Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Diagnostic Imaging Department, Bronglais General Hospital, Hywel Dda University Health Board

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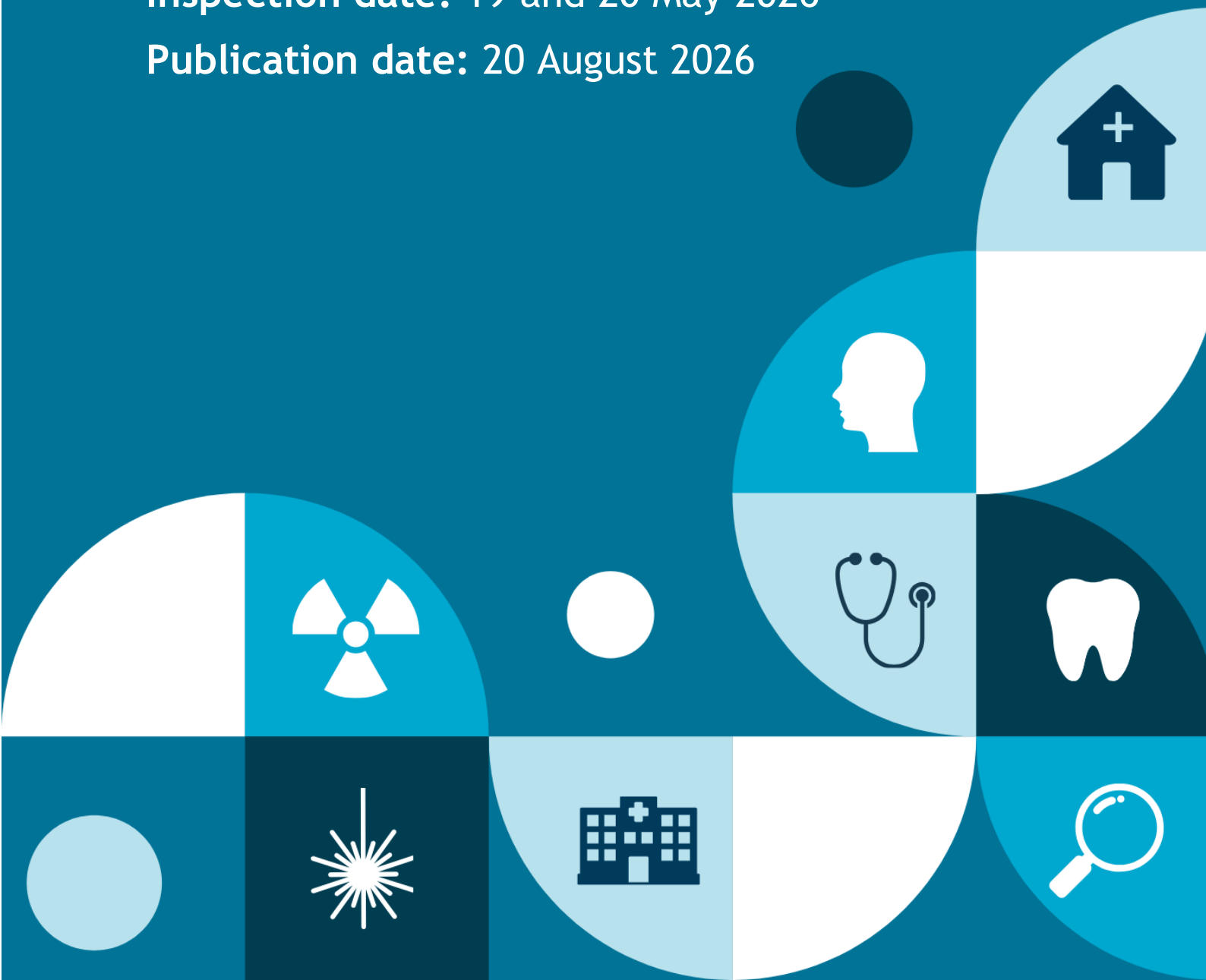

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective and high-quality for everyone.

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 Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations IR(ME)R inspection of the Diagnostic Imaging Department at Bronglais General Hospital, Hywel Dda University Health Board on 19 and 20 May 2026. During our inspection we looked at how the department complied with the Regulations and met the Health and Care Quality Standards.

Our team for the inspection comprised of two HIW healthcare inspectors and a Specialist Clinical Officer, Diagnostic Imaging 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 267 questionnaires were completed by patients or their carers and 42 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 delivered high-quality, compassionate care with strong patient satisfaction. Improvements were needed in communication, access and certain aspects of the care environment.

Patient feedback was highly positive, with most respondents rating the service as good or very good. Patients consistently praised staff for their professionalism, kindness and clear communication, highlighting respectful treatment and reassurance during procedures. The environment was also rated favourably, with the majority describing it as very clean. Free-text comments reinforced these findings, noting efficient service delivery and compassionate care.

We observed that care was largely person-centred, with strong promotion of health and wellbeing through accessible information and materials. Staff maintained dignity and respect, most patients felt involved in decisions about their care. Privacy was generally upheld, although shortcomings were identified in certain areas, such as inadequate changing facilities in the Emergency Department (ED) and limited confidentiality in the computed tomography (CT) waiting area. These issues led to recommendations for environmental improvements.

Timeliness was generally good, with most patients seen promptly and kept informed of delays. Improvements in reporting times and staffing capacity were noted. Communication support was available, including bilingual (Welsh and English) materials and translation services, though the routine identification of patient language preference was inconsistent.

Equality and inclusivity measures were in place, with staff demonstrating awareness of diverse patient needs, including disability, language and gender identity. Whilst most patients felt care was fair and accessible, some reported difficulties accessing services.

This is what we recommend the service can improve:

- Communication with patients, some patients reported gaps in communication, particularly around waiting times and procedure explanations
- Address privacy and environment issues, changing facilities in the Emergency Department lacked adequate privacy and the CT waiting area also posed confidentiality risks.

This is what the service did well:

- High levels of patient satisfaction. Patient feedback was overwhelmingly positive, with almost all rating the service as good or very good. Many patients described their care as professional, kind and reassuring, indicating a consistently high-quality patient experience
- Respectful, compassionate staff interactions. Staff treated individuals with dignity, respect and kindness. Free-text comments from patients frequently praised staff for being friendly, professional and supportive
- Clean environment and well-maintained facilities. Waiting areas had appropriate seating and health promotion materials, contributing to a comfortable and welcoming setting.

Delivery of Safe and Effective Care

Overall summary:

There were examples of good practice, but several governance, documentation and compliance issues required improvement.

Staff demonstrated good awareness of employer's procedures (EPs), which were accessible and regularly reviewed and there were structured quality assurance processes in place. Diagnostic Reference Levels (DRLs) were established and monitored, with appropriate escalation where consistently exceeded. Robust arrangements were also evident for dose optimisation, patient identification, safeguarding, infection control and access to Medical Physics Expert (MPE) advice. Equipment quality assurance programmes were in place and patient dose monitoring systems were used effectively. The service also showed strengths in efficiency, including improved care pathways, proactive clinical practices and plans to introduce artificial intelligence to enhance service delivery.

However, there were several areas of concern. EPs were not fully comprehensive, with gaps in modalities such as mammography and dual-energy X-ray absorptiometry (DXA) and delays in updating procedures to reflect regulatory changes. Referral processes were inconsistent, particularly in theatres where forms were often completed at the point of care, limiting proper justification and safety checks. Mammography referrals and follow-up practices did not meet IR(ME)R requirements, posing potential patient safety risks.

Documentation and record keeping were inconsistent, with multiple systems (paper and electronic) leading to gaps in recording authorisation, pregnancy checks and clinical information. Pregnancy enquiry processes varied widely, with incomplete

recording and unclear procedures in high-risk situations. Similarly, provision and documentation of benefits and risks communication were inconsistent, especially in theatre settings.

Clinical evaluation processes lacked robust audit and governance, particularly for theatre cases, DXA scans and outsourced reporting (Everlight), where peer learning and local oversight were limited. Training and competency records suggested a “tick-box” approach and entitlement processes were unclear for some staff groups, including those working outside radiology.

Additional concerns included limited oversight of equipment quality control, ageing equipment, inconsistent audit follow-up and weak systems for sharing learning from incidents.

Immediate assurances:

- Mammography referral processes showed significant non-compliance with IR(ME)R requirements. There was no evidence of valid referrals from breast surgeons and a single referral was inappropriately reused over a five-year follow-up period without reassessment of clinical need
- Previous audits in 2024 had already identified these issues, but recommended improvements (such as single-use referrals) had not been implemented. Further concerns included low audit compliance, failure to carry out timely re-audits and limited action taken on findings.

This is what we recommend the service can improve:

- Strengthen referral processes and justification, particularly in theatres where forms were often completed at the time of imaging. This limited proper justification, patient identification and pregnancy checks
- Documentation and record keeping, partially due to the use of multiple systems (paper and electronic). Key information such as justification, pregnancy checks and clinical details was not always recorded clearly or transferred between systems
- Enhance audit and governance, particularly for clinical evaluation in theatre cases, DXA scans and areas outside radiology
- Standardise and improve the pregnancy enquiry processes which were inconsistent, with multiple forms and variations in how checks were recorded.

This is what the service did well:

- Well-established quality assurance processes, including routine equipment testing, patient dose monitoring and use of DRLs
- Effective dose optimisation and patient safety practices, staff demonstrated a strong focus on keeping radiation exposure as low as reasonably practicable (ALARP) through appropriate positioning, protocols and patient-specific adjustments
- Positive safety culture and incident reporting, the service also demonstrated examples of learning from incidents, including reviews, reflections and sharing outcomes through governance structures.

Quality of Management and Leadership

Overall summary:

The department benefited from committed staff, strong teamwork and established governance frameworks. Improvements were needed in leadership visibility, staffing resilience, communication and workforce development to strengthen overall management and service delivery.

Staff feedback provided positive views on patient care, safety and teamwork, describing colleagues as supportive, hardworking and dedicated. There was evidence of good peer support and a generally positive culture focused on maintaining professional standards.

However, several key challenges were identified, particularly around staffing, leadership and communication. Staff reported shortages, workload pressures and concerns about lone working, particularly out of hours. Leadership visibility was limited and there was a perceived lack of consistent senior presence, partly due to the absence of a permanent site lead, although a new appointment was pending. Communication from senior management was viewed as inconsistent and many staff felt they were not sufficiently involved in decision-making or service changes.

Governance structures were in place, including regular meetings and reporting systems. Leadership demonstrated a willingness to improve following inspection. Proposals to strengthen governance included introducing a dedicated Quality and Safety (Governance Radiographer) role and developing health board-wide modality leads to improve oversight and coordination.

Workforce issues were a significant concern. Whilst appraisal rates were high and training compliance generally good, gaps existed. Training and competency records appeared inconsistent and, in some cases, retrospectively completed, reducing

assurance of staff competence and scope of practice.

Staff wellbeing support was available and most staff were aware of how to raise concerns, though confidence in action being taken was mixed. Feedback systems for patients were visible and staff demonstrated awareness of the duty of candour. However, engagement with feedback and organisational responsiveness could be improved.

