Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Diagnostic Imaging Department, Nuffield Health Cardiff Bay Hospital

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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 Nuffield Health Cardiff Bay Hospital, on 7 and 8 October 2025. During our inspection we looked at how the department complied with the Regulations and met the National Minimum Standards for Independent Health Care Services in Wales.

Our team for the inspection comprised of two HIW healthcare inspectors and two Specialist Clinical 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. Only one questionnaire was completed by a patient or their carer and 12 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 provided some health promotion resources, including leaflets on healthy eating and drinking and one smoking cessation card, which should be displayed more prominently. Key materials included a pregnancy and breastfeeding advisory poster.

The reception layout supported privacy and confidential discussions occurred in treatment rooms or offices. Treatment rooms were closed when in use and changing facilities were conveniently located. The waiting area was clean, spacious and included refreshments. Staff survey responses confirmed privacy and dignity were upheld, patients were involved in decisions and resources were adequate.

Appointments generally ran on time and staff communicated delays proactively. Most staff reported good system access, organisational support and prioritisation of patient care. Senior managers were visible and committed.

Feedback options included quick response (QR) codes, forms and online reviews, with “You said, we did” evidence displayed. Complaints information was inconsistent, a comprehensive booklet was available, but standardisation was required. Accessibility was supported through hearing loops, bilingual materials and translation services.

Facilities were fully accessible, with inclusive practices for transgender patients and equality training for staff. Diversity was promoted through e-learning, Pride Cymru training and gender inclusivity initiatives.

This is what we recommend the service can improve:

- Ensure that complaints information available to patients is standardised across the department.

This is what the service did well:

- Staff treated patients with kindness and discretion
- Numerous feedback options were available as well as informing patients of the results of the feedback
- Accessibility of facilities.

Delivery of Safe and Effective Care

Overall summary:
The inspection revealed significant gaps in compliance with IR(ME)R regulations, particularly concerning employer responsibilities and governance. Whilst local leadership demonstrated proactive measures by drafting two Employer Procedures (EPs) to address recent regulatory amendments, corporate oversight was weak. Staff were unclear about the designation of the IR(ME)R Employer and evidence suggested the CEO was unaware of their statutory duties.

Many issues identified in the 2015 HIW report remained unresolved, including the need for accurate documentation and robust governance structures. EPs lacked version control, alignment with local practice and correct references to Healthcare Inspectorate Wales as the regulator, with some documents incorrectly citing the Care Quality Commission.

Referral guidelines were based on iRefer, but inconsistencies existed in acceptance processes and documentation control. External referrers did not have access to EPs, which was required under IR(ME)R. Entitlement procedures were unclear, with incorrect duty holder listings and inadequate processes for Medical Physics Experts (MPEs), who were group-entitled by an external organisation rather than individually by the employer.

Clinical practice showed strengths in patient identification and pregnancy enquiry processes, which were inclusive and supported by posters and staff awareness, though a direct link to the safeguarding policy within the pregnancy pathway documentation was not included. Documentation for clinical evaluation and non-medical imaging exposures lacked clarity, particularly for out-of-hours processes.

Audit arrangements were positive, with radiographers leading audits and action plans tracked, but radiologists were not assigned audits and annual IR(ME)R audits by MPEs were not adequate, failing to identify key compliance issues. Incident reporting was strong, with a positive safety culture and multiple mechanisms for sharing learning, but EPs for accidental exposures lacked definitions and referenced the wrong regulator.

Infection control arrangements were generally effective, with good personal protective equipment (PPE) availability and clean environments.

Record-keeping was mostly compliant but showed inconsistencies in identity checks and practitioner sign-off. Equipment quality assurance (QA) programmes were in place, but EPs lacked sufficient detail.

This is what we recommend the service can improve:

- Updating EPs to reflect Welsh regulatory requirements
- Improving QA processes, clarifying employer responsibilities
- Strengthening entitlement procedures
- Involving MPEs in optimisation and audits
- Reviewing paediatric imaging services.

This is what the service did well:

- Local DRLs demonstrated good optimisation of doses
- The environment was clean and in a good state of repair
- The range of audits taking place was seen as positive.

Quality of Management and Leadership

Overall summary:
Staff feedback was highly positive. All respondents were satisfied with the quality of care and support they provided to patients and all but one would recommend the organisation as a place to work. Most staff agreed they would be happy with the standard of care for themselves or their families.

Staff reported feeling well supported by management, noting that senior leaders were visible and approachable. Communication was described as effective, with information shared through emails, verbal updates, online platforms and weekly newsletters. Staff meetings, daily huddles and forums provided opportunities for engagement and managers were praised for involving staff in decision-making. Clear lines of leadership and accountability were evident, supported by questionnaire results showing strong agreement on managerial visibility and communication.

Training and competency records demonstrated that staff had completed appropriate training in radiation safety and statutory obligations. However, some gaps were noted in documentation, such as missing assessor signatures and incorrect IR(ME)R role listings. Mandatory training compliance was high. Staff confirmed that training needs were monitored through a robust system and appraisals were conducted regularly.

Workforce planning was considered effective, with staff reporting adequate numbers and skill mix to perform duties safely. Staff also highlighted organisational efforts to support wellbeing, noting that their roles were not detrimental to health and that work-life balance was maintained. All respondents were aware of occupational health support and felt confident raising concerns under the duty of candour, which they understood well.

Staff engagement with patient feedback was strong, with results displayed in the department and shared through meetings. Complaints were logged and reviewed and staff confirmed that feedback informed service improvements.

This is what we recommend the service can improve:

- Training documentation gaps
- Compliance with portable oxygen cylinder training

This is what the service did well:

- All staff were satisfied with the quality of care provided and would recommend the organisation as a place to work
- Visible leadership, effective communication channels and involvement in decision-making through meetings and forums
- Good organisational support for health and wellbeing, appropriate staffing levels and a positive work-life balance.

3. What we found

Quality of Patient Experience

Patient feedback
HIW issued online and paper questionnaires to obtain patient views on services carried out by Nuffield Health, Cardiff Bay Hospital to complement the HIW inspection in October 2025. As we only received one response we were unable to draw any conclusions or themes from this reply. However, patient feedback was obtained regularly by the hospital.

Health promotion, protection and improvement
The department offered a limited selection of health promotion materials. Leaflets on healthy eating and drinking were available, along with a single information card on smoking cessation. The department were advised that smoking cessation materials should be more prominently displayed in the waiting area. Rather than relying on posters or signage to gather medical information, we were told that staff asked patients about their medical conditions during appointment booking.

The poster advising patients to inform staff if they are pregnant or breastfeeding was prominently displayed in several areas in the department. Additional resources included a “Ready, Teddy, Go” book to explain the Magnetic Resonance Imaging (MRI) scan process to children and a sepsis awareness poster. Symbols were on display with language cards to assist with communication. The patient guide and statement of purpose of the hospital, required by the Independent Health Care (Wales) Regulations 2011, were also available to patients.

