room could be used if patients required it, but this was not advertised. We were told that the department were considering installing screens in reception to reduce the risk of patient details being overheard.

Individual changing rooms were available providing privacy when patients were required to change out of their clothes for their procedure. Doors to rooms where X-rays were performed were closed when being used and the rooms with spacious and clean.

All but two patients in the questionnaire felt they were treated with dignity and respect and felt staff listened to them and answered their questions. All but two patients agreed that measures were taken to protect their privacy. Most patients were able to speak to staff without being overheard by other patients or service users.

Most staff respondents thought patients' privacy and dignity was maintained and all but one agreed that patients were informed and involved in decisions about their care. No respondents felt there were enough staff for them to do their job properly and less than half said they have adequate materials, supplies and equipment to do their work.

Individualised care

There was ongoing building works at the hospital that had led to a relocation of services. The works were currently at phase two of the refurbishment which was due to complete shortly. The radiology department was clean and well-lit despite the building works. There were two X-ray rooms, one computed tomography (CT) scanner, a second CT in the emergency department and one fluoroscopy suite currently in the radiology department. On completion of phase two, the department would have four X-ray rooms and a second CT scanner would be moved into radiology and fluoroscopy moved nearer to the X-ray rooms. One X-ray room contained an Orthopantomogram (OPT) and lateral cephalogram equipment, both items of dental equipment. The second X-ray room had intraoral radiography equipment.

There were diagnostic reference levels (DRLs) on display in the rooms and local benefits and risks posters were on display throughout the waiting areas, including the CT scanner in the emergency department.

All but one patient in the questionnaire felt they were involved as much as they wanted to be in decisions about their examination ~~and~~ that staff explained what

they were doing. All but one patient said they were given information on how to care for themselves following their examination.

Timely

Timely care
During the inspection, patients were seen in a timely manner. Staff we spoke with explained the arrangements for communicating waiting times to patients within the department, including verbally informing the reception of any delay. Reception staff also told us that they would advise patients in the waiting area if there were any delays. There was also a sign in reception informing patients to speak with reception staff if the delay was more than 30 minutes after the agreed appointment time.

All but one respondent to our questionnaire agreed that the wait between referral and appointment was reasonable, 77 percent (%) 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
There was a suggestion box in the main reception with blank forms for patients to complete. Whilst we saw a 'Have your say' poster with a quick response (QR) code seen in one sub waiting area, this was not seen in the main waiting area. The NHS 'putting things right' posters was on display in the department. The leaflet was also available behind the reception desk, but this was only available in English.

Staff we spoke with said that they would try to resolve any concerns or complaints initially at the point the issue was raised. Then it would be escalated to management.

We did not see anything on display to show how the organisation had learned and improved based on feedback received such as a 'you said, we did' board. The department stated that there had not been sufficient data to arrive at any issues currently.

The employer must ensure that:

- **The NHS 'putting things right' leaflets are also available in Welsh in the reception**

- **The department show they had learned and improved based on feedback received on a 'you said, we did' board or similar.**

Posters seen were generally in an easy read format and there were iPads available at various points within the hospital for British Sign Language translation. A translation service was also available for staff to use for various languages. Whilst there was not a hearing loop in the main reception, there was a hearing loop in the sub waiting areas.

We saw a 'iaith gwaith' poster behind reception to indicate to patients that staff could speak Welsh at the department. Whilst we did not see staff wearing a 'iaith gwaith' badge, or other visual prompts to indicate they spoke Welsh, we were told there were several members of staff who could speak Welsh. There was also a list in reception of the Welsh speakers at the department.

The majority of patients said they were sable to find the department easily and most patients said they were given written information on who to contact for advice about any aftereffects from my examination.

Rights and equality
There were arrangements in place to make the service accessible to patients, this included good wheelchair level access, spacious corridors and treatment areas. Staff we spoke with said that equality and diversity was promoted within the organisation. This included everyone being treated fairly and there were equality and diversity policies and processes that included staff training. The examination beds could be lowered to enable easy access for patients and there were also hoists available.

There were also arrangements in place to ensure that transgender patients were appropriately placed upholding their equality rights. Staff told us that they would address patients by their known name.

In the patient questionnaire, four patients said they felt they could not access the right healthcare at the right time regardless of any protected characteristic. Additionally, one patient said they had faced discrimination when accessing or using this health service. They commented:

> ***"Dementia patients no support for patient or family."***

The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.

Delivery of Safe and Effective Care

Compliance with The Ionising Radiation (Medical Exposure) Regulations 2017 (as amended)[1]

Employer's Duties: establishment of general procedures, protocols and quality assurance programmes

Procedures and protocols
The employer had written employer's procedures and protocols in place as required under IR(ME)R. They were found to be detailed. The service had a good process for ensuring non-medical referrers had access to the most recent employer's procedures. This now needs to be extended to all referrers in line with the amendments.

Staff we spoke with were able to confirm, when questioned, where the written employer's procedure and protocols were available for reference. Staff also described how reviews and amendments to the written procedures and protocols were communicated to staff.

Senior staff we spoke with also described the process for reviewing and revising the employer's procedures and protocols.

Some specific improvements and amendments were recommended as part of the inspection. These were shared with senior staff throughout the SAF evaluation meeting and inspection.

Referral guidelines
The self-assessment form (SAF), submitted by the department in advance of the inspection, described how referrals were made in accordance with the latest Royal College of Radiologists imaging referral guidelines 'iRefer' which could be accessed from any NHS Wales site. GPs could access these through the local medical committee and the entitlement letter described how to access iRefer. The Faculty of General Dental Practice (FGDP) selection criteria for dental radiography were used as the dental referral guidelines.

The process for making, amending, and cancelling any referrals for exposure were described in an employer's written procedure. It was noted the document was

[1] As amended by the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2018 and the Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024

created March 2025 however the footer noted October 2018. An audit process had been started exploring the frequency and reasons for duplicate radiology referrals, which was considered an area of good practice.

The employer must ensure that that document control measures are followed and the footer accurately reflects the date the document was created.

For theatre referrals, the surgeon completed the radiology referral form prior to the exposure. The dose and any other relevant information were recorded on this form and scanned onto the relevant system, after each case.

Diagnostic reference levels (DRLs)
There was an employer's procedure on the use and review of DRLs which described the process for establishing, using and reviewing DRLs.

Senior staff described the process, whereby the medical physics experts (MPEs) provided recommended DRL values following completion of a dose audit. Where a suggested local DRL appeared to exceed the national DRL value, the MPE would document the requirement for further investigation and optimisation in the MPE report.

On speaking with staff, it was unclear who was responsible for the ratification of the DRLs. It was also unclear who was responsible for the justification of local DRL where they exceeded national DRL values.

The last dose audit performed by medical physics was completed in 2022, with the 2025 dose audit currently being undertaken at the time of inspection. On review of the DRLs displayed in the department and the 2022 MPE dose audit report, there were discrepancies found between the recommended local DRLs and the DRLs available in the department. It was unclear whether MPE recommendations had been actioned. As evidence of how these local DRLs were ratified or justified (where exceeding national DRL values) was not available during the inspection, it was not possible to determine the origin of these values.

As a result of the findings and discussion with staff, we could not be assured that there was a robust process in place for the ratification of DRLs or that appropriate actions were taken following advice in the report prepared by the MPEs. The employer should therefore investigate the impact of the findings, review the process for the establishment and ratification of DRLs and ensure the employer's procedure clearly outlined the agreed process. Staff should be informed of any changes to DRLs and must read and comply with the updated employer's procedure. This finding was also reported in the inspection dated 11 and 12

December 2018. This was addressed under our immediate assurance process at Appendix B.

Staff we spoke with were aware of the DRLs in the department as well as the procedure setting out the actions required when local DRLs were consistently exceeded. This included escalating the issue to the relevant manager and recording the information on the relevant form. The trends were reviewed by the X-ray lead radiographer monthly.

Medical research
We reviewed the relevant employer's procedure for exposures carried out as part of medical research programmes which outlined the necessary governance arrangements and processes to manage research exposures. However, whilst the department did not participate in research, we noted that the procedure was well written.

Entitlement
Staff we spoke with were aware of their duties and scope of entitlement under IR(ME)R and described their entitlement form which outlined their scope of practice.

Entitlement was delegated from the employer (chief executive) to the medical director and from there to the clinical director (CD) for radiology. The service described the entitlement process, where the CD for radiology sent a group entitlement letter to each relevant CD. Within the letter it required the relevant CD to ensure the individual was trained and competent to perform the relevant duty holder tasks. However, in terms of process, the entitler did not receive assurance of training and competency prior to entitlement. The department was advised that training and competency must be assessed prior to entitlement.