Immediate assurances:

- A training at the department identified low compliance levels for staff in resuscitation level two (9%) and oxygen administration (14%). This meant insufficient assurance that staff could respond to emergencies.

This is what we recommend the service can improve:

- Leadership visibility and communication from management. Only a minority felt communication was effective and many indicated they were not kept well informed about decisions affecting the service
- Staffing levels and workload pressures, there were concerns about insufficient staffing, particularly during busy periods and out-of-hours shifts, including risks associated with lone working
- Staff engagement and involvement in decision-making, a significant proportion of staff felt they were not adequately involved in decisions or service changes.

This is what the service did well:

- Strong teamwork and supportive culture with good peer support across the department. This positive team culture contributed to maintaining patient care and professional standards
- Positive focus on patient care and safety, with most staff satisfied with the quality of care they deliver. Governance structures and leadership engagement during the inspection also demonstrated a commitment to learning and improvement
- Established governance and improvement plans, including regular meetings and reporting systems. There were also proactive plans to strengthen leadership and governance, such as introducing a dedicated Quality and Safety role and developing modality leads to improve oversight and service coordination.

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 a questionnaire to obtain patient views on the care in the Diagnostic Imaging Department at Bronglais Hospital for the inspection undertaken in May 2026. Patient responses were captured onsite via hard copy questionnaires and posters displaying the online survey link. In total, HIW received 267 questionnaire responses from patients. Overall, patient feedback was highly positive, with strong satisfaction across most areas of care:

- Most respondents rated the service as either very good or good
- Patients reported positive interactions with staff, particularly regarding dignity, respect and communication.
- The environment was viewed very positively, with 89% of patients rating it as very clean.

The free text comments from almost a 100 patients indicated professionalism and kindness of staff, clear explanations and reassurance during procedures and efficient service delivery in some departments. Examples of these comments included:

> *"DXA scan - staff were fabulous. Respectful. Aware the procedure could be concerning and have vulnerable feelings. Gave extra gowns to wear for dignity. They talked me through what they were doing. I had some bruises on my legs due to my role and they asked about them for safeguarding but did so in a lovely calm, gentle manner."*
>
> *"I am a cancer patient and over the last 8 years I have had many experiences of having scans in Bronglais Hospital in Ceredigion as my cancer {issues withheld} and the department that do the scans are brilliant, very professional and caring, it is a must for this department remains at Bronglais Hospital."*
>
> *"All staff were wonderful, 5 stars. I have had many CT scans and cannot fault the care and kindness i received."*
>
> *"My daughter had an ultrasound scan and MRI scan at Bronglais. Staff were kind and professional and may her as relaxed as possible. The images were shared with the specialist team in {location withheld} who commented on how good the radiographers were."*

"I am referring to the Radiology dept in Bronglais, when I had an X Ray on my hand less than 2 months ago. Didn't wait long for the appointment and the procedure was swift & efficient."

Other examples of comments from patient included praise for staff being friendly and professional and creating a pleasant experience.

The limited free text comments raising concerns included communication gaps, particularly regarding delays and procedure explanations and access to services, including difficulty obtaining appointments and travel requirements (reflected in comments which noted that difficulty in travelling due to caring/mobility issues). The CT scanner being out of action was noted twice within the comments. Patients commented that:

"CT scanner is not working at Bronglais and we needed one but were told we would have to wait to be seen at Glangwili. There were 2 patients at Bronglais who were also waiting for CT one of which was serious/ life threatening. It is an isolated hospital that needs more funding for equipment etc. The staff are amazing and are doing their best but funding is a priority."

"I would have liked more communication from staff - how long I'd be waiting, what would be happening during the procedure, how long it would take etc. It felt very routine and efficient but I had not had this procedure before so a little reassurance and explanation would have gone a long way! I had to wait a very long time before my scan (not an issue, these things happen) but no staff were around, no one checked on me and I felt fairly abandoned."

Person-centred

Health promotion

Patients' health and wellbeing was promoted through clear information and guidance available in the department. This included leaflets and posters on smoking cessation, healthy lifestyles, support services, cancer screening and bone health. Additional wellbeing resources, such as local walking information and Welsh language materials, were also provided, alongside deaf awareness signage.

Patients were routinely asked to inform staff of their medical history and any existing conditions. Standardised safety questionnaires are in place for CT, Magnetic resonance imaging (MRI) and DXA examinations. Whilst written prompts were not initially available for general X-ray, this was addressed during the inspection through the introduction of appropriate signage in the waiting area. Clear signage was also in place within clinical rooms and waiting areas advising patients to inform staff if they were pregnant or breastfeeding. Signage reminding patients to report any changes in their medical

history was not initially observed; this was addressed and implemented during the inspection. **These concerns were escalated and resolved during the inspection and are detailed in Appendix A of this report.**

Dignified and respectful care

We observed staff being respectful, kind and displaying a patient-centred approach. Interactions at reception and throughout patient pathways, were polite, accommodating and supportive. Staff were discreet and sensitive when communicating with patients and with each other. Treatment room doors remained closed during procedures, waiting areas were adequate with appropriate seating and health promotion materials and facilities such as toilets were generally clean and well-equipped. However, one toilet near the CT scanner lacked a hygiene disposal bin.

Privacy and dignity were largely maintained across the department, particularly in single-occupancy examination rooms and designated changing areas in the main department. However, in the ED, changing facilities were situated along a main patient corridor and separated only by a curtain. This did not provide sufficient privacy and was not suitable for patients with mobility difficulties due to limited space. Similarly, the CT scan waiting area used a curtain partition to separate acute patients (including emergency or stroke cases) from others, which posed risks to confidentiality, as conversations could potentially be overheard. Whilst staff indicated that patients were often allowed to change within X-ray rooms to mitigate privacy concerns, these workarounds highlighted limitations in the current environment.

The health board must ensure:

- **All toilets have hygiene disposal bins**
- **A review is caried out of the layout of the ED X-ray changing areas to provide sufficient privacy for all patients and sufficient space for patients with mobility difficulties**
- **A review is carried out of the layout of the CT in-patient waiting area to ensure there is sufficient privacy for patients attending this area.**

All but one patient in the HIW questionnaire agreed they were treated with dignity and respect. Almost all agreed staff explained what they were doing, staff listened and answered questions and measures were taken to protect their privacy. The majority of respondents felt able to speak to staff without being overheard. One patient commented:

> *"Staff were very kind and friendly and treated me with dignity and respect. They explained everything and provided reassurance throughout the mammogram. The experience of having a mammogram was better than what I had anticipated."*

Staff reported positive views in the HIW questionnaire regarding patient care with 83% agreeing patients' privacy and dignity were maintained and 86% felt patients were informed and involved in decisions.

Individualised care

Most patient respondents in the questionnaire felt well informed and supported. Over 90% were satisfied with information provided about risks and benefits of relevant procedures and over 95% felt involved as much as they wanted in decision-making.

The majority of respondents felt they received sufficient aftercare information and that they were given information on how to care for themselves following their treatment. Less patients, 74%, said they were given written information on who to contact for advice about any after effects from the procedure. However, the need to provide written information was not always required for radiology examinations. One patient commented:

> *"The doctor who dealt with me in A&E had compassion and a good bedside manner. Almost every member of staff was kind and courteous. I had a fairly short wait to be triaged and then went through the system quite quickly. The CT scan was done professionally and with dignity intact. The whole process was very good and I was very impressed."*

Timely

Timely care

Staff at reception reported that patients were usually seen on time, with most appointments running as scheduled and even on a particularly busy day, waiting times rarely exceeded 10 minutes. If delays were anticipated, patients were informed promptly, either in advance or upon arrival. Appointment cancellations due to service issues were described as rare.

Radiology staff we spoke with reported that waiting times were communicated verbally, if there was a delay they would inform patients directly and apologise to patients in the waiting area. They also noted that there was a display board in the waiting room providing estimated waiting times.

Senior staff we spoke with stated that improvement work had been carried out to reduce the cancer pathway reporting times from 12 weeks to 3–4 weeks and overall referral-to-report timelines from 16 weeks to 3–4 weeks. They also reported additional staffing and training in CT and MRI to improve capacity and recruitment strategies including training newly qualified staff in specialist modalities. There had also been a development of staff roles such as a trainee sonographer position.

The majority of respondents to our questionnaire agreed that the wait between referral and appointment was reasonable. A total of 82% 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 were measures in place to support patients with hearing, visual and language needs. A hearing loop was available and an easy-read document was available for patients attending mammogram appointments. Staff we spoke with emphasised their willingness to make reasonable adjustments for patients.

Information about treatments was clearly communicated through posters in waiting areas outlining procedures, what to expect and how treatments worked. Patients were routinely directed to this information and staff were observed explaining procedures clearly, respectfully and in an accessible way, whilst also responding to questions. These interactions appeared professional, friendly and engaging.

A range of materials, including questionnaires (such as for DXA scans) and patient letters, were available in both English and Welsh. Most signage, posters and leaflets were also bilingual. We saw staff wearing 'iaith gwaith' badges and speaking Welsh in the department, there were also opportunities available for staff to learn Welsh.

Staff we spoke with stated that translation services were available including British Sign Language (BSL) support. For patients with learning disabilities, staff reported that patients often attended with carers and staff also relied on colleagues who could assist. Staff reported they did not routinely ask patients their preferred language. A staff member noted they were learning Welsh and planning to attend a course.

Patient feedback about staff was very positive and interactions between staff and patients consistently demonstrated a high standard of communication and care. Almost all patients in the feedback said they were able to find the department.

A total of 42 patients said Welsh was their preferred language, of these less than half said they were actively offered the opportunity to speak Welsh throughout their patient journey. Most said they felt comfortable using the Welsh language within the department regardless of whether they were asked their language preference and that healthcare information was available in Welsh.

Five members of staff in the HIW questionnaire said they were a Welsh speaker but only three said they wore the 'iaith gwaith' badge.

Rights and equality

Arrangements were in place to make the service accessible to patients. All areas of the department appeared accessible for patients. Staff we spoke with stated that all patients were treated the same and fairly, with equal access to care. EDI training was mandatory and policies were available on the intranet. They aimed to maintain dignity, particularly during intimate examinations, using curtains and locked doors.

Staff described the availability of lesbian, gay, bisexual, transexual, queer, plus (LGBTQ+) groups and support networks as well as the ability for patients to request same-sex practitioners for religious or personal reasons. Staff reported awareness of neurodiversity passports and autism training as well as adjustments such as access to work schemes and modified environments. Staff reported use of neutral questioning, awareness of pronouns and recording of preferred names in the clinical systems.

Senior staff also spoke about the existence of equality, diversity and inclusion (EDI) champions and staff support groups across the health board. They made efforts to ensure staff and patients felt welcome and supported, including locum staff integration.

Just over 75% of patients in the questionnaire felt they could access the right healthcare at the right time. However, almost 20% disagreed, often citing delays and access issues, although some of these issues may have been in the community. Additionally, whilst 17 patients said they faced discrimination when accessing or using this health service, again some of the responses suggested this related to patients' experiences outside radiology.