Dignity and respect
Staff were observed treating patients with kindness and respect. Reception staff spoke politely and discreetly, ensuring conversations could not be overheard. The reception desk was in the same room as the waiting area, but the L-shaped layout and seating arrangement helped maintain privacy. For confidential discussions, patients were taken to treatment rooms or to office spaces if the conversation was by phone.

There were no environmental issues noted affecting patient dignity. Treatment room doors remained closed during procedures and changing rooms were located close to imaging rooms. The waiting area was clean, tidy and appropriately sized, with ample seating. A small refreshment area was available near reception.

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

Care planning and provision

We observed appointments generally running on time. We were told that X-rays were normally available on the same day and computerised tomography (CT) scans within seven days. Staff proactively informed patients of any delays and reception staff monitored waiting times and alerted clinical staff if necessary.

Most staff in the questionnaire said that they were able to access systems they needed, to provide good care and support for patients and agreed their organisation was supportive, took swift action to improve and prioritised patient care. Similarly, most staff recommended their organisation as a good place to work and were satisfied with care standards.

Most staff thought that care of patients was the organisation's top priority and that overall they were content with the efforts of the organisation to keep them or their patients safe. Senior managers were seen as visible and committed to patient care, with 83% of staff agreeing that senior managers were committed to patient care.

Patient information and consent

Information about how patients and families could provide feedback was displayed throughout the department. Feedback posters with QR codes were available in the waiting room, alongside a survey box and radiology patient satisfaction forms. Reviews were also collected via online platforms. There was evidence on a "You said, we did" poster to show how the hospital had responded to feedback.

Communicating effectively

Complaints information was included in the patient guide, though it lacked details on contacting HIW if a resolution was not achieved. A flowchart and basic complaints information were available from reception, but these also omitted timeframes and external contact details. However, a more comprehensive complaints booklet was available in the waiting room, outlining the process from local resolution to escalation to head office and external bodies, including HIW.

The hospital director must ensure that complaints information available to patients is standardised across the department, to include timescales, information on HIW and escalation support available.

Accessibility was supported through a hearing loop, pictorial signs and sign language cards. Posters such as “Your X-ray and You” provide pre- and post-procedure advice and were available bilingually. Other posters included “Your X-ray Test” and “Tests and Treatments Using Fluoroscopy”. Staff wore ‘Iaith Gwaith’ badges to indicate Welsh language proficiency and Welsh-speaking consultants and radiologists were available.

Staff we spoke with were aware of resources to support patients with hearing, sight or reading difficulties. Translation services were available via an online platform.

People’s rights
The hospital ensured accessibility for all patients. A health passport poster was displayed in the waiting area, encouraging use of the department. All areas were wheelchair accessible, with suitable toilets equipped with emergency cords and handrails. Chaperone information was available at the reception desk.

Staff had access to an accessibility folder containing information explaining sexual orientation terminology, pictorial signs, sign language aids and blank health passports in English and Welsh. Information on autism and dementia awareness was also included. Equality and diversity was actively promoted through e-learning modules, a survey and communications about patient views. Staff training was monitored via an online platform and included quizzes, presentations and gender inclusivity training.

The department ensured transgender patients were appropriately placed, respecting their equality rights through inclusive pregnancy checks. Staff also participated in Pride Cymru training and the Trac programme, supporting inclusive practices across the organisation.

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
Locally, managers ensured that IR(ME)R Employer procedures (EPs) and other documentation and guidance that was issued from Nuffield Health head office were implemented with local guidance. This local guidance was not always documented within the corporately issued EPs to ensure they accurately reflected local practice. In addition, management told us that Nuffield Health had not yet provided Nuffield Health Cardiff Bay with the additional EPs required under schedule 2 of IR(ME)R related to the amendments that were launched in September 2024. Through proactive local leadership, the two EPs related to IR(ME)R amendments were drafted and implemented locally to ensure that the setting was fully compliant with regulations.

The inspection identified that while local leadership was visible and responsive, there were significant gaps in corporate governance and clarity of IR(ME)R responsibilities. Staff were unclear about the designation of the IR(ME)R Employer, with confusion noted across all levels, from the Medical Physics Expert (MPE) service to the Hospital Director and wider corporate teams. The CEO of Nuffield Health was identified as the IR(ME)R Employer, but there was no evidence available to demonstrate that they were aware of their statutory responsibilities under the regulations.

Documentation provided indicated that the Employer under IR(ME)R was the CEO of Nuffield Health and many EPs in place locally appeared to be authored by Nuffield Health colleagues not based in Wales. We were told that colleagues from the wider Nuffield Health organisation were not available for interview during the inspection.

It was disappointing to note that many actions required as a result of this IR(ME)R inspection were also noted with similar actions in the HIW IR(ME)R Inspection report for Nuffield Health Cardiff Bay in 2015. The action plan at that time, indicated that all actions from the 2015 would be completed by February 2016 at the latest. Evidence reviewed during this inspection in 2025, indicated that this

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

has not been the case as many remained unresolved. It must be noted that some ratified EPs indicated that the Care Quality Commission was the regulator for IR(ME)R this is incorrect as Healthcare Inspectorate Wales regulate IR(ME)R for settings in Wales.

The employer must:

- **Update written documentation for Nuffield Health Cardiff to ensure that the correct regulatory authority and associated notification processes and incident thresholds are indicated**

- **Provide evidence that they are aware of their statutory responsibilities under IR(ME)R, including the establishment of robust written procedures and oversight of duty holder roles**

- **Provide a plan on how they will clarify and communicate their role across the organisation**

- **Finalise and document ratification and processes for the sign off of updates or amendments to any EPs used at Nuffield Health Cardiff.**

Procedures and protocols
A full set of EPs required under schedule 2 of IR(ME)R were in place, this included locally issued EPs related to the two recent IR(ME)R amendments. All EPs required a review and update to ensure alignment with local practice and recognition of Welsh based regulatory requirements.

Written EPs were in place and accessible to staff via a file sharing system and printed IR(ME)R files. Staff we spoke with confirmed that arrangements were in place to notify them of updates when managed. Version control and quality assurance (QA) processes were inconsistent. Some documents lacked clarity and updates were not always communicated effectively to staff. An organisation chart needed to be developed to clearly outline governance structures and IR(ME)R responsibilities from corporate to local levels.

The employer must strengthen IR(ME)R governance systems, including the development of a clear organisational chart linking corporate and local governance structures.

The EP for QA lacked sufficient detail and version control. Supplementary guidance and links should be added to enhance clarity and usability.

The employer must:

- **Improve the QA process for documentation, including version control, review cycles and communication of updates to staff**

- **Update the EP for QA.**

Referral guidelines
Referral criteria were based on iRefer guidelines and were made available to all referrers. However, inconsistencies were noted in referral acceptance processes and documentation control. Management told us that external referrers did not have access to EPs, this is required in line with IR(ME)R. This was identified in the previous inspection when external referrers needed to be informed of the referral guidelines in use and reminded of their responsibilities as described in the employer's procedures. Additionally, the report identified the need to review the content of some of the procedures to ensure they reflect what happens in practice.