The employer must ensure that training and competency is evidenced prior to duty holder entitlement.

The medical director was responsible for assessing the competency prior to entitlement of the radiology CD. However, the relevant employer's procedure did not outline who was responsible for entitling the radiology clinical director.

The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.

The radiology CD entitled the Everlight radiologists through group entitlement. There was a list of the individuals under this group entitlement available to staff.

Evidence of entitlement for medical referrers from other health boards and trusts was not available during the inspection. At the time of the inspection the service did not have a process for sharing the employer's procedures or referral guidelines with this cohort.

The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.

The non-medical referrer entitlement letter was reviewed. It was signed by the superintendent radiographer. However, the employer's procedure identified the radiology CD as the entitler. Senior staff we spoke with confirmed the CD for radiology was responsible for the entitlement of non-medical referrers. The department was advised to ensure it was clear in the entitlement letter who was responsible for entitlement of the duty holder.

The employer must ensure that the entitlement letter of non-medical referrers is signed by the appropriate entitler in accordance with the employer's procedures.

We noted that some non-medical referrers were performing the task of clinically evaluating outside the scope of their entitlement. The entitlement letter evidenced the referrer entitlement and scope of practice in relation to their referrer duties only. The service was advised to review the process of entitlement in relation to operators who were carrying out clinical evaluation.

The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.

During the review of entitlement records, it was noted radiographer were entitled as practitioners for certain CT examinations. However, the department described the process where a radiographer would compare the referral against a set of authorisation guidelines. Where CT exposures sat outside these guidelines, the radiologist acted as practitioner. On further discussion, staff were unclear if the radiographers were acting as a practitioner in this regard or authorising under authorisation guidelines.

The service was advised to review this process to determine if the radiographer was justifying the exposure as a practitioner or authorising the exposure as an operator using authorisation guidelines. If the radiographer was authorising under authorisation guidelines, the guidelines must be issued by an individually named

practitioner, who was responsible for the issuing of authorisation guidelines and takes responsibility for the justification of the exposures listed within.

The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.

During record keeping checks, it was sometimes unclear who acted as the practitioner. For example, in one record the cardiologist signed to state they had justified the examination. However, the cardiologist did not have supporting practitioner entitlement. A similar gap was identified with the gastroenterologists. A gap was also identified with duty holders outside radiology in terms of evidencing operator entitlement for the task of clinical evaluation. The service was advised to review this and ensure the appropriate individuals were entitled with a defined scope of practice and the entitlement was underpinned with training and competency.

The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.

The relevant employer's procedure on the identification of the individuals entitled to act as duty holders was unclear as to who was responsible for entitling operators. We were told that the radiology clinical director entitled radiographers and operators outside radiology. The procedure for entitling practitioners was detailed in the University Health Board's Ionising Radiation Protection Policy.

The employer must ensure that the employer's procedure is updated to reflect further detail and clarification around the processes for duty holders outside radiology and the review of training and competency prior to entitlement.

The issues with entitlement and scope of practice evidenced for duty holders outside radiology (e.g. operators for clinical evaluation) were also highlighted in the previous inspection.

Patient identification
We reviewed the employer's procedure for the correct identification of the individual to be exposed to ionising radiation. Staff we spoke with were aware of the procedure to identify correctly individuals as well as the procedure to identify correctly individuals who may not be able to identify themselves. This aligned to the processes described in the procedure.

The SAF described the observational audits carried out to ensure procedures were correctly followed and to identify any instances of non-compliance. These audits involved observing staff as they performed identity checks before conducting X-ray examinations. Any non-compliance detected during these audits, we were told, was promptly addressed to uphold high standards of practice and ensure patient safety. Retrospective audits using Radis were also performed to monitor operator compliance with procedures.

Individuals of childbearing potential (pregnancy enquiries)
An employer's procedure was in place for making enquiries of individuals of childbearing potential to establish whether the individual was or may be pregnant or breastfeeding. Staff we spoke with described the procedure for making enquiries of individuals of childbearing potential to establish pregnancy. The processes described were consistent with the employer's procedure.

In the procedure, it described theatre staff checking documentation. It was unclear who was performing operator tasks in relation to this. Staff identified the radiographer as the operator for the task of pregnancy enquiry in theatre. The procedure should be clear who was acting as the operator in relation to pregnancy enquiry and the individual must be appropriately entitled.

The employer must ensure that the procedure accurately reflects who is acting as the operator in relation to pregnancy enquiries and that they are appropriately entitled.

There were processes in place to alert individuals who were, or may be, pregnant, that they should inform staff prior to the exposure. These included posters, appointment letters and verbal reminders when the patient attended for the examination.

Benefits and risks
Arrangements were described for providing patients with adequate information on the benefits of having the examination and the risks associated with the radiation dose. We saw posters explaining the benefits and risks clearly displayed within the waiting areas. 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.

When considering how benefits and risks were communicated outside radiology, senior staff we spoke with said that they were currently working with the surgical team on the benefit and risk conversation. During conversations with the MPEs, the MPEs described efforts ongoing to be involved in providing radiation protection training for trainee surgeons.

There was an employer's procedure for the provision of information to patient, their parent, or representative, on benefits and risk associated with radiation dose from exposure. The SAF reiterated that the operator initiating the X-ray exposure would verbally provide the information.

In cases where the patient requested further information regarding the risk and benefit the operator could offer further information, examples of which were included within the employer's procedure.

We were told that radiology staff received training in relation to the benefit risk conversation through preceptorship. It was also discussed during the medical induction process.

In the patient questionnaire, all but two of the respondents said they were provided with enough information to understand the benefits and risks of the procedure.

Clinical evaluation
There was an employer's procedure in place for carrying out and recording an evaluation of medical exposures performed at the department. The SAF described how clinical evaluation was undertaken and evidenced for each type of exposure.

There was no evidence of training records or entitlement for staff performing clinical evaluation outside radiology.

Cardiology staff were entitled through group entitlement and had individual training and competency records to support the entitlement. On review of cardiologist entitlement records, there was evidence of entitlement for referrer and operator duty holders. However, on discussion with staff and through a review of records it appeared the cardiologist may also be acting as practitioner in justifying the exposure.

The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.

An audit of clinical evaluations recorded on RadIS was performed routinely. However, there was no process to audit clinical evaluation performed outside radiology. This was previously reported in the inspection dated 11 and 12 December 2018.

The employer must ensure clinical evaluations performed by individuals outside radiology are audited on a regular basis.

Non-medical imaging exposures
There was an employer's procedure in place for non-medical imaging. We were told that non-medical imaging referrals would only be accepted from registered healthcare professionals. The non-medical imaging supplementary entitlement was reviewed during record keeping, it detailed the individual's scope of practice in relation to non-medical imaging.

Information provided showed that there had not been any non-medical imaging in the last 12 months.

The employer's procedure for non-medical exposures contained an out-of-date reference to 'BIR SCOR RSR 2015…', the current version was dated 2020, this must be updated.

The employer must ensure that the employer's procedure is updated to contain the correct reference.

Employer's duties: clinical audit
IR(ME)R tells us that clinical audit means the systematic examination or review of medical radiological procedures which seek to improve the quality and outcome of patient care through a structured review, whereby medical radiological practices, procedures and results were examined against agreed standards for good medical radiological procedures, with modification of practices, where indicated and the application of new standards if necessary.

The SAF described the clinical audit program and the process to register and agree the audits. An audit management and tracking tool (AMaT)was used to register audits, to upload the agendas of meetings and the results, and to manage post audit actions. The employer's procedure detailed the process for the carrying out of clinical audits and for any appropriate action to be taken following review of the findings and results.

There were some good examples of clinical audit provided as evidence during the inspection. Audits were performed every three months, the results were fed back to the department leads, where compliance had not been achieved. Audit compliance information from the modality leads was forwarded to the QA lead.

We were provided with a copy of the clinical audit schedule for 2025. The employer's procedure noted that the audit programme should include a list of scheduled audits, timeframes and frequency of audit and the individuals

responsible for performing the audit and ensuring findings were actioned. There were two types of clinical audit programmes in place. The department was currently undergoing a transition process in relation to this. The AMaT covered aspects of the clinical audit schedule. The department had a new audit lead radiographer and this role was being developed into a cross-site role.

Whilst the AMaT template was robust, it had not been used consistently across all audits. One audit checked on CT head requests was a good example of the template evidencing robust clinical audit. The department must consider ensuring all AMaT forms were completed fully to ensure a robust audit.