The majority of staff felt the workplace was supportive of EDI. However, 19% reported not having equal access to opportunities. Additionally, 11 members of staff could not answer no to the question "have you faced face discrimination at work within the last 12 months" although eight of these responses were 'preferred not to say'.

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

Staff we spoke with demonstrated general awareness of the EPs and where to access them. Staff said they had read the procedures recently following updates and formally confirmed understanding and compliance. Updated procedures were made available electronically and as hard copies within clinical environments and communal staff areas. Staff said the EPs were clear and reflective of current practice. However, feedback identified that certain specialist areas, particularly mammography and DXA, were not consistent or fully represented within all procedures. Staff indicated that opportunities existed to provide feedback on procedures and that senior staff were accessible and responsive to suggested amendments.

The employer must ensure that EPs are updated to ensure comprehensive inclusion of all modalities, particularly mammography and DXA.

Changes to procedures and protocols were communicated through a range of methods, including email notifications, team briefings and informal communication. Staff were directed to updated documents and were required to read and sign declarations confirming their understanding and intention to comply. Line managers also provided additional oversight to ensure staff awareness and understanding of updates.

The self-assessment form (SAF) described the arrangements in place to ensure compliance with written procedures. All radiology duty holders (referrers, practitioners and operators) were required to read the EPs and sign a declaration confirming their understanding and agreement to comply.

The SAF outlined a structured quality assurance process for procedures and protocols. EPs were reviewed at least every two years by the head of radiology, in collaboration with site lead radiographers and the MPE. Reviews would also be triggered by changes in practice, equipment or guidance. Procedures were formally approved and ratified

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

through the Medical Exposure Group (MEG) and subsequently disseminated to relevant staff groups.

The EP for Quality Assurance Programmes specified reviews following the introduction of new equipment or techniques. However, this EP needed to also explicitly include legislative or regulatory changes as a trigger for review. Evidence indicated that amendments introduced in October 2024 were incorporated into procedures until February 2026, suggesting a potential delay in implementation.

The employer must ensure that the EP for Quality Assurance Programmes includes the need for procedures to be reviewed following legislative or regulatory changes.

Referral guidelines

The 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.

Referral processes were supported by an EP, which had been distributed to all referrers via email with links to IR(ME)R training and iRefer guidance. Clinical audits of referral forms were undertaken to ensure appropriate information, authorisation and national guidance was accessible across NHS Wales.

Concerns were identified in theatres, where referral forms were often completed when the radiographer arrived, preventing proper justification, identification and pregnancy checks.

The employer must ensure referral forms in theatres are completed in advance where cases were known to require imaging.

During the inspection of the department, we reviewed mammography referrals. There was no evidence of a referral from the breast surgeon during record keeping checks of routine mammograms. Staff confirmed they were using the GP letter sent to the clinic requesting that the patients was seen. This was not a referral under IR(ME)R and would not be considered a referral from the referring clinician.

Additionally, where patients were undertaking five years of annual follow up breast surveillance, a single referral was being used multiple times and extending for the five-year period without any checks if the patient should stay on the pathway or if clinical information had changed over this period of time. There had also been an audit in 2024 that identified several areas for improvement, including single use forms to be used for each attendance. If these areas of improvement had been implemented this would have mitigated some of the patient safety concerns identified during this inspection. **These concerns were addressed as part of our Immediate Assurance Process and are detailed in Appendix B of this report.**

The SAF described IR(ME)R audits which were routinely performed on referral forms to ensure appropriate information was provided and forms were appropriately signed. However, clinical evaluation of theatre cases was not being audited for compliance and needed to be added to the audit schedule to ensure compliance with IR(ME)R requirements. All other areas outside radiology performing clinical evaluation should also be audited on a regular basis. If there was no evidence of a clinical evaluation the exposure could not be deemed justified.

There were several ways in which referrers could send in a referral such as paper, electronic and letters. This was not fully reflected in the EPs and senior staff must consider if acceptance of a letter for a referral is in line with EPs. Ideally these referrals should be electronic.

The employer must ensure:

- **All theatre cases involving imaging are appropriately clinically evaluated**
- **The EPs reflect the referral documents received, or only documents listed in the procedures are accepted**
- **Referral process is clearly outlined in the EP and complied with by referrers**
- **Regular audits are carried out on clinical evaluations within patient notes for theatre cases.**

Diagnostic reference levels (DRLs)

Staff interviewed demonstrated awareness of the DRLs in use. Local and national DRLs had been established at the department. They were also familiar with the procedures to follow where local DRLs were consistently exceeded. A fault logbook was maintained to record such instances, alongside formal escalation to management. These logbooks were subject to review every three months, with the MPE requested to provide advice where DRLs were consistently exceeded.

An established EP outlined the use and review of DRLs, clearly describing the processes for their establishment, implementation and ongoing evaluation. Local DRLs were in place, supported by a dose management system used to collate patient dose data.

The process for establishing, using and reviewing DRLs was further detailed within the SAF. This specified that, at appropriate intervals not exceeding three years, the MPE would analyse patient dose data provided by the department under review. Based on this analysis, the MPE would recommend revised DRLs.

Medical research

The relevant EP for exposures undertaken as part of medical research programmes was reviewed. The EP clearly described the process for ensuring that all approved research studies involving imaging exposures were subject to prior review. At the time of inspection, no research trials involving imaging exposures were actively being undertaken.

Entitlement

Staff we spoke with described continuous learning of their IR(ME)R duties through local policies, training, protocols, standard operating procedures (SOPs), competency sign-off and professional development reviews. Responsibilities also included quality control, equipment testing and form checking. However, responses were inconsistent about how they were informed of their entitlement and scope of practice.

The employer must ensure staff are provided with their entitlement and scope of practice and that they are aware of how this is provided to them.

The EPs reviewed set out processes for entitlement under IR(ME)R. There was a need to include explicit reference to all relevant modalities, such as mammography and DXA. In addition, the table for diagnostic radiology would benefit from listing quality control (QC) testing as an operator task.

The employer must ensure the EPs include specific reference to all modalities including mammography and DXA as well as inclusion of tasks such as quality control within operator roles in the relevant table.

Processes for entitlement of radiographers were generally well described. Newly appointed staff had a structured preceptorship period during which competency was assessed.

Radiologists had formal competency assessments during training, with additional governance processes in place, including report validation by senior staff prior to independent practice.

The current NMR policy implied that referrers may review and act upon imaging when within scope of practice. This may have been interpreted as undertaking operator functions, such as clinical evaluation, without formal entitlement. Clarity was required to distinguish between referrer responsibilities and operator duties.

Concerns were also identified regarding staff outside radiology undertaking the operator tasks of clinical evaluation without clear evidence of training, competency or entitlement. This included clinical staff in theatres and the emergency department. These roles should be formally recognised, with appropriate training and entitlement documentation to ensure compliance.

The employer must ensure all staff are aware of their responsibilities and that only those appropriately entitled operators, carry out clinical evaluations. Staff only perform clinical evaluations if they are appropriately entitled as operators and they understand their roles and responsibility to undertake this task.

MPE services for diagnostic radiology are delivered under a service level agreement by the Regional Radiation Physics Service at Swansea Bay University Health Board. Arrangements for entitlement of clinical scientists and technologists required further definition. It was not clearly established who held responsibility for granting entitlement, particularly in relation to the role of the head of the MPE service. Governance processes should ensure that individuals responsible for granting entitlement are themselves appropriately entitled by the IR(ME)R employer.

The employer must ensure the entitlement process for MPEs is reviewed to include the head of the MPE service employed by the health board being appropriately entitled.

Patient identification

We reviewed the EP for the correct identification of the individual to be exposed to ionising radiation. This aligned to the process described in the SAF.

Staff we spoke with were aware of the procedure to correctly identify individuals. This aligned to the processes described in the procedure. A process was also in place for theatre-based staff as well as radiology department staff. This aligned to the processes described in the procedure.

Individuals of childbearing potential (pregnancy enquiries)

Staff we spoke with described the process to ensure that pregnancy enquiries were routinely conducted for patients. If there was uncertainty, additional checks would be carried out.

The SAF also described a similar process for establishing pregnancy or breastfeeding status, particularly for abdominal or lumbar spine imaging. This check would be recorded on both the referral form and the radiology information system, with responsibility assigned to the operator. Patients were also alerted through posters and information within the department and in theatre settings, pregnancy status was obtained from surgical staff or escalated to a consultant radiologist if there was any uncertainty.

The EP included an entry stating that “The pregnancy status of patients in life-threatening situations may be disregarded by the practitioner in the interest of patient management. This clinical reason must be recorded on the radiology referral form.”

Pregnancy status should not be disregarded, consideration should be given to optimising the exposure and consultation with MPE where possible.

The check of referral records showed there was a lack of consistent recording of pregnancy enquiries. It was noted that there were different pregnancy checking forms and method through the department leading to a mix of recording method and in some cases lack of recording. Patients were not asked to sign to confirm pregnancy status checks and in theatre environments, referral forms were often handwritten at the time of examination rather than being prepared in advance, which did not reflect best practice.

The employer must:

- **Introduce a standardisation of documentation to ensure there is a single, consistent method for recording pregnancy enquiries across all areas (paper and electronic systems)**
- **Improve record keeping compliance to ensure all pregnancy checks are clearly and consistently documented, including the outcome and operator details**
- **Review the procedure regarding life threatening situations to emphasise optimisation of exposure and consideration of MPE advice rather than disregarding pregnancy status**
- **Complete theatre referral forms in advance where possible, allowing proper justification, identity checks and pregnancy enquiries before exposure**
- **Reinforce expectations around pregnancy checks, recording requirements and adherence to procedures**
- **Regularly audit compliance with pregnancy enquiry processes to identify gaps and ensure improvement actions are sustained.**

Benefits and risks

We spoke with staff about how they ensured that adequate information was provided regarding the benefits and risks associated with radiation exposures. Staff stated they used a combination of visual materials, such as posters and leaflets, alongside direct communication to support patient understanding. They emphasised the importance of checking that information had been understood and providing opportunities for patients to ask questions.

The EP relating to benefits and risks included that *'the communication of risks and benefits for unconscious individuals or those in life-threatening situations may be disregarded in the interest of patient management.'* This would be more appropriately phrased to reflect that, where practicable, the patient's representative should be

informed of the benefits and risks of the exposure, rather than suggesting that communication may be disregarded.

Senior staff were asked how benefit and risk information was communicated to patients in theatre settings. They stated that the referring clinician was responsible for providing this information. However, there was no evidence available to demonstrate that this was being undertaken consistently in practice. A consistent approach was required to ensure this information is routinely provided. This may include introducing documentation or prompts within referral or consent processes to enable referrers to evidence that benefit and risk discussions had taken place.

The employer must ensure benefits and risks to theatre patients is being carried out in a consistent way. The evidence that that this is happening in practice should be included within the relevant documentation.