The employer must review and update the referral process to ensure clarity and that it reflects local practice. This update must also include a process for how EPs are shared with all referrers.

Diagnostic reference levels (DRLs)
Staff we spoke with described the action they would take should they identify a DRL that had been consistently exceeded. Local DRLs were established and monitored, with audits conducted to ensure compliance. Some local DRLs exceeded national levels due to technique variation. Staff confirmed a range of ways to optimise doses to ensure that they were as low as reasonably practicable (ALARP).

Medical research
No research involving medical exposures was currently undertaken at this site.

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

There was an EP in place to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice. However, the process for entitlement within the EP was not clear and did not include all staff groups. There were actions required at corporate level to ensure documents provided to sites were fit for purpose and the process was clear.

Entitlement records were generally well maintained, locally. However, some duty holders were listed incorrectly (e.g. practitioners performing operator tasks). There was not a consistent process in place to entitle Medical Physics Experts (MPEs) appropriately. Evidence reviewed confirmed MPEs were group entitled by their employer St George's University Hospitals NHS Foundation Trust (St George's) rather than in line with regulatory requirements and entitled by the Nuffield IR(ME)R Employer and entitled individually to better reflect their specific scope of practice. The process for entitling MPEs must be reviewed and updated. The previous report identified that the entitlement procedure needs to be reviewed and amended to explain how duty holders are entitled and refer to their scope of practice.

The employer must ensure that the EP for entitlement Reg 6 Schedule 2 1 (b) includes:

- **A clear process that includes all staff groups acting in duty holder roles**
- **Corporate level documents that are fit for purpose and ensure that the process is clear**
- **Procedures which use correct IR(ME)R terminology and definitions**
- **Entitlement of groups such as referrers which is robust and includes access to referral guidelines**
- **Clear records and documentation that confirms non-medical referrers are not performing clinical evaluation.**

The employer must further ensure that:

- **The entitlement matrix reflects the individual duty holders and records review dates**
- **Entitlement letters are issued by the appropriate IR(ME)R Employer and reflect accurate scope of practice for all duty holders.**

Patient identification

There was an EP in place to correctly identify the individual to be exposed to ionising radiation. Processes were in place for verifying patient identity (ID), including use of three identifiers and 'Pause and Check' and we saw posters to this effect around the department. Staff we spoke with also had a clear understanding of the correct patient identification process. The procedure did not include actions to take when there were discrepancies with patient identification. This detail

would ensure that staff knew when they could proceed and when they needed to go back to the referrer.

We saw evidence relating to making amending and cancelling a referral, where the operator was allowed to change the laterality of the examination without checking with the referrer. This was not detailed in the relevant EP. We also noted that on occasion record keeping in relation to patient identification was inconsistent in some areas.

The employer must update the EP for patient identification to ensure that it fully details when a member of staff can and cannot proceed if there are discrepancies and detail the process of checking.

Individuals of childbearing potential (pregnancy enquiries)
There was an employer's written procedure in place for making enquiries of individuals of childbearing potential, to establish whether the individual was or may be pregnant or breastfeeding. Staff confirmed that inclusive procedures were in place for pregnancy enquiries, with training provided. We reviewed this as notable practice. We saw posters displayed in waiting rooms and other areas of the imaging department to highlight the importance of disclosing the possibility of pregnancy and informing patients of inclusive pregnancy status. Safeguarding links to the EP for minors that may be pregnant would benefit from being added. The previous report included an action for the new pregnancy procedure to be produced which will be amended to include the child protection and Nuffield safeguarding procedure as recommended.

The employer must ensure that the EP includes links to the safeguarding policy and the need to ensure that the local safeguarding teams are informed when a child provides a positive response to the pregnancy question.

Benefits and risks
Information on the benefits and radiation risks was communicated with patients via leaflets, posters and verbal discussion. Staff demonstrated awareness and confirmed that they would refer to a manager if further information or clarification was required.

Clinical evaluation
Clinical evaluation was generally well documented. Some gaps were noted during record keeping checks in practitioner sign-off and identification records. In addition, it was not clear from documentation reviewed, who was performing clinical evaluation out of hours, or where this was documented.

The employer must update the employer process for clinical evaluation. This must specify operator tasks and ensure that the process for performing clinical evaluation out of hours is clear, documented appropriately and reflects clinical practice.

Non-medical imaging exposures
Senior staff confirmed that non-medical imaging exposures were performed in the department. There was an EP in place for these exposures. However, the procedure was unclear and did not specify how these referrals were made, who could refer and if prior clinical history or imaging was checked prior to the exposure.

The employer must review and update the EP for non-medical imaging and ensure that it accurately and correctly reflects clinical practice locally.

Employer's duties - clinical audit
An audit schedule was in place and we reviewed evidence of a range of different audits provided, including clinical audits. Radiographers took responsibility for at least one audit within the department which supported continuous professional development, accountability and Health and Care Professions Council (HCPC) standards. Action plans were developed and tracked, with outcomes shared across teams. Every six months an audit report summarising clinical and IR(ME)R audits performed was produced and shared with departmental staff and clinical governance team. Whilst the range of audits taking place was seen as positive, we noted that radiologists were not assigned audits to lead. Best practice would be to include radiologists in the audit process.

During the inspection we reviewed the annual report from an IR(ME)R compliance audit completed by the MPE service in August 2025. This report did not identify the majority of the issues noted during this IR(ME)R inspection.

The employer must ensure that any commissioned annual IR(ME)R audit is fit for purpose and ensures that current IR(ME)R legislation, regulator guidance and best practice are audited. (IR(ME)R Reg 14)

Employer's duties - accidental or unintended exposures
Staff members we spoke with were able to describe the processes for reporting incidents related to accidental or unintended exposures and this included submitting the details onto the quality management system known as RADAR.

Incident reporting was well established and encouraged, with a strong safety culture. Staff were aware of procedures and learning was shared effectively.

Multiple mechanisms were in place for sharing learning from incidents and near misses.

The EP relating to accidental or unintended exposures did not include any definitions for accidental or unintended exposures, was generic in nature covering Ionising Radiation Regulations (IRR) 2017 as well as IR(ME)R. The EP directed services to the English regulator rather than HIW for reporting. There was no mention of informing the patient and where that information was recorded. In addition, the significant accidental or unintended exposures (SAUE) guidance table at the end of this document was out of date.

The employer must

- **Fully review and update the EP for accidental and unintended exposure. This should include definitions, detail on what constitutes an accidental or unintended exposure, up to date references and details on the appropriate regulator for Wales**

- **Improve trend analysis for SAUE and clinically SAUE and compare local to corporate findings. (IR(ME)R Reg 8 and Sch 2 (1) (k))**

All staff respondents in the questionnaire said their organisation encouraged them to report errors, near misses or incidents, all but one member of staff who were involved stated they were treated fairly. All staff also felt that when errors, near misses or incidents were reported, the organisation took action to ensure that they did not happen again and all but one said they were given feedback about changes made in response to reported errors, near misses and incidents.