The employer must ensure that:

- **All AMaT forms are completed fully to support robust audit**

- **The clinical audit schedule includes the list of all scheduled audits, timeframes and frequency of audit and the individuals responsible for performing the audit and ensuring findings are actioned.**

For audit of reject analysis, the data was pulled from the equipment on a regular basis across the health board. Conclusions and recommendations were shared with the imaging optimisation teams (IOTs) and user group meetings to disseminate learning to staff. The IOT, also discussed quality improvement and clinical effectiveness. Any trends identified would be informed to the professional head of radiography and the superintendent radiographer, would work with the individual staff using an action plan to support this. This was a relatively new process that was being implementing on site. For wider dissemination, a generalised email was sent to the team providing details on shared learning.

Shared learning outside radiology, was currently disseminated through the medical director. Where an audit had relevance for other directorates, the service aimed to have representation from that directorate at the next clinical audit meeting.

Core IR(ME)R compliance audits had been identified and delegated to responsible individuals, with evidence of compliance submitted and reviewed. These audits included the completion of radiology referral forms and reject image analysis, with any trends or themes of non-compliance or areas of concern escalated to the radiation safety committee.

Some of the IR(ME)R audits included, fitted more in line with clinical audit. The IR(ME)R audit schedule was also detailed and clearly identified objectives, responsible individuals and timeframes. However, for both the observational and referral form audits:

- Target compliance was unclear on the reports. Targets should be set at 100% for these audits as they were compliance audits. On the referral form audit compliance was noted as achieved despite 100% compliance not being achieved

- The reports lacked robust analysis of results

- The referral form audit did not include an action plan as outlined in the employer's procedure

- The reports noted that where compliance declined, an interim audit may be performed. As this was a compliance audit, the service should reaudit where the target (100%) had not been achieved, rather than when compliance declined. For example, the initial observational audit was in January 2024, with a reaudit in March 2025 despite compliance not being achieved in January 2024. Similarly with the request forms, 100% compliance was not achieved in terms of recording dose, evidencing justification and authorisation and evidencing the operator in November 2023. This continued to be an issue in December 2024.

The employer must ensure that the:

- **Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe**

- **Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.**

Employer's duties: accidental or unintended exposures
We discussed the six significant accidental or unintended exposures that had been notified to HIW in the last two years. We noted that measures had been put in place to mitigate the risks, including providing extra training, disseminating shared learning and sharing incident alerts with staff. Also, additional training had been provided to all staff to support understanding in terms of the different protocols.

The employer's procedure for reporting and investigation of significant or clinically significant accidental or unintended exposures was very detailed.

The SAF described the process for the immediate management, investigation and follow-up actions of significant accidental or unintended exposures involving ionising radiation. This included removing the equipment from clinical service, if necessary, ensuring that details of the incident were recorded on DATIX and

reporting to HIW in line with SAUE guidance. Thematic analysis and root cause of all radiation incidents and near misses was carried out as they emerged.

The SAF described how all incidents across all hospital sites were analysed together and learning shared via an incident alert. The department had a liaison person nominated for the incident, who would communicate with the patient or representative. The decision to not inform the patient or representative was the role of the clinical director for radiology, the MPE and the referrer. The decision would be documented on DATIX and investigation report. It was recommended to the service to detail these aspects within the relevant employer's procedure.

The incident alerts were shared across all sites with all modality leads. If there were any relevant teams outside radiology involved, it would also be shared with them. An incident alert was noted for staff in the radiography processing area during the department tour.

Staff we spoke with were aware of the procedure for reporting accidental or unintended exposures. They confirmed that learning from incidents was shared. Senior staff we spoke with were also able to describe the procedure for reporting accidental or unintended exposures and other incidents and how learning from incidents, as well as IR(ME)R incidents was shared.

All respondents said their organisation encouraged them to report errors, near misses or incidents and most felt staff who were involved were treated fairly. Whilst 83% of staff said that if they were concerned about unsafe practice, would you know how to report it, just over half said they would feel secure raising concerns about unsafe clinical practice. Fewer (21%) were confident their concerns would be addressed and five answered 'don't know'. Additionally comments and percentages were:

- Their organisation encouraged staff to raise concerns when something had gone wrong and to share this with the patient - 75%

- When errors, near misses or incidents were reported, the organisation took action to ensure they did not happen again - 63%

- They were given feedback about changes made in response to reported errors, near misses and incidents - 38%.

Duties of referrer, practitioner and operator
The entitlement of referrers, practitioners and operators to carry out their duties was included in an employer's procedure and described in the completed SAF. The

SAF also described the training programmes in place for all duty holders under IR(ME)R and how training records for practitioners and operators were managed.

Senior staff we spoke with described how the employer ensured operators and practitioners such as radiologists and those outside radiology were appropriately trained and competent. For specified examinations, the imaging had a canned report on RadIS, directing the individual to where the clinical evaluation was recorded, the department did not currently audit this.

The employer must ensure that there are regular audits of the clinical evaluations performed by the individuals outside radiology.

In terms of entitlement for individuals outside radiology, there was no evidence of training or entitlement for staff performing clinical evaluation outside radiology.

The employer must ensure the entitlement process is robust and staff performing clinical evaluation are appropriately trained and entitled prior to carrying out this task.

Justification of individual exposures
The SAF described the processes of how justification and authorisation was performed and where this was recorded. Whilst staff we spoke with described what they considered when justifying exposures, there appeared to be some confusion around justification and authorising under authorisation guidelines.

The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.

There was a written employer's procedure for justification and authorisation of medical exposures. This stated that, "the practioner (sic) would document the name of the practioner (sic) on the referral form e.g., Everlight". However, it was the radiographer (operator) who documented the name of the practitioner. The procedure needed to be updated to reflect this accurately.

The employer must ensure that the procedure is amended to correctly reflect the actions that needed to be taken when justifying and authorising medical exposures.

Optimisation
An image optimisation team (IOT) had been established. The SAF described how any changes to DRLs would be reviewed via this team. The IOT was chaired by the

Health and Safety Superintendent, to discuss quality improvement and clinical effectiveness as well as reviewing IR(ME)R audits.

The SAF also described how practitioners and operators ensured doses were optimised including exposures to children, high dose exposures and persons who may be pregnant and breast feeding. 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.

Paediatrics
The department provided paediatric imaging. The SAF described how practitioners and operators ensured that the exposure was justified and doses were optimised. Trained operators would use specific protocols as well as paediatric exposure charts in the general X-ray rooms. The CT scanners and General X-ray rooms could provide preset exposures depending on the patient's age. These could then be manually adjusted accordingly to the individual child's size and weight.

There was a member of the medical physics team currently leading on paediatric dose audits. However, the paediatric cohort and sufficiency of data was small.

Carers or comforters
There was a suitable employer's procedure in place to establish appropriate dose constraints and guidance for the exposures of carers and comforters for the department. The process for recording justification of exposures to carers and comforters had recently changed. It was now evidenced on the carers and comforters form. The superintendent radiographer would audit compliance of this whilst scanning the forms onto the system monthly.

Staff we spoke with were aware of the guidance in relation to carers and comforters, this included completing the relevant form, checking for pregnancy and wearing a lead gown.

Expert advice
We saw evidence that the MPE was involved in every type of diagnostic practice, including providing expert advice on compliance with all aspects of IR(ME)R. A list of the typical type of advice offered by the MPEs was listed in the SAF. This included review of patient dose auditing and QA reports, establishing and implementing QC tests (level B QC) and advice and training of operators for level A QC tests.

MPE reports were sent to the professional head of radiography and senior leadership within the organisation. Depending on the nature of the report, it would

be sent to a site-specific lead or a modality lead. For organisation wide dissemination, the report would go through the radiation protection committee (RPC) or be sent directly to specific senior individuals. For example, a more localised topic will go to the relevant individual involved. The MPEs would also indicate who the report should be shared with and how it could be disseminated more widely.

Where tolerances were exceeded during level A testing, if it was a remedial level, the MPE would be contacted, and a decision made whether the equipment could remain in use. If suspension levels were exceeded the equipment was suspended until the issue had been identified and rectified.

Any actions regarding equipment would be documented on an equipment log. The professional head of radiography would email the modality lead to ensure the recommendations had been actioned. Actions were also discussed and minuted at the RPC.

The MPEs had recently provided training for level A quality control testing to radiographers in specific modalities, which was positive to note. The MPEs would provide additional training as requested. We were told that the MPEs recently held a radiation protection supervisor training day, with half the training day focused on IR(ME)R. Staff we spoke with said they were aware of how to access MPE advice.

Equipment: general duties of the employer
We noted the employer's procedure for ensuring that quality assurance programmes in respect of written procedures, written protocols and equipment were followed and the policy for Quality Assurance and Routine Testing of Diagnostic Imaging Equipment.