Clinical evaluation

Clinical evaluation requirements were clearly set out within the SAF and EPs, outlining how evaluations should be undertaken and recorded for each exposure. However, gaps in audit coverage were evident. Clinical evaluation of theatre cases was not currently audited and should be added to the organisations audit schedule. Similarly, areas outside radiology that undertook clinical evaluation were not subject to consistent review. The absence of recorded clinical evaluation meant exposures could not be considered justified, presenting a regulatory risk. DXA examinations were also not clinically evaluated and required action.

The employer must ensure images from all areas including theatre and DXA are clinically evaluated to ensure they can be considered as justified.

Non-medical imaging exposures

An appropriate EP was in place for non-medical imaging. Staff described the process for chest X-ray (CXR) examinations for tuberculosis (TB) screening. Referral are received from the respiratory clinics for patient who have contact without symptoms or where there is a confirmed outbreak. Radiation doses for TB screening examinations were optimised in line with standard protocols for chest X-ray imaging. Processes were in place to review previous imaging, ensuring prior examinations were considered as part of the assessment.

Employer's duties - clinical audit

The SAF described the process for clinical audit and how any follow-on actions were identified and completed as part of the audit. There was also an EP relating to the clinical audit. We were provided with evidence of the clinical audit and IR(ME)R audit schedule.

We noted that the audit of clinical evaluation outside radiology was currently not being performed and should be added to the organisations audit schedule. Additionally, there needed to be evidence of in-house peer learning for Everlight and there was a lack of methodology for staff to follow when carrying out audits for example reviewing paper or electronic records

The Everlight reporting process involved direct reporting onto the radiology system, with referrers liaising with Everlight radiologists to agree examinations and protocol referrals. Although this pathway was established, there were concerns regarding assurance and governance. In particular, the audit of Everlight clinical evaluations was not undertaken and senior staff reported there was low confidence in the quality of some reports. Whilst the company provide its own audits, these were not integrated into local clinical governance arrangements. Discrepancies in reporting are discussed at Radiology Events and Learning Meeting (REALM). Additionally, reporting radiographers were regularly audited, but mammography reporting lacked formal peer review processes.

The employer must ensure:

- **There is in-house peer review of Everlight reporting and mammography reporting in line with professional standards**
- **The scope of IR(ME)R audits includes clinical evaluation for all areas both within and outside radiology**
- **Methodology is written for staff to follow when carrying out audits.**

We reviewed the IR(ME)R compliance audit of mammography surveillance at Withybush, Prince Philip and Bronglais Hospitals (which was conducted in December 2024). An initial audit of 100 patients from each site were analysed to identify if the relevant EPs were being followed and if any trends relating to non-compliance could be identified. The results for Bronglais showed a low percentage compliance in a number of areas. The action included a reaudit in six months.

There was no evidence that a reaudit was carried out and the findings of the audit showed a serious lack of understanding to meet the requirement of IR(ME)R and a clear non-compliance with their own EPs. In view of the findings this should have been re-audited as soon as actions had been implemented.

We also reviewed IR(ME)R audits from across the radiology department which did not have 100% compliance with IR(ME)R and the health board EPs. For these audits there was little evidence of any action taken in a timely way to investigate or implement appropriate actions based on the findings. Again, appropriate reaudit should occur in a timely manner and sooner than in six months. **These concerns were addressed as part of our Immediate Assurance Process and were detailed in Appendix B of this report.**

Employer's duties - accidental or unintended exposures

Staff we spoke with were aware of the correct process to manage, accidental or unintended exposures through a clear incident reporting process using Datix. They also described additional actions such as informing the patient, notifying the patient through the duty of candour and escalating to managers or Radiation Protection Supervisors (RPS) where appropriate.

Whilst staff we spoke with felt the culture of reporting was positive and without blame, they stated that learning from incidents appeared less consistently embedded, with limited formal feedback. Some learning was shared through reflections, team briefs, or informal discussions, it was not routinely a structured agenda item.

The employer must ensure feedback mechanisms are strengthened and learning from incidents shared with the relevant staff and addressed to reduce recurrence.

The department had taken several steps to address and learn from radiation-related incidents. The Automatic Exposure Control (AEC) issues and actions included reflective practice, involvement of applications specialists, use of "pause and check" prompts and detection through reject analysis. The vendor had also been consulted for potential technical solutions.

The CT incident investigated through a reflective account and discussed at CT leads meetings, demonstrated some level of review and learning. Incident investigations were initiated by staff reporting to the RPS or directly on Datix, with support from the MPE and escalation to HIW where required.

Trend analysis was supported by incident coding and systematic review processes and learning was shared at organisational level, including with clinical care group (CCG). Near misses were recorded on Datix, there was recognition of underreporting and that further work was suggested to strengthen this area, alongside deeper analysis of procedural deviations and implementation of changes to reduce recurrence.

The MPE assessed whether the exposure was significant (SAUE) and if notification to HIW was required. For notifiable incidents, the MPE provided dose and risk assessments. A full investigation report was submitted within 12 weeks. Lessons learned were shared through the MEG to support improvement.

Over 90% of staff respondents to the questionnaire said their organisation encouraged them to report errors, near misses or incidents. However, only 57% felt staff who were involved were treated fairly. When errors, near misses or incidents were reported, 75% of staff indicated the organisation took action to ensure this did not happen again. A smaller percentage, 67%, agreed they were given feedback about changes made in response to reported errors, near misses and incidents.

Duties of practitioner, operator and referrer

The entitlement of referrers, practitioners and operators to undertake their respective duties was documented within the relevant EP and in the completed SAF. This outlined the training programmes in place for all duty holders under IR(ME)R, including the arrangements for maintaining and managing training records for practitioners and operators.

In addition, the SAF set out how the employer assured compliance with written procedures across all duty holders. All radiology staff acting as duty holders were required to review the EP and formally confirm, via a signed declaration, their understanding of and commitment to comply with, these requirements.

Justification of individual exposures

Staff we spoke with stated that justification of exposures focused on ensuring requests were appropriate, complete and clinically necessary. This included checking patient identification details, referrer information, signatures and relevant clinical history or previous imaging. Staff would also consider whether the exposure would answer a clear clinical question and would challenge requests or suggest non-ionising alternatives where more appropriate.

There were some variations in practice and documentation, with different forms used across modalities (for example mammography and surgical teams) and some reliance on information provided in GP referral letters. Authorisation was generally guided by established protocols such as departmental authorisation guidelines (DAGs), although use appeared inconsistent between staff.

The SAF described the processes (electronic or written) of how justification and authorisation was performed and where this was recorded. Referrals were received via both paper and electronic systems. Paper referrals were completed by the referrer and sent to the radiology department by post or email, then entered and scanned onto the radiology information system to create a permanent record. Electronic requesting allowed referrals to be submitted via the Welsh Clinical Portal and transferred directly to the radiology system, though rollout was ongoing. All referrals were reviewed on an electronic vetting list, where a practitioner (or authorised operator) assessed justification, accepted or declined the request and recorded the decision and any relevant protocol information on the system.

Optimisation

We spoke with staff about optimisation of radiation doses as low as reasonably practicable (ALARP). They stated this was achieved through a combination of good positioning, appropriate techniques and use of standardised protocols. Staff were aware of the correct processes to follow including positioning patients correctly. We were also told that modality-specific approaches were used, including compression in mammography and adherence to local DRLs. Only the necessary views were taken to answer the clinical question and exposure parameters were tailored to the patient's size and condition.

Practitioners and operators ensured exposures were justified and optimised. This included confirming the correct modality had been requested, following agreed protocols and using dose-reduction techniques. Governance arrangements supported this, with dose monitoring systems (Qaelum), regular audits by MPEs and review and setting of local DRLs. A multidisciplinary CT User Group (Image Optimisation Team (IOT)) helped standardise protocols, reduce dose variation and share best practice across the organisation. The department would benefit from setting up IOT for the other modalities.

For higher-risk groups, additional safeguards were applied. In pregnant patients, exposures were carefully justified, considering whether the examination could be delayed or replaced with an alternative modality. Alternatively, if not, justification was escalated to a consultant radiologist. Timing of the exposure was also considered where relevant. High-dose procedures such as CT were closely monitored through audit and governance processes to ensure doses remained within acceptable limits and optimisation opportunities were identified.

Paediatrics

Paediatric imaging was provided at the department. The SAF described how practitioners and operators ensured that the exposure was justified and doses were optimised. For paediatric patients, the identity would be checked with an accompanying nurse, carer or relative if the child was unable to answer all of the questions.

The SAF described that for paediatric patients, referrals were justified by practitioners who have access to additional specialist advice, if needed. Standardised protocols were tailored to the child's size and age, adjusting exposures accordingly and reviewing images and doses to ensure diagnostic quality. Exposure charts provided guidance in examination rooms. Radiation dose was minimised through collimation, avoiding grids where possible and using AEC, when appropriate.

Carers or comforters

There was an EP in place with an established dose constraint for diagnostic X-ray and guidance for the exposures of carers and comforters for the department. The EP would benefit from including reference as to the modalities the dose constraint applies.

The employer must ensure that the EP includes reference as to the modalities to which the dose constraint applies.

The SAF described the process for justification of exposures to carers or comforters as well as the guidance for the exposure of carers and comforters, including any dose constraints established.

Staff we spoke with recognised the need to minimise exposures and follow appropriate safeguards. This included completing relevant documentation, providing PPE, explaining risks and ensuring individuals had not undertaken this role recently. Processes such as questionnaires or support and holding records were used, with an emphasis on using carers and comforters only when necessary and documenting their involvement appropriately.

Expert advice

Staff demonstrated good awareness of how to access MPE support and advice, with positive engagement in areas such as dose audits, training and learning resources. Training provided by the MPE on SAUE and CSAUE was highlighted as an area of good practice. There were clear arrangements for governance, including a requirement for EPs to be reviewed at least every two years by the Head of Radiology in collaboration with site lead radiographers and the MPE. Additional strengths include enhanced quality control (QC) testing on mammography equipment due to the age of the equipment, the establishment of local DRLs and ongoing MPE support.

MPE services for diagnostic radiology were delivered under a service level agreement to Bronglais General Hospital. All MPEs were appropriately certified by RPA2000. The MPE played an active role in a wide range of activities, including equipment testing, staff training, development of employer's procedures, dose audits and regulatory advice. A multidisciplinary CT User Group led by an MPE further supported dose optimisation, protocol standardisation and shared learning across the Health Board. Patient dose data is routinely collected through the Qaelum system and reviewed to inform local DRLs and audits.

Equipment: general duties of the employer

A comprehensive quality assurance (QA) programme was in place for all radiology equipment, supported by both external and local processes. All equipment was installed and maintained by qualified service engineers, with oversight from Swansea Bay Radiation Physics. The QA programme included acceptance testing prior to first clinical use, routine performance testing at scheduled intervals and additional testing following maintenance or repair. This was complemented by more frequent, locally conducted radiographer QC checks using an MPE-provided handbook.