All but one member of staff said they felt secure raising concerns about unsafe clinical practice and were confident their concerns would be addressed. All staff also said that if they were concerned about unsafe practice, they knew how to report it.

Duties of practitioner, operator and referrer
Staff we spoke with mostly understood their roles, but confusion remained around the distinction between practitioner and operator responsibilities. Documentation should be reviewed to ensure correct role assignment.

The employer must review and update all documentation to ensure that IR(ME)R roles are correctly identified and understood. This must include additional training to ensure that all duty holders are fully aware of the IR(ME)R roles. (IR(ME)R Reg 10, Reg 17and Sch 2 1 (b))

Justification of individual exposures
The process of justifying an exposure and how and where authorisation was recorded was explained in the self-assessment form (SAF) provided prior to the inspection. Justification processes were in place, but authorisation guidelines were currently embedded within examination protocols and required further detail as to their objective and scope.

The employer must review the authorisation guidelines and update them to ensure that the correct IR(ME)R terminology is used, the purpose of the guidelines is clear for duty holders and reflective of local practice. (IR(ME)R Reg 6 (5) (a) and 11)

Optimisation
Discussions with staff confirmed that they used a range of techniques to ensure doses were ALARP. Currently, any local DRLs set were aligned to or below the national DRL which demonstrated good optimisation of doses. Staff we spoke with were able to describe how they ensured that doses were ALARP.

MPE involvement in optimisation was limited and could be enhanced.

Paediatrics
DRLs reviewed were tailored to paediatric imaging and reviewed by appropriate specialists.

Carers or comforters
Procedures were in place for managing carers and comforters, including consent and documentation.

Expert advice
MPE services were provided by St George's to Nuffield Healthcare. There appeared to be confusion over the links between local and corporate processes. We were unable to establish how the MPEs were entitled and what additional services they provided from any documentation reviewed. Staff told us MPEs provided audit and training support but were not consistently involved in equipment procurement or EP review. We reviewed IR(ME)R audit documentation provided by the MPE service that did not indicate some of the IR(ME)R compliance issues identified in this inspection. This audit documentation referenced out of date information and did not provide any information on the amendments to IR(ME)R regulations that were laid in October 2024.

Entitlement documentation for MPEs required clarification as entitlement forms provided indicated that this group were entitled by St George's rather than Nuffield Health.

The involvement of the MPE in quality improvement activities was limited. Although the MPE provided templates and general advice, there was no evidence of active support in areas such as optimisation or document review.

The employer must review the current provision of MPE support and ensure that it meets requirements and is appropriately documented. (IR(ME)R Reg 14)

Equipment: general duties of the employer
Senior staff we spoke with confirmed that an equipment replacement programme was in place. MPEs were involved in the commissioning and acceptance testing of new equipment once in place. The equipment inventory reviewed was compliant with IR(ME)R. We saw that QA programmes were in place, with regular testing and documentation. However, EP QA documentation lacked sufficient detail and should be strengthened to ensure that it reflected local practice.

The employer must review and update EP QA to ensure that it reflects local practice and that appropriate involvement of MPE's is in place. (IR(ME)R Sch 2 1 (d))

Safe

Managing risk and health and safety
The hospital was accessible and easy to find, with disabled access and facilities for people with mobility difficulties. The department was clearly signposted with open double doors. All doors entering the building were push button at low height, some were automatic. There were accessible toilets and low reception desks as well as wide walkways and space within waiting rooms.

The environment was clean and generally well maintained. Furniture was clean and in a good state of repair, fittings and fixtures in place were all working appropriately. The treatment rooms were spacious with mobility aids seen in the rooms. Shoehorns and leg raisers were available to help patients within treatment rooms. Signs when entering the building directed patients to the main reception desk within the radiology department. Signage was clearly displayed to alert patients and visitors not to enter controlled areas where ionising radiation was being used.

Infection prevention and control (IPC) and decontamination
There were suitable handwashing and drying facilities available and staff were seen using relevant PPE, which was readily available and well stocked. All areas seen in the department were clean and well maintained.

Staff were aware of the specific arrangements in place for symptomatic patients or patients with confirmed infections attending the unit. They also knew how to access the relevant policies and procedures on the hospital intranet. Sharps bins were available and used appropriately. Staff were aware of the nominated IPC lead nurse.

Senior staff were able to describe how medical devices, equipment and relevant areas of the unit were decontaminated. The equipment seen was visibly clean. Staff we spoke with were aware of their responsibilities in relation to IPC and decontamination. The specific arrangements in place to treat symptomatic patients or patients with confirmed infections when attending the unit were also described.

All staff who answered the questionnaire thought their organisation implemented an effective infection control policy and that appropriate PPE was supplied and used. All staff thought there was an effective cleaning schedule in place and that the environment allowed for effective infection control.

Safeguarding children and safeguarding vulnerable Adults
Staff told us that safeguarding procedures were in place and demonstrated awareness of safeguarding responsibilities. Compliance with mandatory safeguarding training was high and staff were able to confirm where they would find information to complete a safeguarding referral, this included a flowchart that staff would follow. The safeguarding policy reviewed was a corporately issued document and did not include local detail.

The employer must ensure that the safeguarding policy and process in place reflects local practice and refers to local guidance and support. (NMS – Safeguarding)

Staff we spoke with said they would escalate to management any safeguarding concerns.

Effective

Record management
A sample of five records were reviewed and were generally well maintained, though inconsistencies were noted in documentation of ID checks and practitioner sign-off.

The referral documentation seen was electronic. For one of the five records checked there was not a referrer listed on the main system but was listed on a separate document.

The referrals checked included three unique patient identifiers as well as having sufficient clinical details and was appropriately completed. Pregnancy status was confirmed where necessary.

The forms were signed by an appropriately entitled referrer. In one case the form was not signed by an entitled practitioner but there was evidence of a signature and protocol by a radiologist elsewhere. Doses were recorded for every record checked.

Quality of Management and Leadership

Staff Feedback

HIW issued an online questionnaire to obtain staff views on services carried out at the diagnostic imaging department at Nuffield Health Cardiff Bay Hospital and their experience of working there. The questionnaire complemented the HIW inspection in October 2025. In total, we received 12 responses from staff.

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

> *"I believe that my manager does what she can to support our department, she is fair and listens to what we have to say.*
> *We have struggled this year with staffing however, we have new staff joining our department soon which will help.*
> *The radiology department is a department that I enjoy working in and is a strong team.*
> *It is noticeable that the organisations priority is not patient centred.*
> *Our department we are and we are lead by a manager who strongly believes that patient's and the safety of them and us come first."*

> *"Our current manager in Radiology is very thorough and hard working. There has been a definite improvement in policies and procedures since she has started."*

> *"My manager is very supportive, however, senior management are not. I would have left the company if my manager had not been appointed.*
> *She does a fantastic job in supporting us all but seems to have an uphill struggle when raising issues further up the chain when they need to be addressed.*
> *There is a knee jerk reaction to any issues. Senior management pursue a blame culture often overlooking the chance that they might be in the wrong. Errors are drilled down to blame individual staff members rather than accept there is leadership fault*
> *Risk is assessed based on company reputation rather than staff members working their hardest to do a good job."*

"Communication between SMT and staff is good - there is a daily am meeting where issues are discussed - so all staff are aware of any issues they should take into account on their working day."