The SAF described the quality assurance programme in place for all relevant equipment including testing of any equipment before first use, performance testing at regular intervals and testing following maintenance.

We noted that the health board had a QA coordinator to oversee the development and instigation of routine performance testing on all X-ray equipment. There was a lead radiographer for quality assurance who had oversight as well as the oversight of the RPC.

The routine testing for C-arms used in theatre had been added to an appendix in the QA policy. Baselines were established six weeks previously and the department intended to perform the QC every three months. The orthopantomogram (OPG) testing as described in the QC policy (for the Royal Glamorgan Hospital) was the

same process for the OPG at Prince Charles Hospital. The service needed to update the policy to accurately reflect this.

We noted gaps in the CT QC testing, the reasons behind this were not clear or whether these gaps had been appropriately escalated. Whilst the QC was audited, following discussion with senior staff the department would focus on in-depth detail to ensure it was being performed.

The CT QC folders were reviewed in the department. The folders contained instructions on the manufacturer recommended testing. Some of the baseline values in the manufacturer document differed from the QC policy and it was difficult to determine if QC results had exceeded tolerances. The department needed to review this with support from the MPEs.

The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.

The MPEs we spoke with noted they had not been involved in the level A QC testing policy but noted this as a priority to review.

We noted that the equipment inventory was compliant with the requirements of IR(ME)R 2017. The software inventory had the current install date and date of installation as the same dates for all software. The department confirmed there had been no updates to software versions.

At the time of submitting the SAF, the service had not been using artificial intelligence (AI) software. However, since the SAF submission, the AI was being used to support chest reporting and for CT colons. The AI software was being used in an assistive capacity with the operator carrying out the formal clinical evaluation.

Safe

Risk management
The environment of the department was accessible with disabled access and facilities for people with mobility difficulties. There was good signage from the temporary entrance, because of building work, to the department. The environment was clean and in a good state of repair, including furniture, fixtures and fittings. The department was fit for purpose with enough chairs and facilities. There was a large spacious main waiting area with a small sub-waiting area. We saw that patient flow was controlled and with no overcrowding observed. The area was safe and secure, with no hazards such as blocked corridors, clutter or tripping hazards. Patient areas and corridors were kept clear.

Infection prevention and control (IPC) and decontamination

All areas seen in the department were clean and well maintained, despite the building work. There were suitable handwashing and drying facilities available and staff were seen using relevant personal protective equipment. IPC policies and procedures were in place and staff knew how to access them.

Staff we spoke with were aware of their responsibilities in relation to IPC and decontamination and were able to describe how medical devices, equipment and relevant areas of the unit were decontaminated. Personal protective equipment (PPE) was available within the examination rooms and staff we spoke with confirmed they had access to suitable PPE which was readily available.

Most patients who expressed an opinion in the questionnaire said that IPC measures were being followed and all but one felt the setting was clean. Most staff respondents thought the organisation implemented an effective infection control policy and that there was appropriate PPE supplied and used. However fewer than half of respondents felt there was an effective cleaning schedule in place and just over half felt that the environment allowed for effective infection control.

Safeguarding of children and safeguarding adults

Staff we spoke with were aware of the health board's policies and procedures on safeguarding and where to access these. All staff we spoke with were able to describe the actions they would take if they had a safeguarding concern. They were aware of the health board's policies and procedures on safeguarding and where to access these.

We examined a sample of five staff training records which showed that four of the five staff were up to date with safeguarding training, completed at an appropriate level according to their role within the department. Senior staff we spoke with stated that they had arranged bespoke radiology safeguarding training for radiology staff.

Effective

Patient records

We found there were suitable arrangements in place for the management of records used within the department.

We checked a sample of five patient referral documentation, a mixture of current and retrospective referrals. 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.

We were told that regarding the confirmation of pregnancy status, the pregnancy enquiry process changed on 28 April 2025. Previously signatures were not required, the requirement for patient and staff signatures was then introduced.

There was evidence of clinical evaluation for each type of exposure included in the episode of care. The canned report on theatre exposures did not direct the reader to where the clinical evaluation was available but it did note the referring clinician performing the evaluation. For endoscopic retrograde cholangio pancreatography (ERCP), canned reports were directing to the Welsh Clinical Portal, the clinical evaluation was reviewed on the Welsh Clinical Portal.

Efficient

Efficient
The arrangements and systems in place to promote an efficient service were described. Examples included:

- Rapid access chest clinic, if a patient was identified in the chest clinic as needing a CT they could have a scan the same day
- If patient had a specific suspicious malignancy they could have a same day CT
- Working with an imaging academy training programme on a QA project to improve cannulation delays
- Lung health checks, the health board were piloting this and leading the rolling out of this nationally.

Quality of Management and Leadership

Staff feedback- *delete section if staff questionnaires have not been used and include feedback under individual sub sections.*

HIW issued an online questionnaire to obtain staff views on services carried out at Prince Charles Hospital and their experience of working there. The questionnaire complements the HIW inspection in May 2025. In total, we received 24 responses from staff. Responses from staff were mixed, with most of the negative responses relating to management and staffing issues. All but two respondents were satisfied with the quality of care and support they gave to patients. However, fewer (59%) agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family and less than half (29%) recommended their organisation as a place to work.

We received comments on the service, some of which were:

> ***"This department has no leadership or management; staff problems are not dealt with. Staff feel alone and not supported, issues and problems are not dealt with and left to fester causing staff distress. Managers are not approachable and if you take an issue to them you are made to feel stupid and incompetent."***

> ***"Most of the issues we face in department come from lack of staffing (particularly out-of-hours) and poor communication from management with lack of staff consultation of decisions. When asking advice or alerting certain members of management to emerging issues in department, the response can often feel hostile and accusatory. On the plus side, patient care and efficiency are definitely the priority of the department, but often to the detriment or at the expense of staff/staff wellbeing."***

Leadership

Governance and leadership

The Chief Executive was designated as the 'employer' in relation to 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.

The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements, where needed. They were also keen

to put processes in place to address previous issues, including ensuring a senior management presence at the department.

There was a clear governance and management structure demonstrated within the self-assessment, which was completed comprehensively, as well as being provided within the timescale required. The SAF was also completed, with all supporting documents in a timely manner.

Staff we spoke with were aware of where to find general polices relevant to their practice and had a good understanding of their roles and responsibilities under IR(ME)R as well as the health and care quality standards.

Staff we spoke with said that senior managers did not visit the department on a regular basis. Senior staff we spoke with said they had a plan to make sure there was management presence on each of the three main hospital sites in the health board on each day. This was to provide support and to speak to staff and follow up on issues and to ensure that staff felt valued. They believed that managers presence at the department had been a challenge due to the ongoing building work at the site and the managers' office had been away from the department. Now the manager was based at the department, the next step would be to bring the consultants back into the radiology area.

Senior staff also said they had acted recently to improve communication with staff such as a quarterly newsletter for staff to look at it and to engage staff, as well as sharing incidents and user groups to capture info. They were also keen to start continuous professional development (CPD) lunch time sessions. Management agreed that regular staff meetings needed to restart, at various levels such as the Professional Head of Radiography meeting with the band sevens, the band sevens meeting with the band sixes and onwards. There was also a band five healthcare support worker (HCSW) who was overseeing the HCSWs.

Management was also considering introducing safety huddles such as a '10 at 10'.

Staff we spoke with said that they were made aware of reviews and amendments of general policies and procedures by email. They also stated that they would have to sign to say they had read and understood the changes. Senior staff described the process to change policies and procedures, through various groupings. They stated they were looking at introducing a document management system and streamlining protocols across the health board prior to the new radiology information system.

Staff percentages agreeing with the comments of the organisation were as follows:

- My organisation was supportive --8%

- My organisation supported staff to identify and solve problems - 8%

- My organisation took swift action to improve when necessary - 4%.