There were two equipment QC testing radiographers, which impacted service resilience and continuity. The frequency of testing required was not being complied with as set out by the MPE's instructions. Current paper-based recording methods were inconsistent, making oversight difficult and introducing risk. Additionally, it was reported as being difficult for senior staff and MPE to have overarching insight on QC testing due to no central recording of results. Any QC issues were escalated through the Medical Exposure Group (MEG). Consideration should be given to the establishment of a centralised electronic system for recording QC data, expand staff training and work with the MPE to develop a more robust and sustainable QA framework with strengthened senior management oversight.

The employer must ensure:

- **The frequency of QC testing complies with that set out by the MPEs**
- **There is central recording of the audit results to allow for overarching management insight**
- **Additional staff are trained to carry out QC testing.**

Remote access by engineers was possible for certain modalities, but only when enabled by radiographers. However, a formalised handover process for such access is not yet fully established.

The employer must ensure a formal written handover process is established for remote access with external engineers for access and repairs. This process should follow the same process as if the engineer was on site to ensure that equipment is accepted and put back into clinical practice in a safe way.

Patient dose was routinely monitored and recorded through established procedures. Dose indicators for modalities such as general radiography, CT and mammography were automatically captured by the patient dose management system (Qaelum) or manually recorded on the radiology information system (RIS) where integration was unavailable. This data was accessible to the MPE for audit and reviewed in line with DRL policies. Dose information was also recorded on patient referral forms, including for mobile fluoroscopy in non-radiology settings (e.g. theatres). Despite these systems,

audit findings had identified inconsistent compliance with dose recording requirements (ranging from 25–55%) and evidence of limited follow-up action to address these gaps.

The employer must ensure there is regular timely re-audit until the compliance is reached and then at regular intervals thereafter.

Procedures were in place to manage defective or inadequate equipment. Faults were recorded on paper sheets kept within each room and handover documentation was completed before equipment returns to use. However, fault records were not centrally collated, limiting senior management oversight. Additionally, the equipment inventory currently had gaps, including missing key information such as the year of manufacture and required updating to fully meet IR(ME)R requirements.

The employer must ensure:

- **Fault records are centrally managed and reviewed regularly by management and signed to that effect to ensure management oversight and to avoid any relevant actions being missed**
- **The equipment inventory is updated to include all the information required by IR(ME)R.**

Several items of equipment at the department were ageing, with the mammography and X-ray unit at 12 years old and the DXA scanner at 21 years old, significantly exceeding the typical 10-year replacement recommendation. Although these units remained in use and were reported as producing acceptable image quality and passing dose assessments, their age placed them at risk of reduced reliability. It was positive to note that both the DXA and mammography units were included in National Imaging Equipment Capital Priorities Group (NIECP) and that procurement for a new DXA scanner was underway.

There was an established DXA referral pathway, including referrals from GPs and non-medical referrers and the service focused on bone mineral density assessments rather than body composition. Local DRLs were in place, which was an area of good practice. The age of the equipment restricted available imaging views. Additionally, formal clinical reporting was not consistently undertaken, with reliance on technical output only, representing a breach of IR(ME)R requirements.

The employer must ensure that there is formal clinical reporting on all DXA scans.

For breast imaging, symptomatic pathways were in place, with GP referrals triaged through surgical teams and managed via a triple assessment clinic. Services provided locally included digital breast tomosynthesis (DBT) and fine needle aspiration, while more advanced procedures such as vacuum-assisted biopsy were undertaken at another site. Regular quality control checks, MPE support and established DRLs contributed to optimisation, although the mammography unit remained amber-rated due to age.

Safe

Managing risk and health and safety

All areas of the department were observed to be clean, tidy and well-organised, with no evidence of clutter. Furniture, fixtures and fittings were generally in good condition and suitable for use. However, one operator's chair in a general X-ray room containing the resuscitation trolley was noted to have torn upholstery, which would prevent effective cleaning and needed to be replaced.

The health board must ensure the ripped chair in the general X-Ray room is replaced and that all equipment is suitable for its use and can be effectively cleaned.

The department was dispersed across different areas of the hospital rather than being co-located. There were no blocked corridors or visible trip hazards. Overall, the environment was appropriate for its intended use, although co-location would likely enhance efficiency in an ideal setting.

Staff stated that incidents were recorded via the Datix system, escalated to line managers and the MPE and subsequently investigated. Relevant procedures were outlined within the EPs. Senior staff confirmed that incident reporting followed a structured process, including notification to the RPS, investigation, action planning and feedback to staff.

We were told that safety alerts were received centrally and disseminated to site leads, with actions followed up as required. These were also shared through governance structures, including CCG meetings and Quality and Safety patient experience meetings. Welsh Health Circulars were similarly distributed via the CCG.

Infection prevention and control (IPC) and decontamination

The department was clean, tidy and well organised, with minimal clutter. Equipment was appropriately maintained and visibly clean. Privacy curtains displayed clear records of their installation dates.

Medical sharps bins in the CT scan area were appropriate, not overfilled and correctly labelled, these were dated and disposed of in line with expected procedures. Handwashing and drying facilities in both staff and patient areas were suitable and readily accessible. Personal protective equipment (PPE) was available and conveniently located for staff use.

Staff reported that IPC training was provided, including guidance on the management of spills and infections. They confirmed that cleaning could be undertaken between patients and as required. Staff were aware of the appropriate protocols for managing

infectious patients, including necessary cleaning procedures. Senior staff outlined established IPC governance arrangements, which included designated IPC champions, regular hand hygiene audits and nursing-led IPC audits. Cleaning schedules encompassed routine daily cleaning as well as additional deep cleaning when required.

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. The majority of respondents felt there was an effective cleaning schedule in place and that the environment allowed for effective infection control.

Safeguarding children and safeguarding vulnerable Adults

Staff we spoke with were aware of the organisation's policies and procedures on safeguarding and where to access these. They were also able to describe the actions they would take should they have a safeguarding concern and how to escalate these concerns.

Staff said they had received mandatory safeguarding training at level two and three for adults and children.

Effective

Patient records

We checked a sample of five patient records, the review identified several areas of concern relating to documentation, authorisation and consistency of record keeping. This appeared to be influenced by multiple documentation systems (paper forms, letters and electronic records), leading to inconsistency and gaps in information. Staff may be unclear about where specific information should be recorded, contributing to variation in practice.

There was no clear evidence of authorisation in some cases. Although relevant information was present on paper forms, it was not consistently transferred to the patient's electronic record. Additionally, tick-box confirmations were noted without accompanying initials or signatures to demonstrate accountability.

Important clinical details were not always captured at the point of referral. For example, a patient's post–caesarean section status was only identified within the report and not clearly documented on the referral form or electronic system.

In one mammography referral, the GP was listed on the form whereas the referral appeared to originate from a breast surgeon. No supporting documentation from the breast surgeon was available, resulting in ambiguity regarding the responsible referrer.

Documentation practices were inconsistent, with variability in how and where information was recorded. Some records were incomplete, particularly in relation to key safety checks. Pregnancy status checks were not consistently documented and differed across modalities due to the use of multiple forms.

Regarding DAGs in CT, some referral categories, including orthopaedic and major trauma requests, lacked sufficient detail to enable operators to appropriately authorise exposures under delegated authority.

There was evidence that radiation doses and relevant exposure parameters were recorded for each type of exposure within the episode of care. Referrals included three unique patient identifiers, supporting appropriate patient verification. There was clear evidence that patient identity was confirmed prior to exposure, including the use of the WHO checklist for theatre patients.

The employer must ensure patient records comply with the requirements of IR(ME)R including:

- **A robust system for referrals is established and implemented that eliminates variation and reduce risk**
- **Referrals are completed in full with sufficient clinical detail**
- **Authorisation of the exposure is being recorded**
- **Pregnancy enquiries are consistently completed and clearly documented**
- **There is evidence of clear clinical evaluation in all cases**
- **Information is consistently recorded on every occasion**
- **The various forms are standardised for every modality**
- **The CT DAG includes the necessary detail for such as orthopaedic requests and major trauma to allow operators to authorise under the DAG.**

Efficient

Efficient

The department demonstrated a proactive and forward-looking approach to improving efficiency, patient flow and service delivery, with clear opportunities to strengthen governance and document control processes.

Staff we spoke with provided several examples of initiatives designed to improve efficiency and patient flow. These included the implementation of a direct-to-CT stroke pathway, whereby patients identified by paramedics as having a suspected stroke in an emergency ambulance were taken directly to the CT department. A designated holding area was used in radiology, where patients were met promptly by the stroke team, who assessed and determined the most appropriate imaging required. This pathway supported timely diagnosis and treatment.

Radiographers described proactive practices that enhanced efficiency, including escalating significant findings directly for further imaging and avoiding unnecessary delays by requesting additional scans at the point of care. These included:

- Encouraging radiographers to liaise with radiologists in real time, facilitating timely clinical decision-making and additional imaging where appropriate
- Direct referral to the ED in cases such as suspected fractures, ensuring prompt clinical management
- Immediate CT request generation during endoscopy when a tumour is identified, reducing delays in diagnosis and treatment within cancer pathways
- Ongoing work to improve urgent and emergency care pathways, including exploring ways to reduce ED attendance and waiting times through more efficient access to imaging.

Senior staff highlighted the use of a centralised booking system integrated with the RIS, which enables patients to be offered appointments across multiple sites, improving access and flexibility. They also outlined ongoing strategic planning, including workforce development and pathway redesign, aimed at improving patient flow and reducing waiting times.

Additionally, the health board had entered into a ten-year partnership to explore the implementation of artificial intelligence (AI) in radiology. This work was currently at the scoping stage and aimed to enhance reporting capacity, streamline processes, improve patient communication and potentially enable patients to self-schedule appointments.

It was identified that the health board did not have a document management system to improve the handling of paper-based records including EPs. The department and the wider health board would benefit from the implementation of a document

management. Such a system would support better version control, tracking of review dates and confirmation of staff engagement with documents. It is noted positively that this has been recognised as an area for development, with plans already identified by the Head of Radiology.

The employer should invest in an electronic document management system to support better version control, tracking of review dates and confirmation of staff engagement with documents.

It was also positive to note that there were MEG meetings, but these did not represent all areas of radiology. Additionally, IR(ME)R audits should be a standing item to ensure actions are being carried out

Quality of Management and Leadership

Staff Feedback

HIW issued a questionnaire to obtain staff views on a wide range of areas such as patient care, professional development and management at the department for the inspection undertaken in May 2026. Staff responses were captured onsite via posters displaying the online survey link. In total, HIW received 42 survey responses from staff who had shared their views on the setting. Free-text comments have been summarised into themes and individual responses are not quoted to maintain anonymity.

Staff reported generally positive views on patient care, safety and professional standards. However, the survey identified significant challenges related to staffing levels, leadership visibility, communication and staff engagement in decision-making. This was reflected within the comments where some staff reported the need for improvements in permanent senior leadership posts whilst also reflecting positive management through periods of change.

The positive key themes from free text comments included staff describing teams as supportive, hardworking and dedicated. Some staff highlighted improvements in leadership support with other comments noting the need for further improvements.

There were also positive views of peer support and teamwork across services.