Governance and accountability framework

Staff we spoke with felt supported by management and said that they were always visible in the department. They said that they were always provided with sufficient information from events, incidents and discussions from management meetings. Information was provided by email or verbally as well as online applications. There were also staff meetings and regular catch ups as well as staff representatives in the morning staff forum in addition to a weekly newsletter from the hospital director.

Staff told us they knew where to find general policies and procedures relevant to their practice on the shared drive and the intranet. Any changes to general policies and procedures were made known to staff by the radiology manager mainly by email. Staff were then required to sign to say they understood the changes.

Senior staff we spoke with said they engaged with staff on a regular basis through daily huddles, team meetings and appraisals. Senior staff emphasised the importance of respect and kindness as well as psychological safety, wellbeing champions and they operated an open-door policy. They also described the way information was shared between management and staff.

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

- The organisation was supportive - 92%
- The organisation supported staff to identify and solve problems - 92%
- The organisation took swift action to improve when necessary - 92%.

Immediate managers were highly regarded for support and clear feedback, with most involving staff in decisions. The percentage agreement with the questions below relating to staff's immediate and senior manager were as follows:

- Immediate managers could be counted on to help with a difficult task at work - 100%
- Immediate managers gave clear feedback on their work - 100%

- Immediate managers asked for their opinion before making decisions that affected their work - 92%

- Senior managers were visible - 92%

- Communication between senior management and staff was effective – 83%.

Workforce planning, training and organisational development
We checked a sample of five training and competency records. There was clear evidence that radiology staff had completed suitable training on equipment, radiation protection and statutory obligations relating to ionising radiations. This included evidence of assessing competence. However, this was not signed by the assessor and there was not a space on the form for the assessor signature on the form.

The scope of practice was clear on the records checked, in four out of five instances, but on one record there was a need to add dates to show when entitlement was given and reviewed.

For the radiologist competency checks, whilst the room training record was signed by the radiologist, there was a need for the additional signature from the trainer.

It was also noted that staff were listed as practitioners when it should be operator.

The employer must ensure that training and competency records are completed in full including all relevant signatures and that staff are listed with their correct IR(ME)R role. (IR(ME)R Reg 6 (3) (b) Sch 3)

We checked the mandatory training of five staff members and saw evidence that staff had completed relevant mandatory training to the required level. This included safeguarding, safe moving and handling and IPC training.

Training records checked were clear and there was an appropriate system to identify when training was due. Any training courses that were out of date would be flagged to the radiology manager and the relevant member of staff would be emailed. The department used their own learning system and the matrix used was a good example of a training matrix.

Staff we spoke with said that the number and skill mix of staff in the department was appropriate and they had enough time to perform their duties. Staff also confirmed they received regular supervision and appraisals on a six monthly and annual basis.

All staff in the questionnaire felt they had received appropriate training and had an appraisal or development review within the last 12 months.

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

All staff in the questionnaire felt they had appropriate training to undertake their role, one member of staff commented:

> **"In my main area of work yes my training is of a high standard."**

Staff we spoke with were able to describe the duty of candour and said they had received training on the duty. Regarding the duty of candour in the questionnaire, all staff agreed they knew and understand the duty of candour and their role in meeting the duty of candour standards. All staff said that their organisation encouraged them to raise concerns when something had gone wrong and to share this with the patient.

Citizen engagement and feedback

Most staff reported no discrimination at work and confirmed there was fair access to opportunities and a supportive, inclusive workplace. However, a concern about inappropriate comments and senior management's response was noted. One member of staff commented:

> ***"There have been inappropriate comments on the workplace Facebook group by two {redacted} concerning religious beliefs. When raised on the peakon survey, they did not engage."***

Leaders confirmed that the Facebook group is tightly regulated with strict administrative controls to ensure compliance with organisational standards. Following this review, we have found no evidence of staff raising concerns related to inappropriate comments via Peakon or any comments about religious beliefs on the Facebook group. Leaders remain committed to and inclusive and respectful workplace environment.

When staff were asked whether they had fair and equal access to workplace opportunities, regardless of any protected characteristics, all but one agreed. All but one member of staff agreed that the workplace was supportive of equality and

diversity, the other ticked ‘prefer not to say’. One member of staff commented that:

“In the radiology department we are supportive of one another.”

We noted the results of the hospital patient satisfaction survey for August were displayed. There were also several compliments given by patients in the form of letters and cards on display in the hospital.

Staff we spoke with were able to explain how verbal and informal complaints were captured. Information from complaints would be shared with staff through various methods.

Information was clearly displayed around the department about how patients and families could provide feedback about their care. The results of which were reviewed monthly. A record of the verbal and written patient complaints was maintained. There had been four complaints in the last 12 months with no themes to these complaints.

All staff agreed in the questionnaire that patients and service user experience feedback was collected within the department. All but one member of staff said that they received regular updates on patients and service user experience feedback. All staff who had an opinion said that feedback from patients and service users was used to make informed decisions within the department.

Responses in the staff questionnaire were as follows:

- Staff were involved in deciding on changes introduced that affected their work area - 75%

- Staff were able to meet the conflicting demands on their time at work - 100%.

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 on this inspection.			

Appendix B - Immediate improvement plan

Service: Diagnostic Imaging Department at Nuffield Health Cardiff Bay Hospital

Date of inspection: 7 and 8 October 2025

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

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	No immediate non-compliance issues.					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: Diagnostic Imaging Department at Nuffield Health Cardiff Bay Hospital

Date of inspection: 7 and 8 October 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.	Complaints information was included in the patient guide, though it lacked details on contacting HIW if a resolution was not achieved. A flowchart and basic complaints information were available from reception, but these also omitted timeframes and external contact details.	The hospital director must ensure that complaints information available to patients is standardised across the department, to include timescales, information on HIW and escalation support available.	National Minimum Standards (NMS) - Communication	Patient Guide in hospital reception to mirror Complaints leaflets re escalation to HIW; to include timeframes and external contact details.	Clinical Governance Lead	Completed