Few respondents felt their immediate manager could be counted on to help them with a difficult task at work (29%) and fewer said their manager asks for their opinion before making decisions that affect their work (17%). Furthermore only 25% agreed that their immediate manager gave them clear feedback on their work. Very few respondents felt that senior managers were visible (17%) and that communication between senior management and staff was effective (12%). More staff, 41% agreed that senior managers were committed to patient care. Some comments we received on management were:

> ***"Some managers are more visible than others, I feel it's unsafe that since we are short staffed at the minute they have been taking staff off the night shift to cover the day shifts, and it is concerning as this could be unsafe on nights and the staff weren't consulted about this..."***
>
> ***"There is a lack of support from managers in the setting which then impacts mental health."***
>
> ***"Management aren't on the floor so don't understand what is happening in their own department; when those of us who are clinical mention problems, we can for see getting worse we are written off every time without clear reasoning or excuses. We aren't allowed a day in the deployment of staff to make the department run in an efficient and safe manner; we haven't got a guarantee of three nights shift staff which leaves us vulnerable out of hours, especially when there is only one CT trained member of staff. The system is incredibly fragile and doesn't allow us to give patients the best care we can."***
>
> ***"Communication between senior management and line management with staff is poor. Lack of staff on night shifts, unsafe working conditions..."***
>
> ***"Management are only concerned about how many patients you can fit in, irrelevant of how many staff are in. We have proved that 3 members of staff are needed on a night although when we cannot staff this (by overtime) the day lists should be cancelled and a staff member moved from the day onto the night, but this is not done. If I ask my line manager for help with an issue, there is usually a feeling they do not want to help (or do not know how to help as they don't work clinically). Overall,***

management have made me want to come to work less and less over the last few years, through poor work life balance and lack of communication when decisions are made. Also, when asking for help my line manager can be quite unhelpful."

"Complete lack of support from management and huge disregard for staff wellbeing. We have lost multiple members of staff for these reasons. Management do not welcome feedback, or ideas to improve the service for patients. Lack of responsibility from managers, would rather staff argue amongst themselves than admit when they have said/done something wrong. This causes a very unpleasant working environment amongst staff."

"The managers totally ignore us. If we do something correct, they don't care. If we do something wrong, we are made to feel like idiots. The staffing at the moment is disgusting. There isn't any training or attempts to do CPD projects for the department. We are lost at sea like a rudderless ship. There are no signs of improvement. Everybody works incredibly hard whilst management seem to not care in the slightest."

"Listen to staff:
- appropriate number of members of staff on nights 2 on a 12 hour shift is not enough and very dangerous especially for sliding/ making the work flow easier and more effective and also for patient care and safety…."

"The reception area doesn't feel safe as it {is}. It is too open to the public."

Workforce

Skilled and enabled workforce
Staff we spoke with felt that the number and skill mix of staff in the department was appropriate by day but that there was concern about the safety of staff on night shifts as the established number of two radiographers could result in one member of staff being alone at times. There had been an unofficial programme recently of three radiographers on duty at night.

Senior staff said there was not an establishment for three staff at night but they considered there was a requirement for a third. We were told that a business case had been submitted to this effect. Additionally, out of hours acuity and demand had increased.

The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.

Whilst staff believed there was generally enough time to perform their duties, they did not believe there was additional time to complete their required training.

We checked a sample of five individual staff records and noted that all the staff had completed resuscitation training in both adult and paediatric resuscitation. However, only two out of the five had completed IPC training at level two. Overall departmental compliance on ESR system was 80.82%. Training records were clear and there was an appropriate system to identify when training was due on the electronic staff record (ESR). Compliance status and expiry dates were clearly displayed within the ESR system. In addition to staff being informed by ESR when training was due, management were also informed monthly by senior management. There was also a module of the month highlighted by management to staff.

There was clear evidence that staff have completed suitable training on equipment, radiation protection and statutory obligations relating to ionising radiations. We noted good induction records for new staff. There was clear evidence that staff had completed suitable training relevant to their area of work with some evidence of DRL training. The induction presentation for medical staff from the consultant radiologist and the e-modules described were also positive to note.

There were some mismatches and gaps identified between competency and entitlement records. For radiographers acting as non-medical referrers, the entitlement process deviated from the process described in the employer's procedures. This was where there was not clear evidence of assessing competencies with some gaps in dates and trainers signature for CT. There was also one record with no evidence of a CT competency assessment. Regarding evidence of entitlement there were inconsistencies between one entitlement record and the entitlement matrix. We also noted the radiologist who acted as an operator to perform an exposure in fluoroscopy was not entitled for this exposure.

Non-medical referrers were required to receive sufficient training to ensure familiarity with the principles set out in this guidance and completed several relevant e-learning modules on ESR which was seen as an area of good practice.

The SAF stated that the Head of Radiology was responsible to ensure that all staff received appropriate training before completing practitioner and operator functions. It further stated that training records were to be assessed during personal development reviews (PDRs) and the entitlement matrix were updated accordingly. We noted that two documents supplied as evidence with the SAF, the radiologist entitlement and evidence and the radiographer entitlement. Both documents were dated several years ago (2018/2019). We were told that

entitlement was reviewed during annual appraisal but this did not appear to be evidenced. However, it was unclear whether this occurred on the records checked. There was an entitlement matrix, during record keeping it was noted that the matrix did not match the entitlement record on every occasion. The department was advised to include a method to evidence review of entitlement to ensure the entitlement record accurately reflected the individual's entitlements.

The employer must ensure that the process to ensure that training records and the review of entitlement are checked at suitable intervals and evidenced appropriately.

Staff we spoke with were aware of the occupational health support available. However, not all staff we spoke with said they had received regular supervision and appraisals in the last 12 months. This was supported by the percentage of appraisals completed, which was at 75%. In the staff questionnaire, around half of the respondents said they have had an appraisal, annual review or development review of their work. Management stated they received regular updates and reports on the percentage compliance and had a plan to increase this number.

The health board is to inform HIW of the actions taken to increase this percentage compliance.

In the staff questionnaire, regarding their health and wellbeing at work, only 38% of staff agreed that, in general, their job was not detrimental to their health and 22% said that their organisation took positive action on health and wellbeing. More staff, 54% stated that their current working pattern and off duty allowed for a good work-life balance and 63% were aware of the occupational health support available to them.

Many respondents (70%) felt they had appropriate training to undertake their role, the remainder felt they had 'partially' received appropriate training. Some comments received on professional development were:

> ***"No training on new X ray rooms after refurbishment."***
>
> ***"I originally had appropriate training in my role, although, where new equipment has been installed in the refurbishment (CT control panel) I have had no training at all and expected to just know how it works, with very little help from management."***
>
> ***"More input from (Department withheld} superintendent during training, and better structured training/planning during this would've been appreciated (more focus on sign-off sheets etc). Training across***

department is more ad-hoc than actively planned and feels too individual-led."

"QA training not complete. {Department withheld} training post - no sign off sheets provided, need better structure and planning, is more ad hoc than planned."

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.

Culture

People engagement, feedback and learning
Staff we spoke with stated that verbal complaints would be dealt with on the day, although they would still be logged with Patient Advice and Liaison Service (PALS). These complaints would be dealt with by the radiographers who would complete a complaints form. There had been 22 complaints about the health board radiology department in the last 12 months. These were analysed by theme within the department. Management had set up a dashboard for these complaints.

The department told us that they worked with the 'putting things right' (PTR) to close the complaints in a timely manner. The complaints were reported to the clinical governance care group. There was good evidence to show that complaints were well managed and well controlled.

Senior staff described the arrangements in place to allow patients to provide feedback or raise concerns. Senior staff worked on patient feedback and were considering appointing patient experience champions at each site. Patient feedback could be provided by paper forms and online.

Staff we spoke with were aware of the process of how verbal and informal concerns (complaints) were captured. Staff said that information from complaints was shared mainly by emails and there was sharing of learning across the departments and organisation.

Staff we spoke with were able to describe the duty of candour procedure but not all could confirm whether they had received duty of candour training. For the questions asked about the duty of candour in the questionnaire, just over half agreed that they knew and understood the Duty of Candour and understood their role in meeting the Duty of Candour standards.

The health board must ensure that all staff receive duty of candour training.

Whilst only 25% of staff agreed that patient or service user experience feedback was collected within the department, 29% did not know and only 8% of staff said they received regular updates on patient or service user experience feedback. Whilst only one respondent said that feedback from patients or service users was used to make informed decisions within the department, 12 said they did not know.

In total 57% of patients said they would know how to complain about poor service, if they wanted to.