The areas for improvement in the free text comments included references to staffing shortages and workload pressures as well as weak communication and limited visibility from senior management. Staff identified a lack of consistent leadership and absence of site leads as well as limited staff involvement in decision-making and service changes. There were departmental layout constraints identified which affected privacy, dignity and workflow.

Leadership

Governance and leadership

The Chief Executive was designated as the 'Employer' under IR(ME)R 2017, holding overall responsibility for regulatory compliance, with duties appropriately delegated to managers and duty holders as outlined in the Ionising Radiations Safety Policy.

Management teams across inspected departments demonstrated a positive and receptive approach to learning and improvement following inspection findings. Departmental managers and leads engaged well throughout the inspection process.

Staff we spoke with confirmed that whilst information was communicated via multiple channels, visibility of senior leadership was reported as limited in recent periods.

Senior staff highlighted established governance and communication structures, including weekly site lead meetings and the Radiology Quality and Safety Patient Experience meetings (open to all staff, with reporting to board level). There were also plans to strengthen leadership roles, with a greater focus on quality and governance going forward.

We were told that the Head of Radiation Physics employed from Swansea Bay and the Head of Radiology had been advocating for the establishment of a dedicated Governance Radiographer (Quality and Safety role) across Hywel Dda University Health Board. This role would provide central coordination of clinical audit activity, incident learning and follow-up to promote a more integrated, standardised approach to governance, supporting compliance with IR(ME)R. A formal proposal had been developed, with identified investment and was currently under consideration at executive level as part of the organisational change process. This role was considered essential in addressing the current fragmented approach to governance arrangements. In addition, there were plans to progress radiology accreditation, which this role would help support and strengthen.

The employer should consider the establishment of a dedicated Governance Radiographer (Quality and Safety role). This role would include addressing some of the areas requiring improvement in this report including providing clinical audit activity, incident learning and follow-up and to standardise the approach to governance, supporting compliance with IR(ME)R.

The Head of Radiology also outlined proposals to appoint health board-wide modality leads for MRI, CT and ultrasound services. This structure would provide greater strategic oversight while enabling local leads to focus on operational management, workforce planning, training and staffing at a site level.

The staff feedback regarding immediate managers was mixed with 64% of staff saying they felt their manager could support them with difficult tasks and 62% said their immediate manager gave clear feedback on their work. Additionally, 55% of staff said their immediate manager asked staff opinion before making decisions that affected their work.

Perceptions of senior leadership were less positive with only 45% saying senior managers were visible. Communication was also a concern, 40% of staff felt communication was effective and 60% believed senior managers were committed to patient care.

We also appreciated the pressures on the service relating to the lack of a full-time site lead and noted that a new site lead had been appointed and would start shortly as well as other plans to improve the service. We were also told regarding raising concerns or reporting incidents to senior staff that whilst blame was previously attributed to staff, senior staff had been trying to work with staff to improve this.

Workforce

Skilled and enabled workforce

Staff we spoke with reported that staffing levels were not always sufficient, particularly when covering multiple areas, during theatre activity and out of hours. Concerns were raised about lone working overnight, with associated risks to safety and workload. Whilst staff generally felt able to raise concerns this could be challenging.

Senior staff acknowledged that current staffing met minimum establishment requirements but was not sustainable in the long term. Recruitment was ongoing, alongside plans to develop modality-specific workforce models to improve resilience.

A range of staff support and wellbeing initiatives were highlighted as good practice. These included access to occupational health services, wellbeing resources, coaching and mentoring programmes, increased frequency of one-to-one meetings and support schemes such as the carers passport. Staff also had access to ‘Canopi’, a confidential mental health support service for NHS and social care staff in Wales.

The out of hours cover and the regular rotation of staff through CT was described to maintain competency. Radiologist reporting overnight was provided by an external service (Everlight), covering both CT and MRI. An up-to-date list of radiologists, including GMC registration details, was shared across the health board and documented within clinical evaluation and justification processes.

We reviewed a sample of training and competency records for four staff members, including examples of practitioner, operator and referrer roles. Overall, the training records appeared to have been completed only recently. There was limited assurance that staff had full awareness or engagement with these records, as documentation typically included only a printed name and date, with no signatures to confirm accountability. Furthermore, the majority of records were completed in April 2026, including for staff who have been established in the department for several years.

Training and competency records reviewed indicated that sign-off often occurred on a single date, suggesting a potential 'tick-box' approach rather than a robust assessment of competence over time. This may weaken assurance that staff were appropriately trained and competent within their defined scope of practice.

There were also inconsistencies identified within the records. For example, dates relating to equipment training and competency sign-off did not align. In one case, records indicated sign-off in January 2026 with no additional supporting training documentation available. Training and competency documentation should be completed progressively over time, with competencies signed off at the point they are achieved. Furthermore, there was no clear mechanism within the documentation to record changes in scope of practice, such as adding or removing competencies.

The records gave the impression of being retrospectively completed and did not provide sufficient assurance that they accurately reflect ongoing training, competency development, or current scope of practice.

The employer must ensure training and competency records are appropriately assessed over time and each element is signed off once deemed competent.

Staff we spoke with confirmed that they had received an appraisal in the previous year and this was supported by the records which showed 100% compliance with appraisals. We were also told significant time was invested in student development when on site.

Overall training compliance evidence through ESR was 91%. However, a review of the mandatory training and other training at the department identified low compliance levels for staff with resuscitation level two at – 9% compliance and the safe administration of oxygen in the event of an emergency at 14%. This meant that assurance could not be provided that a sufficient number of appropriately trained staff were available on each shift, to respond effectively to a medical emergency. Although management had taken steps to book staff onto the next available training courses, the risk remained present at the time of the inspection. **These concerns were addressed as part of our Immediate Assurance Process and were detailed in Appendix B of this report.**

In the staff questionnaire, regarding their health and wellbeing at work, 71% of staff agreed that, in general, their job was not detrimental to their health and 67% said that their organisation took positive action on health and wellbeing. More staff, 71% stated that their current working pattern and off duty allowed for a good work-life balance and 95% were aware of the occupational health support available to them.

Only 57% of staff felt there were enough staff to do their job properly and 48% of staff agreed they were involved in decisions regarding involvement in change. The majority of respondents (64%) felt they had received appropriate training for their role. Staff comments relating to what other training they would find useful were:

> *"More computer skills particularly with the new booking system."*
>
> *"New system in place and although we had some training it didn't really reflect everyday use and has had a lot of issues."*
>
> *"Postgraduate training."*

Culture

People engagement, feedback and learning

The department displayed several resources informing patients and families how to provide feedback on their care. This included the 'Listening to People' poster, outlining the NHS Wales complaints, incidents and redress process and explaining how concerns could be raised with the Health Board. An 'It Matters to Us' poster encouraged patients to share feedback on their recent experience and provided a quick response (QR) code, website link and telephone contact. In addition, a 'Big Thank You' poster offered an opportunity for patients to recognise staff or the care received via QR code or telephone. These materials were visible throughout the department.

Limited information was observed regarding additional support services. No visible information relating to Llais (the patient advocacy service) was identified. A leaflet on raising a concern was available at reception and further posters were being displayed during the inspection.

A 'You Said, We Did' board was positioned at the department entrance and highlighted actions taken in response to patient feedback.

Staff demonstrated an awareness of the duty of candour and the importance of being open when things go wrong. Some staff also indicated an understanding of incident reporting requirements. Senior staff confirmed awareness of duty of candour obligations, including the importance of reporting incidents and maintaining openness.

In the staff questionnaire 95% of staff said they knew and understood the Duty of Candour and 93% understood their role in meeting the Duty of Candour Standards. Additionally, 71% of staff said their organisation encourages them to raise concerns when something had gone wrong and to share this with the patient. Also 72% of staff agreed that patient or service user experience feedback was collected within the department and 43% of staff said they received regular updates on patient or service user experience feedback. Whilst 67% of those with an opinion said that feedback from patients or service users was used to make informed decisions within the department.

In total 69% felt their organisation was supportive and 57% felt the organisation took swift action to improve. Most staff were satisfied with the quality of care and support they gave to patients (93%), slightly less 76% said they would be happy with the standard of care provided by their department for themselves or for friends and family and slightly less 72% would recommend their organisation as a place to work. Other responses in the staff questionnaire were as follows:

- Care of patients was the organisation's top priority - 78%
- Content with the efforts of the organisation to keep staff and patients safe - 83%
- They were able to meet the conflicting demands on their time at work - 76%
- They were able to access ICT systems needed to provide good care and support for patients – 90%

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

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
Signage reminding patients to report any changes in their medical history was not initially observed.	Changes to patients' medical history are missed that could affect the patient outcomes.	Lead Radiographer informed.	This was addressed and implemented during the inspection and appropriate signage prominently displayed.

Appendix B – Immediate improvement plan

Service: **Diagnostic Imaging Department, Bronglais General Hospital**

Date of inspection: **19 and 20 May 2026**

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.

Findings	A review of the mandatory training and other training at the department identified low compliance levels for staff with the following subjects: • Resuscitation Level Two Adult Basic Life Support training – 9% compliance • The safe administration of oxygen in the event of an emergency – 14% compliance. This low compliance rate meant that assurance could not be provided that a sufficient number of appropriately trained staff were available on each shift, to respond effectively to a medical emergency and we could not be assured the risks of harm to patients would be appropriately managed. Although management had taken steps to book staff onto the next available training courses, the risk remained present at the time of the inspection.