2.	The local guidance was not always documented within the corporately issued EPs to ensure they accurately reflected local practice. In addition, management told us that Nuffield Health had not yet provided Nuffield Health Cardiff Bay with the additional EPs required under schedule 2 of IR(ME)R related to the amendments that were launched in September 2024. There were significant gaps in corporate governance and clarity of IR(ME)R responsibilities. Staff were unclear about the designation of the IR(ME)R Employer, with confusion noted across all levels, from the Medical Physics Expert (MPE)	The employer must: • Update written documentation for Nuffield Health Cardiff to ensure that the correct regulatory authority and associated notification processes and incident thresholds are indicated • Provide evidence that they are aware of their statutory responsibilities under IR(ME)R, including the establishment of robust written procedures and oversight of duty holder roles	Care Standards Act 2000 and Ionising Radiation (Medical Exposure) Regulation 2017 (IR(ME)R) Regulation 8 IR(ME)R Regulation 6	MPE to update and cross reference Appendix 2 schedule to include 2 new EPs. 2 additional EPs to be completed and shared with all sites following Expert Advisory Group (EAG) and Executive Quality Safety Committee (EQSR) approval. EPs to be updated to include reference to HIW as regulator for IRMER in Wales. Flowchart demonstrating corporate responsibilities and delegation to be included in RAD01.	Nuffield Health Medical Physics Expert National Lead – Diagnostic Imaging	End of Q1 2026 End of Q1 2026

	service to the Hospital Director and wider corporate teams. The CEO of Nuffield Health was identified as the IR(ME)R Employer, but there was no evidence available to demonstrate that they were aware of their statutory responsibilities under the regulations.	• Provide a plan on how they will clarify and communicate their role across the organisation	IR(ME)R Regulation 6	Corporate IR(ME)R templates to be updated with local variations and local author. Ratification and approval at local level with governance confirmation. Local SOPs will be uploaded to the newly introduced policy management system which was introduced Nov 2025	Clinical Governance Lead	End of Q1 2026
	Many EPs in place locally appeared to be authored by Nuffield Health colleagues not based in Wales. It must be noted that some ratified EPs indicated that the Care Quality Commission was the regulator for IR(ME)R this is incorrect as Healthcare Inspectorate Wales regulate IR(ME)R for settings in Wales.	• Finalise and document ratification and processes for the sign off of updates or amendments to any EPs used at Nuffield Health Cardiff Bay.	IR(ME)R Regulation 6 and Schedule 2, 1 (d)	Corporate IR(ME)R templates to be updated with local variations and local author. Ratification and approval at local level with governance confirmation. Local SOPs will be uploaded to the newly introduced policy management system which was introduced Nov 2025	Clinical Governance Lead	End of Q1 2026

3.	All EPs required a review and update to ensure alignment with local practice and recognition of Welsh based regulatory requirements. Version control and quality assurance (QA) processes were inconsistent. Some documents lacked clarity and updates were not always communicated effectively to staff. An organisation chart needed to be developed to clearly outline governance structures and IR(ME)R responsibilities from corporate to local levels.	The employer must strengthen IR(ME)R governance systems, including the development of a clear organisational chart linking corporate and local governance structures.	IR(ME)R Regulation 6	Employers Procedures to be updated to include reference to HIW as regulator for IRMER in Wales. It is acknowledged that some EPs submitted were on old formats, as opposed to the newer Sharepoint versions. The content of both remained identical and hence a decision was taken to not replicate until a change in content or review date required. All EPs had been reviewed and document history confirmed this. The old versions featured a change management history chart which had been omitted on newer versions; this change management history chart will be added back to SOPs in addition to Policies - NH has recognised this and it be amended - This change	Nuffield Health Medical Physics Expert and Head of Clinical Governance	End of Q1 2026

				has been submitted to EQSR for approval The introduction of a new policy management system which was implemented 25 Nov 2025 will improve version control and compliance as all team members will be able to gain access to our policies and associated documents in one central location. Instant access to up-to-date documents. Eliminates outdated paper folders and manual updates Clear audit trails for compliance and accountability. Automated review and expiry tracking		
4.	The EP for QA lacked sufficient detail and version control. Supplementary guidance and links should be added	The employer must: • Improve the QA process for documentation,	IR(ME)R Regulation 6 (2) and Schedule 2, 1 (d)	National Imaging Lead to add reference to RAD03 QA handbook for Diagnostic Imaging which is a comprehensive handbook	National Lead – Diagnostic Imaging	End of Jan 2026

	to enhance clarity and usability.	including version control, review cycles and communication of updates to staff • Update the EP for QA.		with full QA processes detailed. EAG & EQSC approval will be sought then implemented across all sites.		
5.	Inconsistencies were noted in referral acceptance processes and documentation control. Management told us that referrers did not have access to EPs, this is required in line with IR(ME)R.	The employer must review and update the referral process to ensure clarity and that it reflects local practice. This update must also include a process for how EPs are shared with referrers.	IR(ME)R Regulation 6 (2) and (5)	We will provide: 1. Dedicated Online Access for Healthcare Professionals We will create a clearly labelled webpage titled "Referral Guidelines for Healthcare Professionals" within the Cardiff Bay Hospital section of the Nuffield Health website. This page will include: • Referral guidelines and EPs relevant to imaging exposures • Clear disclaimers: "For use by entitled referrers only – not patient information"	Nuffield Health Web Team	Q2 2026

				• Version control indicators (last updated date) and contact details for queries This ensures guidelines are accessible to all entitled referrers, as required by IR(ME)R, without imposing impractical distribution methods. 2. Structured Communication All GP practices will receive a formal notification email by February 2026, providing the link and instructions for accessing the guidelines. Updates will be communicated through the same secure channel. 3. Professional Alignment Our guidelines will incorporate recommendations from the Royal College of Radiologists, annotated for local context, as suggested in IR(ME)R guidance. 4. Governance and Audit		

				Internal version control and update logs will be maintained. Oversight will be provided by our Radiation Safety Committee, with biennial review or earlier if regulations change. Justification for Approach IR(ME)R Regulation 6(5)(a) requires that referral guidelines be available to all entitled referrers, but does not prescribe the method of distribution. Publishing guidelines on a dedicated, easily accessible webpage with structured communication meets the legal requirement and reflects common compliance practice across NHS and independent providers. This approach avoids the impracticality and risk of outdated versions associated with		

				hard-copy distribution to thousands of GPs. We believe this plan is proportionate, legally compliant, and aligned with best practice. We will provide HIW with progress updates and confirm completion by Q2 2026.		
6.	There was an EP in place to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice. However, the process for entitlement within the EP was not clear and did not include all staff groups. There were actions required at corporate level to ensure documents provided to sites were fit for purpose and the process was clear.	The employer must ensure that the EP for entitlement Reg 6 Schedule 2 1 (b) includes: • A clear process that includes all staff groups acting in duty holder roles • Corporate level documents that are fit for purpose and ensure that the process is clear	IR(ME)R Regulation 6 and Schedule 2, 1 (b)	MPE to amend IRMER 05, IRMER 06 & IRMER 07: Process for entitlement needs to be clear, all staff groups need to be included within these EPs MPE to provide scope of practice and training records to NH central team to allow entitlement by D31). MPEs will be individually issued with a letter of entitlement. These will be shared with all sites who will document the MPEs scope of entitlement within entitlement matrix held	Nuffield Health Regional Quality Leads	End of Q1 2026