Other responses in the staff questionnaire were as follows:

- Care of patients was the organisation's top priority - 79%
- Overall, staff were content with the efforts of the organisation to keep staff and patients safe - 42%
- They were involved in deciding on changes introduced that affected their work area - 17%
- They were able to meet the conflicting demands on their time at work - 38%
- They were able to access ICT systems needed 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 summarises 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 as this inspection			

Appendix B – Immediate improvement plan

Service: Diagnostic Imaging Department, Prince Charles Hospital

Date of inspection: 20 and 21 May 2025

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
1.	We reviewed the Diagnostic Reference Levels (DRLs) and found that local DRLs for certain examinations exceeded national DRLs. We reviewed the dose audit report. The MPE report recommended local DRL values for these examinations that were either equivalent to or below the national DRL. We found that the local DRLs available in the department	The employer must ensure that: • The ratification process for DRLs is robust and clearly outlined in the employer's procedure	Ionising Radiation (Medical Exposure) Regulations 2017 regulation 12 (1) and (3), regulation 6 (5) (c) and Schedule 2, 1 (f)	Amend EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose reference levels to ensure the ratification process for DRLs is robust. Amended EP to be shared with the chair of the Radiation Safety Committee for ratification prior to the	Sarah Rees Sarah Rees	Complete 22.5.25 Complete 29.5.25

	differed from the recommended local DRLs in the MPE report. On discussion with staff, it was not possible to determine the origin of the local DRL values, which were available and on display in the department. During discussions with senior staff, evidence could not be provided on how these values were agreed and ratified prior to them being put into clinical use. Staff could not demonstrate how the local DRL values, which exceeded national DRL values, had been justified by the employer. On discussion with the MPEs, they explained that the local DRL values on display may have been based on equipment specific mean dose values,	• The current DRLs are reviewed immediately to ensure that they are appropriate		next meeting (October 2025) Current DRLs reviewed and cross referenced with Radiation Protection Service Cardiff's dose audit 1 December 2021 and 31 May 2022. No Local DRLs exceed National DRLs. Current DRLs removed, National DRLs displayed until local DRLs ratified. CTM DRL group to be set up to provide close monitoring of any optimisation required prior to ratification, acceptance and implementation of DRLs. The DRL group will feed into CTM image optimisation team and radiation safety committee.	Sarah Rees Sarah Rees Alex Wallace	Complete 22.5.25 Complete 2.6.25 Inaugural meeting 5.6.25

	rather than the recommended values. We were also told by the MPEs, that findings from the dose audits carried out in 2018, 2022 and 2025 showed a reduction in dose, evidencing optimisation. The 2025 dose audit is awaiting agreement and publication. As a result of the findings and discussion with staff, we could not be assured that there was a robust process in place for the ratification of DRLs or that appropriate actions were taken following advice in the report prepared by the MPEs.	• If local DRLs exceed national DRLs, the decision is justified by the Employer and evidenced, with consideration for optimisation or further investigation • Any changes to DRLs are communicated to staff and staff read and comply with the		It is not expected that CTMUHB local DRLs will exceed national DRLs. However, EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose reference levels has been amended to include that if local DRLs exceed national DRLs, the decision is justified and documented by the Head of Radiography and Medical Physics Expert, with evidence of consideration/completion of optimisation or further investigation Following ratification, the updated DRLs and EP6 Schedule 2, 1 (f) Procedure for the use and review of diagnostic reference level and dose	Sarah Rees Sarah Rees	Complete 29.5.25 2.6.25

		employer's procedure in relation to the use and review of DRLs.		reference levels will be emailed to all staff. These will be made available on SharePoint. These will be discussed and confirmed in relevant modality user group, CTM Image Optimisation Team, Radiology Clinical Governance and Radiation Safety Committee. A read and sign confirmation will be sent to staff via Microsoft forms to provide evidence of receipt. Compliance will continue to be monitored via the 'DRL Exceeded Logbook' audit	Sarah Rees Andrew Thomas	2.6.25 27.6.25

	The department provided further clarification to HIW comments.	HIW comment	PCH comment
		The improvement plan (the service) described national DRLs being displayed currently:	
		It was unclear if the service has followed the ratification process described in the revised employer's procedure to adopt the national DRLs. Could you please confirm that adoption of the national DRLs has been ratified by the radiation safety committee for use at PCH?	These documents have been approved out of committee through RSC Chairs actions and will be formally ratified at the next RSC meeting. Confirmation of approval has been sent via email to all RSC members by the Deputy Director of Allied Health Professions and Health Science (RSC chair).
		The service provided a document titled 'CT diagnostic reference levels'. This document appeared to contain local DRLs, which would contradict the statement in the action plan around the use of national DRLs. The document lists an author, but it was unclear if these local DRLs had been ratified as per process described in the procedure. It was also unclear if this document was in use at PCH. Could you please clarity these points.	In the interim, local DRLs were removed and replaced with national DRL. Subsequently, revised DRLs incorporating both national and, where applicable, local DRLs were ratified and have now been implemented within PCH CT. An amendment has been made to the CT DRLs document to evidence that the document had been ratified through RSC. Ratified DRLs are currently on display in the CT control rooms at Prince Charles Hospital.

		In terms of the employer's procedure in relation to the use and review of the DRLs:	
		The service described the individuals responsible for the justification of local DRLs where they exceed national DRLs. However, it was unclear how the employer was informed of this. Could you provide assurance in relation to this and this should be reflected in the relevant procedure (or policy)?	The employer's procedure will be updated to state that, following each RSC meeting, a written highlight report will be prepared by the Head of Radiography to inform the Executive Team of any radiation safety matters requiring escalation. If applicable, the report will also include justification for any local DRL that exceed the national DRL.
		The service described the introduction of a DRL group. This should be detailed in the relevant procedure and where this sits in relation to the governance structure around DRLs.	The employer's procedure will be revised to specify that the DRL group is accountable for auditing and monitoring DRLs, as well as identifying optimisation opportunities to be escalated and reviewed at Image Optimisation Group.

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): **Sharon Donovan**

Job role: **Head of Radiography**

Date: **2.6.25**

Appendix C - Improvement plan

Service: Diagnostic Imaging Department, Prince Charles Hospital

Date of inspection: 20 and 21 May 2025

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.	The process for making, amending, and cancelling any referrals for exposure were described in an employer's written procedure. It was noted the document was created March 2025 however the footer noted October 2018.	The employer must ensure that document control measures are followed and the footer accurately reflects the date the document was created.	Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Regulation 6, Schedule 2 (1) (p)	Footer amended to display March 2025. Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP. All amended EPs will be shared and acknowledgement of changes required and recorded.	Sarah Rees Melanie Barker Sarah Rees	Complete 17.7.25 By end of August 2025 By end of September 2025

				Amended EPs will be added to CTMUHB SharePoint.	Sarah Rees	By end of September 2025
2.	In terms of process, the entitler did not receive assurance of training and competency prior to entitlement. The department was advised that training and competency must be assessed prior to entitlement.	The employer must ensure that training and competency is evidenced prior to duty holder entitlement.	IR(ME)R Regulation 17, Schedule 2 (1) (b), Schedule 3	Review existing practitioner and operator duty holders training and competency evidence. Ensure that practitioner and operator training and competency prior to entitlement is assessed for specific tasks e.g. Cardiologists practitioner training to justify imaging in theatre Duty holder competency will be assessed by ongoing referral form audit i.e. accurate completion of request form; signature, adequate clinical information, date.	Alex Wallace Sarah Rees Ian Mcquilham Sally Bolt	By end of September 2025

3.	The medical director was responsible for assessing the competency prior to entitlement of the radiology CD. However, the relevant employer's procedure did not outline who was responsible for entitling the radiology clinical director.	The employer must ensure that the employer's procedure is updated to reflect the process of entitlement for the radiology clinical director.	IR(ME)R Schedule 2 (1) (b)	EP2 – Schedule 2, 1 (b) Procedure for the identification of the individuals entitled to act as referrer or Practitioner or Operator within a specified scope of practice Page 5 amended to include medical director responsibility for entitling radiology clinical director.	Sarah Rees	Complete 17.7.25
				Deputy Director of Allied Health Professions and Health Science, Corporate Development, outside of Radiation Safety Committee, will ratify EP.	Melanie Barker	By end of August 2025
				All amended EPs will be shared and acknowledgement of changes required and recorded.	Sarah Rees	By end of September 2025
				Amended EPs will be added to CTMUHB SharePoint.	Sarah Rees	By end of September 2025