Improvement needed	**Standard / Regulation**

1.	The employer must ensure: • Staff receive appropriate training on resuscitation and the safe administration of oxygen in the event of an emergency • Staff are able to access resuscitation training in a timely manner and that robust interim mitigation measure have been implemented.	Delivery of Safe and Effective Care Welsh Health Circular 2024/036 - Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder

Service Action:	Responsible officer	Timescale
a. Improvement needed: Resuscitation Level Two Adult Basic Life Support training- ensure all relevant staff are appropriately trained		
i. Validate the current mandatory training compliance position within the Diagnostic Imaging Department, ensuring data accuracy against ESR records. Complete: Compliance increased to 19.1% as of 29.05.26 (evidence ref: Doc1)	Site Leads	Completed 29.05.26
ii. Identify, agree, and implement additional training capacity with Resuscitation Trainers to support delivery against compliance targets. Complete: Additional training sought 22.05.26 (evidence ref: Doc 2); Future training report completed 29.05.26 (evidence ref: Doc1), but pending further staff bookings	Site leads	Completed 29.05.26
iii. Completion of Level 2 Adult Basic Life Support module for clinical staff to Health Board compliance training target level	Deputy Head of Radiology	By 30.07.26
iv. Implement weekly compliance tracking with timely corrective actions initiated where performance deviates from the agreed training trajectory.	Deputy Head of Radiology	Between 01.06.26

		30.07.25
b. Improvement needed: The safe administration of oxygen in the event of an emergency- ensure all relevant staff are appropriately trained		
I. Complete verification of staff compliance with safe administration of oxygen training in partnership with the Health Board Learning and Development (L&D) Officer Complete: Baseline training compliance of 77.8% on 29.05.26 Doc, evidence Ref: Doc 1	Site Leads	29.05.26
II. Ensure that all remaining identified staff (N= 7) complete the safe administration of oxygen on-line training, with progress monitored via the reports obtained via the L&D Officer	Deputy Head of Radiology	19.06.26
1.3 Mitigating actions:		
I. To mitigate the risk of patient harm while maintaining service provision during the interim period to achieve training compliance, compliant staff will be distributed across the rota to ensure they are spread across as many shifts as possible, avoiding concentration within the same shifts. Shifts will only be covered by staff awaiting completion of training when it is service critical to do so.	Site lead	Between 01.06.26 and 30.07.26
II. Any lone-working staff who are not complaint to training, have been advised to request that patients attending the department are accompanied by an escort who is level 2 BLS trained	Site lead	Between 01.06.26 and 30.07.26
Completed: Email sent to staff 29.05.26 (evidence ref: Doc 3)	Site Lead	29.05.26

Findings	We reviewed the IR(ME)R compliance audit of mammography surveillance at Withybush, Prince Philip and Bronglais Hospital (which was conducted in December 2024). The aim outlined in this audit was to identify the level of compliance with current Employer's Procedures in relation to follow up examinations for mammography patients. Patients attending for mammogram

	surveillance studies across the 3 sites were noted as being subject to different booking and recall processes. An initial audit of 100 patients from each site were analysed to identify if the relevant Employer's Procedures were being followed and if any trends relating to non-compliance could be identified. The results for Bronglais were as follows: • 22% justification by clinician information • 23% correct form used • 23% referrer identified their entitlement • 23% requested signed and dated • 92% pregnancy checks. The action included a reaudit in six months. There was no evidence that a reaudit was carried out and the findings of the audit showed a serious lack of understanding to meet the requirement of the Ionising Radiation (Medical Exposure) (Amendment) Regulations (IR(ME)R 2024) and a clear non-compliance with their own Employer's Procedures. Additionally, in view of the findings this should have been re-audited as soon as actions had been implemented. In addition, we reviewed IR(ME)R audits from across the radiology department which did not have 100% compliance with IR(ME)R and the health board Employer's Procedures. For these audits there was little evidence of any action taken in a timely way to investigate or implement appropriate actions based on the findings. Again, appropriate reaudit should occur in a timely manner and sooner than in six months. Due to the level of non-compliance with IR(ME)R, which imposes duties on employers to ensure safe and effective medical exposures practice, HIW could not be assured that patient safety was being maintained.
Improvement needed	**Standard / Regulation**

2.	The employer must ensure: • Where there is non-compliance with IR(ME)R on audits, any reaudits must occur as soon as appropriate actions had been implemented • There is effective management and control of audits to ensure staff conducting the audits are aware of what they are checking, there is consistency in the checks carried out, actions are identified and assigned and reaudits occur in a timely manner.	IR(ME)R Regulation 6(2), 10, 11 and 12

Service Action:	Responsible officer	Timescale
2.1 Improvement needed: IR(ME)R audits. To ensure effective and consistent application of the audit cycle		
I. Complete a retrospective audit of 100 mammography patients who attended Bronglais to establish the baseline level of compliance with IR(ME)R and Employers Procedures.	Site lead	26.06.26
II. Complete the immediate improvements identified from the re audit across all 3 sites	Site lead	10.07.26
III. Complete monthly spot checks of compliance of IR(ME)R compliance with requirement to cease unauthorised clinical forms and letters – 10 per month across each site	Site leads	Ongoing June, July August
IV. Schedule the re-audit of IR(ME)R compliance at Bronglais Hospital, and share findings and associated action plan to be shared with HIW. Timing of audit will depend on findings from retrospective audits and spot checks, the latest this will be scheduled will be 30.09.26	Site lead	30.09.26
V. Schedule the audit of IR(ME)R compliance in Prince Philip (PPH) and Withybush General, findings and associated action plan to be shared with HIW. Timing of audit will depend on findings from retrospective audits and spot checks, the latest this will be scheduled will be 30.10.26	Site leads	30.10.26

VI.	Establish and implement a standardised audit management process to ensure: • staff undertaking audits are appropriately briefed on audit scope and requirements • audit criteria are applied consistently across all sites • actions arising are clearly identified, assigned to named leads, given defined deadlines and applied across all sites • re-audits are scheduled and completed in a timely manner, with progress tracked and findings shared	Deputy Head of Radiology and Clinical Director	30.11.26

Findings	During the inspection of the department, we reviewed mammography referrals. There was no evidence of a referral from the breast surgeon during record keeping checks of routine mammograms. Staff confirmed they were using the GP letter sent to the clinic requesting that the patients was seen. This is not a referral under IR(ME)R and would not be considered a referral from the referring clinician. Additionally, where patients were undertaking five years of annual follow up breast surveillance, a single referral was being used multiple times and extending for the five-year period without any checks if the patient should stay on the pathway or if clinical information had changed over this period of time. The audit referred to in the above immediate improve plan (2.) identified the following areas for improvement: • Discontinuing use of unauthorised clinical forms/letters • Single use forms to be used for each attendance. This will need to be identified on the form within the clinical information e.g. 3rd year of 5 year surveillance • Remove forms and have clinical review of patients under clinicians who have left the health board. If these areas of improvement had been implemented this would have mitigated some of the patient safety concerns identified during this inspection.

	Due to the level of non-compliance with IR(ME)R, HIW could not be assured that patient safety was being maintained.

Improvement needed		Standard / Regulation
3.	The employer must safely ensure: • Mammograms only occur when there is a completed referral received from an entitled referrer to request the mammogram • The use of a single referral form over multiple exposures is reviewed to ensure that a referral is received from an entitled referrer to request each individual surveillance mammogram.	IR(ME)R regulation 6 and 10. Schedule 2 (b)and (p)

Service Action:	Responsible officer	Timescale
3.1 Improvement needed: Mammograms only occur when there is a completed referral received from an entitled referrer to request the mammogram with the use of a single referral form over multiple exposures is reviewed to ensure that a referral is received from an entitled referrer to request each individual surveillance mammogram.		
I. Immediate discontinuation of unauthorised clinical forms/letters Complete 20.05.26, evidence ref: Doc 4	Head of Radiology	20.05.26
II. Advise staff of implementation of single use forms for each attendance, specifically: • no single referral form which requests multiple exposures will be accepted as of 21.05. 26. • To ensure a safe transition, patients referred before 21.05.26 for multiple examinations will have only the next examination honoured on the existing referral, (with a lead time not	Head of Radiology	20.05.26

	exceeding 20 May 2027). The surveillance scan report will confirm that any further follow-up imaging requires a new radiology request. Complete 20.05.26 evidence ref: Doc 4		
III.	Communicate the requirement for single-use referral forms for each attendance, with the specific surveillance stage clearly documented within the clinical information (e.g. “Year 3 of 5-year surveillance”), supported by follow-up in-person attendance at HDUHB Breast MDT meeting.	Head of Radiology	01.06.26
IV.	Review patients on surveillance whose initial referral was via clinicians who have left the Health Board. A data pull was completed on 26.05.26 which is informing ongoing work to safely transition these referrals.	Radiology System Manager	12.06.26
V.	Create a Standard Operating Procedure for transition of existing surveillance patients into the single referral form whilst maintaining the planned appointment in place from previous system (i.e. those in process prior to 29 May 2026) and use of non IR(ME)R compliant radiology forms for all mammography referrals. The SOP will be disseminated in advance to all clerical staff involved to ensure they are aware of the actions and procedure.	Radiology System Manager	30.07.26
VI.	Include newly created SOP (as above) within the Employee Procedure EP4 -Procedure for making amending and cancelling of referrals for Radiology examinations	Deputy Head of Radiology	30.08.26

	Improvement needed	Standard / Regulation
4.	The employer must ensure the issues identified in this immediate improvement plan are not replicated elsewhere in the health board and if they are, they must take the relevant actions across the health board.	Delivery of Safe and Effective Care

Service Action:	Responsible officer	Timescale
Action: 4.1 As detailed within sections 1-3 assurance is given that all actions are being applied equally to all Radiology sites within the Health Board.		

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: Gail Roberts Davies

Name (print): Gail Roberts Davies

Job role: Head of Radiology **Date:** 22/ 06/ 2026

Appendix C – Improvement plan

Service: **Diagnostic Imaging Department, Bronglais General Hospital**

Date of inspection: **19 and 20 May 2026**

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.	A toilet near the CT scanner lacked a hygiene disposal bin. In the ED, changing facilities were situated along a main patient corridor and separated only by a curtain. This did not provide sufficient privacy and was not suitable for patients with mobility difficulties due to limited space. Similarly, the CT scan waiting area	The health board must ensure: • All toilets have hygiene disposal bins • A review is carried out of the layout of the ED X-ray changing areas to provide sufficient privacy for all patients and sufficient space for patients with mobility difficulties • A review is carried out of the layout of the CT	Health and Care Quality Standards (H&CQS)– Dignified and respectful care	A departmental review of hygiene disposal bins will be undertaken and new bins installed where not currently available. A review of the Emergency Department X-ray changing area layout will be completed to assess options for improving privacy and accessibility. Findings and recommendations will be reported to Site General Manager to support consideration of proposed improvements	BGH Site Lead Radiographer BGH Site Lead Radiographer	30th September 2026 31st October 2026

	used a curtain partition to separate acute patients (including emergency or stroke cases) from others, which posed risks to confidentiality, as conversations could potentially be overheard.	in-patient waiting area to ensure there is sufficient privacy for patients attending this area		A review of the layout of the CT inpatient waiting area will be undertaken to identify opportunities to improve patient privacy and dignity. Findings and recommendations will be shared with Site General Manager to support consideration of any required improvements	BGH Site Lead Radiographer	31st October 2026
2.	Staff said the EPs were clear and reflective of current practice. However, feedback identified that certain specialist areas, particularly mammography and DXA, were not consistent or fully represented within all procedures. Staff indicated that opportunities existed to provide feedback on procedures and that senior staff were accessible and responsive	The employer must ensure that EPs are updated to ensure comprehensive inclusion of all modalities, particularly mammography and DXA.	Ionisation Radiation (Medical Exposures) Regulations (IR(ME)R) regulation 6 (4) and Schedule 2	The 24 Health Board Employer's Procedures will be reviewed and updated to include mammography, DXA and fluoroscopy where appropriate.	BGH Site Lead Radiographer.	30th November 2026

	to suggested amendments.					
3.	The EP for Quality Assurance Programmes specified reviews following the introduction of new equipment or techniques. However, this EP needed to also explicitly include legislative or regulatory changes as a trigger for review. Evidence indicated that amendments introduced in October 2024 were incorporated into procedures until February 2026, suggesting a potential delay in implementation.	The employer must ensure that the EP for Quality Assurance Programmes includes the need for procedures to be reviewed following legislative or regulatory changes.	IR(ME)R regulation 6 and Schedule 2 1 (d)	Employer Procedure 14 will be updated to state that Quality Assurance programmes will also be reviewed in the event of any legislative or regulatory changes.	Withybush (WGH) Site Lead Radiographer.	30th November 2026
4.	Concerns were identified in theatres, where referral forms were often completed when the radiographer arrived, preventing proper	The employer must ensure referral forms in theatres are completed in advance where cases were known to require imaging.	IR(ME)R regulation 6 (2) and10(5)	Referral process and procedure will be reinforced with all appropriate staff. Dissemination of Employer's Procedures 4, 5 & 6 via email communication.	Deputy Medical Director	30th September 2026