	Entitlement records were generally well maintained, locally. However, some duty holders were listed incorrectly (e.g. practitioners performing operator tasks). There was not a consistent process in place to entitle Medical Physics Experts (MPEs) appropriately. Evidence reviewed confirmed MPEs were group entitled by their employer St George's University Hospitals NHS Foundation Trust (St George's) rather than in line with regulatory requirements and entitled by the Nuffield IR(ME)R Employer and entitled individually to better reflect their specific scope of practice. The process for entitling MPEs	• Procedures which use correct IR(ME)R terminology and definitions • Entitlement of groups such as referrers which is robust and includes access to referral guidelines • Clear records and documentation that confirms non-medical referrers are not performing clinical evaluation.		locally. Access to this evidence and entitlement letters will be available to all Radiology Managers via Sharepoint. Access to referral guidelines for external referrers as discussed in point 5. Non medical referrers acceptance form IRMER App 01 Acceptance procedure for non medically qualified referrers will be updated to accurately reflect practice - Non medical; referrers do not undertake clinical evaluation		

	must be reviewed and updated.					
7.	As above	The employer must further ensure that: • The entitlement matrix reflects the individual duty holders and records review dates • Entitlement letters are issued by the appropriate IR(ME)R Employer and reflect accurate scope of practice for all duty holders.	IR(ME)R Schedule 2, 1 (b)	Entitlement matrix will be updated to record entitlement dates for Radiologists. Occupational Health GP entitlement date has been added to the entitlement matrix. Health Screening consultants and MPEs will be formally entitled by central team and scope of practice and entitlement letters will be shared will all sites as appropriate. Regional Medical Officers (RMOs) will be individually entitled rather than group entitlement.	National Lead – Diagnostic Imaging	End of Jan 2026
8.	The procedure did not include actions to take when there were discrepancies with patient	The employer must update the EP for patient identification to ensure that it fully	IR(ME)R Schedule 2, 1 (a)	IRMER 01 Identification of Patients - specific reference will be made to what actions staff would	Nuffield Health Medical Physics Expert	End of q1 2026

	identification. This detail would ensure that staff knew when they could proceed and when they needed to go back to the referrer. We saw evidence relating to making amending and cancelling a referral, where the operator was allowed to change the laterality of the examination without checking with the referrer. This was not detailed in the relevant EP. We also noted that on occasion record keeping in relation to patient identification was inconsistent in some areas.	details when a member of staff can and cannot proceed if there are discrepancies and detail the process of checking.		take if a discrepancy regarding laterality or site. Additional EP Making, Amending and Cancelling referrals EP to be produced and shared throughout Nuffield - this will include details directing staff what to do if a discrepancy found and in what occasions they can/cannot proceed with examination. This EP will detail what staff must do if a referral received details a discrepancy such as laterality.		
9.	Safeguarding links to the EP for minors that may be	The employer must ensure that the EP	IR(ME)R			End of Q1 2026

	pregnant would benefit from being added.	includes links to the safeguarding policy and the need to ensure that the local safeguarding teams are informed when a child provides a positive response to the pregnancy question.	Regulation 11 (1) (f) and Schedule 2, 1 (c) NMS - Safeguarding	Link to safeguarding policy to be added to RAD02 IRMER SOP09	Nuffield Health Medical Physics Expert	
10.	Clinical evaluation was generally well documented. Some gaps were noted during record keeping checks in practitioner sign-off and identification records. In addition, it was not clear from documentation reviewed, who was performing clinical evaluation out of hours, or where this was documented.	The employer must update the employer process for clinical evaluation. This must specify operator tasks and ensure that the process for performing clinical evaluation out of hours is clear, documented appropriately and reflects clinical practice.	IR(ME)R Regulation 12 (9) and Schedule 2, 1 (j)	Locally produced out of hours SOP to be updated to detail who would perform clinical evaluation out of hours if an emergency Xray undertaken. The updated SOP will include details regarding who will perform clinical evaluation and where it will be documented.	Radiology Manager	End of Q1 2026
11.						

	Senior staff confirmed that non-medical imaging exposures were performed in the department. There was an EP in place for these exposures. However, the procedure was unclear and did not specify how these referrals were made, who could refer and if prior clinical history or imaging was checked prior to the exposure.	The employer must review and update the EP for non-medical imaging and ensure that it accurately and correctly reflects clinical practice locally.	IR(ME)R Regulation 6 (4) and Schedule 2, 1 (m)	RAD02 IRMER SOP04 to be updated to state 'referrals will be treated and made in the same way as medical imaging exposure referrals'. An amendment to local EP will be made until corporate version is produced. RAD 02 IRMER SOP04 to specify how referrals will be made and accepted, who will make them, who can refer and how clinical history checked – all in line with medical exposures	Nuffield Health Medical Physics Expert Radiology Manager Nuffield Health Medical Physics Expert	End of Q1 2026 End of January 2026 End of Q1 2026
12.	During the inspection we reviewed the annual report from an IR(ME)R compliance audit completed by the MPE service in August 2025. This report did not	The employer must ensure that any commissioned annual IR(ME)R audit is fit for purpose and ensures that current IR(ME)R legislation, regulator	IR(ME)R Regulation 14	NH have appointed a new RPA who commences employment Jan 2026. The SLA in place with St Georges has been reviewed and meets criteria of IR(ME)R Regulation 14	Charity and Medical Director, Responsible Officer	End of Q1 2026

	identify the majority of the issues noted during this IR(ME)R inspection.	guidance and best practice are audited.				
13.	The EP relating to accidental or unintended exposures did not include any definitions for accidental or unintended exposures, was generic in nature covering Ionising Radiation Regulations (IRR) 2017 as well as IR(ME)R. The EP directed services to the English regulator rather than HIW for reporting. There was no mention of informing the patient and where that information was recorded. In addition, the significant accidental or unintended exposures (SAUE) guidance table at the end of this document was out of date.	The employer must • Fully review and update the EP for accidental and unintended exposure. This should include definitions, detail on what constitutes an accidental or unintended exposure, up to date references and details on the appropriate regulator for Wales • Improve trend analysis for SAUE and clinically SAUE and compare local to corporate findings.	IR(ME)R Regulation 8 and Schedule 2, 1 (k)	EP to be updated to include definitions for accident and unintended exposures; detail what constitutes and accidental or unintended exposure. SAUE reference will be updated to include updated references and detail HIW regulations and how to submit an incident notification. Updated EP will reference Nuffield policy regarding Duty of Candour, and document where the evidence that duty of candour has taken place will be saved.	Nuffield Health Medical Physics Expert Nuffield Health Medical Physics Expert National Lead – Diagnostic Imaging	End of Q1 2026 End of Q1 2026 End of Q1 2026