4.	Evidence of entitlement for medical referrers from other health boards and trusts was not available during the inspection. At the time of the inspection the service did not have a process for sharing the employer's procedures or referral guidelines with this cohort.	The employer must ensure referrers external to the health board are appropriately entitled as referrers and have access to the employer's procedures.	IR(ME)R Regulation 10 (1), Schedule 2 (1)(b)	PACs team to generate a list of individual external referrers with GMC numbers. Scoping work to commence internally and nationally re: practicable ways to issue entitlement to external referrers.	Sharon Donovan	By w/c 11th August.
				CTMHUB employer's procedures will be available via the intranet to employers/referrers outside CTMUHB.	Sarah Rees	August 2025
				Entitlement will be issued to external referrers in other health boards via email to indicate their duty holder roles and responsibilities, information on how to access referral guidelines, and how to make/amend/ cancel a referral.	Sally Bolt	End of August 2025
				CTMUHB is leading a benchmarking exercise to	Sharon Donovan	End of August 2025

				understand the approaches in place across Wales Discussion and escalation at national groups, with a view to developing an agreed All Wales approach. Entitlement of external referrers will be an agenda item at the following groups: The All-Wales Imaging Quality Forum Radiography Professional Heads Group	Melanie Barker Sarah Rees Sharon Donovan	 3.9.25 13.8.25
5.	The non-medical referrer entitlement letter was reviewed. It was signed by the superintendent radiographer. However, the employer's procedure identified the radiology CD as the entitler. Senior staff we spoke with confirmed	The employer must ensure that the entitlement letter of non-medical referrers is signed by the appropriate entitler in accordance with the employer's procedures.	IR(ME)R Regulation 6 (1), Schedule 2 (1) (b)	Non-Medical referrer entitlement letter template updated to include Radiology Clinical Director as responsible for entitlement of non-medical referrers.	Sarah Rees	Complete 21.7.25

	the CD for radiology was responsible for the entitlement of non-medical referrers. The department was advised to ensure it was clear in the entitlement letter who was responsible for entitlement of the duty holder.					
6.	We noted that some non-medical referrers were performing the task of clinically evaluating outside the scope of their entitlement. The entitlement letter evidenced the referrer entitlement and scope of practice in relation to their referrer duties only. The service was advised to review the process of entitlement in relation to operators who are carrying out clinical evaluation.	The employer must ensure that the non-medical referrers who were clinically evaluating are appropriately entitled and that the entitlement is supported by relevant training and competency.	IR(ME)R, Regulation 6 (1), Schedule 2 (1) (b)	Review of NMR documentation in relation to operators that carry out clinical evaluation. Scope of practice for clinical evaluation and entitlement by Radiology CD will be sent to existing NMRs on receipt of evidence of training and competency. Policy for NMRs will be updated to include entitlement for clinical evaluation.	Ian Mcilquham	Complete May 2025 By end of September 2025 By end of September 2025

7.	The service was advised to review this process to determine if the radiographer was justifying the exposure as a practitioner or authorising the exposure as an operator using authorisation guidelines. If the radiographer was authorising under authorisation guidelines, the guidelines must be issued by an individually named practitioner, who was responsible for the issuing of authorisation guidelines and takes responsibility for the justification of the exposures listed within.	The employer must ensure that there is a better understanding and staff are clear of the separate role of the practitioner justifying the exposure and operator authorising under authorisation guidelines.	IR(ME)R Regulation 11 (1) (b)	Email all CT staff to remind them of: their responsibilities as a practitioner, justifying the exposure; the role of the operator authorising under authorisation guidelines. Retrospective audit of CT forms justified by a Radiographer to ensure exposures have been justified appropriately. To be discussed at CT modality user group meeting, pan-CTM to clarify justification or authorisation process for Radiographers. If authorisation as an operator is agreed, guidelines will be issued by an individually named practitioner.	Sarah Rees Sarah Rees Sarah Rees Sally Bolt	Complete 31.7.25 By end of August 2025 By end of September 2025 By end of October 2025

8.	During record keeping checks it was sometimes unclear who acted as the practitioner. For example, in one record the cardiologist signed to state they had justified the examination. However, the cardiologist did not have supporting practitioner entitlement. A similar gap was identified with the gastroenterologists. A gap was also identified with duty holders outside radiology in terms of evidencing operator entitlement for the task of clinical evaluation. The service was advised to review this and ensure the appropriate individuals were entitled with a defined scope of practice and the entitlement was underpinned with training and competency.	The employer must ensure that individuals outside radiology performing practitioner and operator tasks are appropriately entitled. The entitlement should be underpinned with the appropriate training and competency.	IR(ME)R Regulation 10 (3), Regulation 11, Regulation 12 (9), Regulation 17 (4)	Review duty holder entitlement outside of Radiology. Identify any gaps and entitle, where appropriate, following confirmation of training and competency.	Alex Wallace and Sarah Rees	30 September 2025

	On review of cardiologist entitlement records, there was evidence of entitlement for referrer and operator duty holders. However, on discussion with staff and through a review of records it appeared the cardiologist may also be acting as practitioner in justifying the exposure.					
9.	The relevant employer's procedure on the identification of the individuals entitled to act as duty holders was unclear as to who was responsible for entitling operators. We were told that the radiology clinical director entitled radiographers and operators outside radiology.	The employer must ensure that the employer's procedure is updated to reflect further detail and clarification around the processes for duty holders outside radiology and the review of training and competency prior to entitlement.	IR(ME)R Regulation 6 (1), Schedule 2 (1) (b)	EP2 – Schedule 2, 1 (b) Procedure for the identification of the individuals entitled to act as referrer or Practitioner or Operator within a specified scope of practice amended to clarify that the Professional Head of Radiography will entitle Radiographers as referrers, practitioners and operators.	Sarah Rees	Complete 21.7.25

				The Radiology Clinical Director will entitle the Professional Head of Radiography to entitle Radiographers. The Radiology Clinical Director will entitle medical and non-medical referrers.		
10.	In the procedure, it described theatre staff checking documentation. It was unclear who was performing operator tasks in relation to this. Staff identified the radiographer as the operator for the task of pregnancy enquiry in theatre. The procedure should be clear who was acting as the operator in relation to pregnancy enquiry and the individual must be appropriately entitled.	The employer must ensure that the procedure accurately reflects who is acting as the operator in relation to pregnancy enquiries and that they are appropriately entitled.	IR(ME)R Regulation 6, Schedule 2 (1) (c)	Amended EP3 – Schedule 2, 1 (c) Procedure for making enquiries of individuals of childbearing potential to establish whether the individual maybe pregnant or breastfeeding: Page 7 clarifies Radiographers are appropriately entitled as operators and perform the pregnancy check in theatre.	Sarah Rees	Complete 17.7.25

11.	The employer's procedure for non-medical exposures contained an out-of-date reference to 'BIR SCOR RSR 2015…', the current version is dated 2020, this must be updated.	The employer must ensure that the employer's procedure is updated to contain the correct reference.	IR(ME)R Schedule 2 (1) (m)	EP13 Schedule 2, 1 (m) Procedure for non-medical exposures updated to include 2020 version	Sarah Rees	Complete 17.7.25
12.	Whilst the AMaT template was robust, it had not been used consistently across all audits. One audit checked on CT head requests was a good example of the template evidencing robust clinical audit. The department must consider ensuring all AMaT forms were completed fully to ensure a robust audit.	The employer must ensure that: • All AMaT forms are completed fully to support robust audit • The clinical audit schedule includes the list of all scheduled audits, timeframes and frequency of audit and the individuals responsible for performing the audit	IR(ME)R Regulation 7, Schedule 2 (1) (o)	Meet with clinical audit team, and radiology audit leads to ensure that all audits are registered on AMaT, and all documentation is complete. Ensure clinical audit schedule is updated to include timeframes, frequency of audit and responsible person for carrying out audit.	Alex Wallace	End of October 2025

		and ensuring findings are actioned.				
13.	Some of the IR(ME)R audits included, fitted more in line with clinical audit. The IR(ME)R audit schedule was also detailed and clearly identified objectives, responsible individuals and timeframes. • Target compliance was unclear on the reports. • The reports lacked robust analysis of results • The referral form audit did not include an action plan as outlined in the employer's procedure • The reports noted that where compliance declined, an interim audit	The employer must ensure that the: • Compliance targets for IR(ME)R audits should be set at 100%, with robust analysis and appropriate reaudit within a specified timeframe • Scope of IR(ME)R audits should be broadened to include clinical evaluation outside radiology.	IR(ME)R Regulation 6 (2), Schedule 2 (1 (j)	Review of observational and referral form compliance audit. Target for compliance set to 100%. Observation and referral form audit will be added to AMaT system to ensure action plans in place, robust analysis and re-audit in an appropriate time frame. Clinical evaluation audit outside Radiology to be added to IR(ME)R schedule i.e., evidence of clinical evaluation documented within patient notes. Audit frequency changed from annual to every 2 months. Reaudit of areas	Sarah Rees Sarah Rees Alex Wallace Sarah Rees Alex Wallace Sarah Rees	Complete May 2025 Complete 14.7.25 End of October 2025 End of September 2025 End of August 2025

	may be performed. As this was a compliance audit, the service should reaudit where the target (100%) had not been achieved, rather than when compliance declined.			that fall below 100% will take place as required.		
14.	There was a written employer's procedure for justification and authorisation of medical exposures. This stated that, "the practioner (sic) would document the name of the practioner (sic) on the referral form e.g., Everlight". However, it was the radiographer (operator) who documented the name of the practitioner. The procedure needed to be updated to reflect this accurately.	The employer must ensure that the procedure is amended to correctly reflect the actions that needed to be taken when justifying and authorising medical exposures.	IR(ME)R Regulation 11	EP19 Procedure for justification and authorisation of medical exposure Page 5 amended to clarify that the operator documents the name of the practitioner on the referral form. EP will be ratified via chairs action outside Radiation Safety Committee. All amended EPs will be shared and acknowledgement of changes required and recorded.	Sarah Rees	Complete 21.7.25

				Amended EPs will be added to CTMUHB SharePoint.		
15.	Some of the baseline values in the manufacturer document differed from the QC policy and it was difficult to determine if QC results had exceeded tolerances. The department needed to review this with support from the MPEs.	The employer must review the gaps in the QC records and the inconsistencies in baselines between the policy and manufacturer recommendations.	IR(ME)R Regulation 15 (1)	QC gaps reviewed and addressed. Documentation updated to ensure all QC tests required are included. Meeting with MPEs to review baselines and manufacturer recommendations. Will review policy and amend.	Marc Phillips Sharon Donovan Andrew Thomas	Complete 17.7.25 29.7.25
16.	There was an entitlement matrix, during record keeping it was noted that the matrix did not match the entitlement record on every occasion. The department was advised to include a method to evidence review of entitlement to ensure the entitlement record	The employer must ensure that the process to ensure that training records and the review of entitlement are checked at suitable intervals and evidenced appropriately.	IR(ME)R Regulation 6 (3) (b), Schedule 2 (1) (b)	All training records and entitlement will be reviewed at personal development reviews. All staff that perform PDR's will be reminded. The process has been reviewed to ensure any changes are identified are documented. Develop	Alex Wallace Alex Wallace	July 2025 End of August 2025

	accurately reflected the individual's entitlements.			proforma to evidence review and prompt update of entitlement and matrix.		
17.	An audit of clinical evaluations recorded on RadIS was performed routinely. However, there was no process to audit clinical evaluation performed outside radiology. This was previously reported in the inspection dated 11 and 12 December 2018. For specified examinations, the imaging had a canned report on RadIS, directing the individual to where the clinical evaluation was recorded, the department did not currently audit this.	The employer must ensure clinical evaluations performed by individuals outside radiology are audited on a regular basis.	IR(ME)R Regulation 7, Schedule 2 (1) (o)	Audit of orthopaedic follow up referrals to be implemented. IR(ME)R audit schedule updated to include frequency.	Alex Wallace	September 2025

18.	Whilst staff we spoke with described what they considered when justifying exposures, there appeared to be some confusion around justification and authorising under authorisation guidelines.	The employer must ensure that staff are reminded of the intellectual task of justification and exposure and how this differs to authorising under authorisation guidelines.	IR(ME)R Regulation 10 (2)	CPD session to be delivered on changes to employers procedures to include the difference between justification and authorisation.	Alex Wallace	September 2025
19.	We did not see anything on display to show how the organisation had learned and improved based on feedback received such as a 'you said, we did' board. The department stated that there had not been sufficient data to arrive at any issues currently.	The employer must ensure that: • The NHS 'putting things right' leaflets are also available in Welsh in the reception (H&CQS – Communication and Language) • The department show they had learned and improved based on feedback received	H&CQS – Communication and Language.	Putting things right leaflets will be available in Welsh. Patient experience champions have been appointed on each site to support gathering of feedback. Feedback Friday to be implemented i.e., staff will actively ask patients to give feedback	Alex Wallace Alex Wallace Sarah Rees	August 2025 July 2025 August 2025

		on a 'you said, we did' board or similar.		Once feedback has been gathered 'you said, we did' board will be displayed		
20.	Senior staff said there was not an establishment for three staff at night but they considered there was a requirement for a third. We were told that a business case had been submitted to this effect. Additionally, out of hours acuity and demand had increased.	The department must continue to highlight the business case to the employer and ensure that a decision is made in a timely manner.	H&CQS - Skilled and enabled workforce	A case has been submitted for additional radiography staff that supports the future workforce model and demand as part of the IMTP investment priorities for 2025-26 across the sites. This will continue to remain the priority for Radiology. To date, no source of funding has been identified. Additional staff have been rostered out of hours at RGH temporarily while services from POW are temporarily relocated.	Carl Verrecchia	April 2026
21.	However, not all staff we spoke with said they had received regular	The health board is to inform HIW of the actions taken to	H&CQS - Skilled and enabled workforce	Action plan developed to support timely appraisals. Dates are pre-planned.	Marc Phillips Bronwyn Baldwin	Ongoing – Dec 2025

	supervision and appraisals in the last 12 months. This was supported by the percentage of appraisals completed, which was at 75%.	increase this percentage compliance.		There is a process for escalation should the expected date not be met. Plan to have documented 1:1 interim meeting every three months to support staff with ongoing objectives and wellbeing Quarterly modality/staff user groups re-established to support peer discussion around performance and development	Marc Phillips Sarah Rees Alex Wallace	End of September 2025 July 2025
22.	Various comments and responses from staff in the questionnaire were mixed, with most of the negative responses relating to management and staffing issues.	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.	H&CQS – Leadership	There are processes in place to address the negative responses and concerns, including staffing. There are already reports of staff confirming that morale in the department is much improved during staff survey face to face discussions.	Sharon Donovan	July / August 2025

				Regular band 7 meetings and information sharing with the 8a site superintendent is contributing to staff feeling more positive. CTMUHB has appointed a Professional Head of Radiography in 2025 who has oversight of each Radiology department and is leading this work. A review of staffing and activity and demand is also underway on all sites to ensure equity and safe working practices.		
				Staff training In CT have been assigned a mentor and the health board are supporting CT staff to attend external CT training courses to further enhance skills.	Sharon Donovan Yana Marie Philpott	June – July 2025
				Radiology has a newly appointed Quality manager in the team who is actively working with the national QSI	Alex Wallace	July 2025

				improvement partner There is investment from the health board to promote and support this work.		
				The Head of Radiography, Quality Team and Directorate Manager have been meeting and working with staff to assure and support in the following ways:	Sharon Donovan Alex Wallace Sarah Rees Ian Mcilquham Bronwyn Baldwin	June 2025
				Re-establishment of modality user groups – promote team communication.	Alex Wallace Sarah Rees	June 2025
				Leadership team development (AFFINA questionnaire and development days)	Bronwyn Baldwin Sarah Rees	July 2025
				Staff Newsletter	Alex Wallace	July 2025
				Pilot of patient safety huddles: share staffing levels, equipment issues, site	Sarah Rees Alex Wallace	June 2025

				concerns – opportunity for staff to voice concerns and feel involved and valued.		
				Patient experience champions on all sites established.	Alex Wallace Sarah Rees	End of September 2025
				Wellbeing champions to be established.	Alex Wallace Sarah Rees	July 2025
				Radiology staff survey roadshow days at all sites. To discuss staff survey themes and listen to areas of concern and ideas for improvement.	Bronwyn Baldwin Sarah Rees Alex Wallace	July 2025
				Preceptorship programme to be developed for Band 7 team leaders.	Alex Wallace	End of December 2025
				Head of Radiography to meet monthly with the Site 8a Superintendents. Communication to be cascaded down to the teams	Sharon Donovan	July 2025

				and staff to escalate concerns and suggestions up. Senior managers have developed a weekly roster across all sites to improve visibility.	Sharon Donovan	May 2025
23.	Staff we spoke with were able to describe the duty of candour procedure but not all could confirm whether they had received duty of candour training.	The health board must ensure that all staff receive duty of candour training.	H&CQS – Culture	Source appropriate duty of candour training for staff i.e., e-learning	Marc Phillips	End of September 2025
24.	Whilst patient comments and responses were generally positive, they were some comments, where four patients said they felt they could not access the right healthcare at the right time regardless of any protected characteristic. Additionally,	The health board is to inform HIW of the actions they will take to ensure all patients have equal and fair access to the right health care at the right time, without fear of discrimination.	H&CQS – Patient Experience	All patients will be treated fairly and in turn in CTMUHB – staff are trained to recognise patients' individual needs and to be always responsive. Staff meetings and PDRs will provide opportunities to remind staff to be alert and sensitive to each service users' needs	Sharon Donovan Marc Phillips	July 2025 onwards

	one patient said they had faced discrimination when accessing or using this health service.			when they are visiting this service. The Health board is actively looking at innovative ways to ensure all patients can access the right healthcare at the right time regardless of any protected characteristic. We will ensure all staff complete mandatory training modules by assigning a module of the month.	Bronwyn Baldwin	June 2025

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): **Sharon Donovan**

Job role: **Professional Head of Radiography**

Date: **24/07/2025**