				Access to corporate trend analysis reports via Tableau has been shared throughout Nuffield allowing Radiology Managers to share and compare across all sites. Thematic reviews considering corporate trends will be incorporated in local staff meetings in addition to the existing local trend analysis that is current practice	National Lead – Diagnostic Imaging	Completed 21/11/2025
14.	Staff we spoke with mostly understood their roles, but confusion remained around the distinction between practitioner and operator responsibilities. Documentation should be reviewed to ensure correct role assignment.	The employer must review and update all documentation to ensure that IR(ME)R roles are correctly identified and understood. This must include additional training to ensure that all duty holders are fully aware of the IR(ME)R roles	IR(ME)R Regulation 10, Regulation 17 and Schedule 2, 1 (b)	EPs detailing duty holder roles have been reviewed and clarification sought from Nuffield RPA St Georges. To support this specific duty holder practitioner training has been arranged with MPE for the Nuffield organisation Jan 2026. RAD 01 Radiation Protection Policy has been	Nuffield Health Medical Physics Expert / National Lead – Diagnostic Imaging / Clinical Educator (radiography)	End of Feb 2026 End of Feb 2026

				reviewed; this is currently with EAG before EQSC as major changes. Following approval this will be shared across the organisation to all sites. Specifically, the appendix form in place to confirm acceptance of referrers wishing to evaluate own images in theatre will be reviewed and wording amended to reflect accurate duty holder role.	Nuffield Health Medical Physics Expert	
15.	Justification processes were in place, but authorisation guidelines were currently embedded within examination protocols and required further detail as to their objective and scope.	The employer must review the authorisation guidelines and update them to ensure that the correct IR(ME)R terminology is used, the purpose of the guidelines is clear for duty holders and reflective of local practice.	IR(ME)R Regulation 6 (5) (a) and Regulation 11	Authorisation Guidelines to be created for Xray.	Regional Quality Leads	End of Q1 2026

16.	*Improvement removed following factual accuracy comments.*			.		
17.	There appeared to be confusion over the links between local and corporate processes. We were unable to establish how the MPEs were entitled and what additional services they provided from any documentation reviewed. Staff told us MPEs provided audit and training support but were not consistently involved in equipment procurement or EP review. We reviewed IR(ME)R audit documentation provided by the MPE service that did not indicate some of the IR(ME)R compliance	The employer must review the current provision of MPE support and ensure that it meets requirements and is appropriately documented.	IR(ME)R Regulation 14	- Corporate entitlement of MPEs; sites to be issued with oversight of training documentation and breakdown of differing entitlement of MPEs. NH have appointed a new RPA who commences employment Jan 2026. The SLA in place with St Georges has been reviewed and meets criteria of IR(ME)R Regulation 14 MPE services provided by St Georges who are included in all equipment procurement, in addition involved in the GE partnership as part of their SLA. RPA was responsible for the review of all EP's	National Lead – Diagnostic Imaging / Charity and Medical Director, Responsible Officer	End of Q1 2026

	issues identified in this inspection. This audit documentation referenced out of date information and did not provide any information on the amendments to IR(ME)R regulations that were laid in October 2024. Entitlement documentation for MPEs required clarification as entitlement forms provided indicated that this group were entitled by St George's rather than Nuffield Health. The involvement of the MPE in quality improvement activities was limited. Although the MPE provided templates and general advice, there was no evidence of active support in areas such as			with a drop box issued for updates and access to the central team. Corporate entitlement of MPEs; sites to be issued with oversight of training documentation and breakdown of differing entitlement of MPEs NH have appointed a new RPA who commences employment Jan 2026. The SLA in place with St Georges has been reviewed and meets criteria of IR(ME)R Regulation 14	National Lead – Diagnostic Imaging / Charity and Medical Director, Responsible Officer Charity and Medical Director, Responsible Officer / Procurement Director	End of Q1 2026 End of Q1 2026

	optimisation or document review.					
18.	EP QA documentation lacked sufficient detail and should be strengthened to ensure that it reflected local practice.	The employer must review and update EP QA to ensure that it reflects local practice and that appropriate involvement of MPE's is in place.	IR(ME)R Schedule 2, 1 (d)	National Imaging Lead to add reference to RAD03 QA handbook for Diagnostic Imaging which is a comprehensive handbook with full QA processes detailed. EAG & EQSC approval will be sought then implemented across all sites	National Lead – Diagnostic Imaging	End of Q1 2026
19.	The safeguarding policy reviewed was a corporately issued document and did not include local detail.	The employer must ensure that the safeguarding policy and process in place reflects local practice and refers to local guidance and support.	NMS – Safeguarding	Corporate safeguarding policy to include reference to local process - detail will be added stating that local flowcharts are displayed on all sites	National Safeguarding Lead	End of Q1 2026
20.	We checked a sample of five training and competency records. This	The employer must ensure that training and competency records are	IR(ME)R Regulation 6 (3)	Peer assessments for radiologists equipment training to be introduced to	Radiology Manager	End of Jan 2026

	included evidence of assessing competence. However, this was not signed by the assessor and there was not a space on the form for the assessor signature on the form.	completed in full including all relevant signatures and that staff are listed with their correct IR(ME)R role.	(b) and Schedule 3	strengthen the training records for cases where specific applications training on Ultrasound or Fluoroscopy equipment has not been possible. Radiologists Competency training form to be updated to include a peer review assessors signature.		
	The scope of practice was clear on the records checked, in four out of five instances, but on one record there was a need to add dates to show when entitlement was given and reviewed.			Radiology Manager will review all scope of practices for Radiographers to verify entitlement dates are clear.	Radiology Manager	End of Q1 2026
	For the radiologist competency checks, whilst the room training record was signed by the radiologist, there was a need for the additional signature from the trainer.			Peer assessments for radiologists equipment training to be introduced to strengthen the training records for cases where specific applications training on Ultrasound or	Radiology Manager	End of Q1 2026

				Fluoroscopy equipment has not been possible. Radiologists Competency training form to be updated to include an assessors signature. Entitlement matrix to be updated to reflect accurate duty holder roles.		
	It was also noted that staff were listed as practitioners when it should be operator.			We have reviewed the comment regarding the role of Radiographers under IR(ME)R regulations and acknowledge the importance of clarity around duty-holder roles. Under IR(ME)R (2017/2024), a Practitioner is the duty-holder responsible for justifying medical exposures. Radiographers can act as Practitioners if they are formally entitled by the Employer and have completed the required training as outlined in Schedule 3. Without	Radiology Manager	End of Q1 2026

				written entitlement and documented training, a Radiographer remains an Operator. We have considered this statement carefully, and to ensure full understanding across the team, staff will undergo CPD training focused on IR(ME)R duty-holder roles and responsibilities. This will reinforce compliance and support safe, legally robust practice.		
21.	It was noted that staff had not completed training in the usage of portable oxygen cylinders, available online. During the inspection the radiology manager created an online account with the oxygen company for staff	The employer must ensure that all relevant staff complete the relevant training for portable oxygen cylinders.	Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder Welsh Health Circular	Radiology Manager requested an online BOC account during the day of inspection and all staff including bank employees have been asked to complete the Oxygen cylinder training	Radiology Manager	Completed 24/11/2025

	to complete the relevant training.					

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): **Rob Thomas**

Job role: **Hospital Director**

Date: **3 December 2026**