	justification, identification and pregnancy checks.			A Health Board-wide audit will be undertaken to assess compliance with the referral process. Findings will inform an action plan, and re-audit will be undertaken to evaluate the effectiveness of the improvements	PPH Site Lead Radiographer	31st January 2027
5.	Clinical evaluation of theatre cases was not being audited for compliance and needed to be added to the audit schedule to ensure compliance with IR(ME)R requirements. All other areas outside radiology performing clinical evaluation should also be audited on a regular basis. If there was no evidence of a clinical evaluation the exposure could not be deemed justified. There were several ways in which referrers could send	The employer must ensure • All theatre cases involving imaging are appropriately clinically evaluated • The EPs reflect the referral documents received, or only documents listed in the procedures are accepted • Referral process is clearly outlined in the EP and complied with by referrers • Regular audits are carried out on clinical evaluations within patient	IR(ME)R regulation 7, 12 (9) and Schedule 2 1 (j)	The responsibilities of clinicians to ensure that a clinical evaluation is undertaken and documented within the patient record will be reinforced through email communication and dissemination of EP12. Referrers and appropriate Radiology staff will be reminded via email communication that only the referral documents listed in Employer's Procedure 4 will be accepted. Health Board wide audit will be added to the Radiology IR(ME)R audit schedule to ascertain compliance with Employer's	Deputy Medical Director Deputy Medical Director GGH Site Lead Radiographer	30th September 2026 30th September 2026 31st January 2027

	in a referral such as paper, electronic and letters. This was not fully reflected in the EPs and senior staff must consider if acceptance of a letter for a referral is in line with EPs. Ideally these referrals should be electronic.	notes for theatre cases.		Procedure 12, where reporting has been delegated to ensure a clinical evaluation is documented in the patient notes.		
6.	Responses were inconsistent about how staff were informed of their entitlement and scope of practice.	The employer must ensure staff are provided with their entitlement and scope of practice and that they are aware of how this is provided to them.	IR(ME)R regulation 10 (3) and Schedule 2 1 (b)	Agree a standardised process for informing staff of their entitlement and scope of practice. Implement process for current and new staff to be introduced to ensure staff are provided with their entitlement and scope of practice.	Head of Radiology Head of Radiology	30th November 2026 31st March 2027
7.	The EPs reviewed set out processes for entitlement under IR(ME)R. There was a need to include explicit reference to all relevant modalities, such as mammography and DXA.	The employer must ensure the EPs include specific reference to all modalities including mammography and DXA as well as inclusion of tasks such as quality	IR(ME)R Schedule 2	Employer's procedure 1 will be reviewed and updated to include mammography, DXA and quality control operator tasks within the respective tables.	BGH Site Lead Radiographer.	30th November 2026

	In addition, the table for diagnostic radiology would benefit from listing quality control (QC) testing as an operator task.	control within operator roles in the relevant table.				
8.	The current NMR policy implied that referrers may review and act upon imaging when within scope of practice. This may have been interpreted as undertaking operator functions, such as clinical evaluation, without formal entitlement. Clarity was required to distinguish between referrer responsibilities and operator duties. Concerns were also identified regarding staff outside radiology undertaking the operator tasks of clinical evaluation without clear evidence of training, competency or	The employer must ensure all staff are aware of their responsibilities and that only those appropriately entitled operators, carry out clinical evaluations. Staff only perform clinical evaluations if they are appropriately entitled as operators and they understand their roles and responsibility to undertake this task.	IR(ME)R regulation 6, 10 (3) and 12 (3) (b) and Schedule 2 1 (b) and (j)	A review of the NMR register will be undertaken to identify referrers who are undertaking clinical evaluation. These identified individuals will be appropriately provided with confirmation that they are entitled and informed individually of their entitlement, responsibilities and scope under IR(ME)R.	Deputy Head of Radiology	30th November 2026

	entitlement. This includes clinical staff in theatres and the emergency department. These roles should be formally recognised, with appropriate training and entitlement documentation to ensure compliance.					
9.	It was not clearly established who held responsibility for granting entitlement, particularly in relation to the role of the head of the MPE service. Governance processes should ensure that individuals responsible for granting entitlement are themselves appropriately entitled by the IR(ME)R employer.	The employer must ensure the entitlement process for MPEs is reviewed to include the head of the MPE service employed by the health board being appropriately entitled.	IR(ME)R regulation 6 (1) and Schedule 2 1(b)	A review of the entitlement process for the Head of the MPE service will be undertaken to ensure that appropriate entitlement for them and their Medical Physics Expert line reports. Employer's Procedure 1 will be duly revised and updated. These individuals identified as appropriately entitled will be informed individually of their entitlement, responsibilities and scope under IR(ME)R.	Executive Director of Allied Health Professions and Health Science	30th November 2026
10.	The check of referral records showed there was a lack of consistent	The employer must	IR(ME)R regulation 11 (1) (f), 11 (3)	Complete a review of all request forms (paper and electronic) to ensure the information recorded	Deputy Head of Radiology	30th September 2026

	recording of pregnancy enquiries. It was noted that there were different pregnancy checking forms and method through the department leading to a mix of recording method and in some cases lack of recording. Patients were not asked to sign to confirm pregnancy status checks and in theatre environments, referral forms were often handwritten at the time of examination rather than being prepared in advance, which did not reflect best practice.	• Introduce a standardisation of documentation to ensure there is a single, consistent method for recording pregnancy enquiries across all areas (paper and electronic systems) • Improve record keeping compliance to ensure all pregnancy checks are clearly and consistently documented, including the outcome and operator details • Review the procedure regarding life threatening situations to emphasise optimisation of exposure and consideration of MPE advice rather than disregarding pregnancy status • Complete theatre referral forms in advance	(d) (i), 12 (8) (d) and Schedule 2 1 (c)	on the request fulfils the Employer Procedure and is standard across both forms. Any required amendments will be implemented to ensure all request forms include the necessary fields. Review EP8 concerning life threatening situations and pregnancy. Review will include MPE advice. Memo to be issued to all staff reminding them of procedure for pregnancy and their role in ensuring pregnancy checks are always undertaken when required. IR(ME)R audit performed to check compliance for pregnancy checks. Any gaps or non-compliance to have an immediate action plan developed, with re-audits scheduled	 Deputy Head of Radiology Deputy Head of Radiology PPH Deputy Site Lead Radiographer	 30th November 2026 31st August 2026 31st January 2027

		where possible, allowing proper justification, identity checks and pregnancy enquiries before exposure • Reinforce expectations around pregnancy checks, recording requirements and adherence to procedures • Regularly audit compliance with pregnancy enquiry processes to identify gaps and ensure improvement actions are sustained.				
11.	Senior staff were asked how benefit and risk information was communicated to patients in theatre settings. They stated that the referring clinician was responsible for providing this information. However, there was no evidence	The employer must ensure benefits and risks to theatre patients is being carried out in a consistent way. The evidence that that this is happening in practice should be included within the relevant documentation.	IR(ME)R regulation 11 (2) (d) and Schedule 2 1 (i)	Email communication to all medical staff regarding their responsibilities under IR(ME)R, to include documented risk benefit conversations within the consent process for any patients who may require x-rays during theatre procedures.	Deputy Medical Director	30th November 2026

	available to demonstrate that this was being undertaken consistently in practice. A consistent approach was required to ensure this information is routinely provided. This may include introducing documentation or prompts within referral or consent processes to enable referrers to evidence that benefit and risk discussions had taken place.			Update Procedure for ID and pregnancy checks for patients within theatre across all sites in EP8.	Deputy Head of Radiology	31st January 2027
12.	Areas outside radiology that undertook clinical evaluation were not subject to consistent review. The absence of recorded clinical evaluation meant exposures could not be considered justified, presenting a regulatory risk. DXA examinations were also not clinically	The employer must ensure images from all areas including theatre and DXA are clinically evaluated to ensure they can be considered as justified.	IR(ME)R regulation 12 (9) and Schedule 2 1 (j)	As per action 5, Health Board wide audit will be added to the Radiology IR(ME)R audit cycle to ascertain compliance with EP 12, where reporting has been delegated to ensure a clinical evaluation is documented in the patient notes. Findings will be shared at Medical Exposure Group	GGH Site Lead Radiographer	31st January 2027

	evaluated and required action.			Advertise for a qualified DXA reporter to ensure clinical evaluation is undertaken.	Deputy Head of Radiology	31st October 2026
13.	The Everlight reporting process involved direct reporting onto the radiology system, with referrers liaising with Everlight radiologists to agree examinations and protocol referrals. Although this pathway was established, there were concerns regarding assurance and governance. In particular, the audit of Everlight clinical evaluations was not undertaken and senior staff reported there was low confidence in the quality of some reports. Whilst the company provide its own audits, these were not integrated into local clinical governance arrangements.	The employer must ensure: • There is in-house peer review of Everlight reporting and mammography reporting in line with professional standards • The scope of IR(ME)R audits includes clinical evaluation for all areas both within and outside radiology • Methodology is written for staff to follow when carrying out audits.	IR(ME)R regulation 7 and Schedule 2 1 (o))	Establish a peer review schedule of Everlight reporting. Establish a peer review schedule for mammography reporting. Schedule of IR(ME)R audits will be updated and undertaken as advised in actions 5 &12. To include a written methodology for undertaking and presenting IR(ME)R audits. One complete, these will be tabled at Medical Exposure Group	Clinical Director of Radiology Clinical Director of Radiology Deputy Head of Radiology	30th November 2026 30th November 2026 31st January 2027

	Discrepancies in reporting are discussed at Radiology Events and Learning Meeting (REALM). Additionally, reporting radiographers were regularly audited, but mammography reporting lacked formal peer review processes.					
14.	Whilst staff we spoke with felt the culture of reporting was positive and without blame, they stated that learning from incidents appeared less consistently embedded, with limited formal feedback. Some learning was shared through reflections, team briefs, or informal discussions, it was not routinely a structured agenda item.	The employer must ensure feedback mechanisms are strengthened and learning from incidents shared with the relevant staff and addressed to reduce recurrence.	IR(ME)R regulation 9	Non-medical staff- Standardised method to ensure feedback and learning from incidents will be documented and introduced as a standing agenda item for team brief in addition to existing methods of feedback. Medical staff- a section for relevant learning from incidents will be added to the Radiology Clinical and Audit meeting which falls outside of REALM.	WGH Site Lead Radiographer Clinical Director of Radiology	30th November 2026 30th September 2026
15.	There was an EP in place with an established dose constraint for diagnostic	The employer must ensure that the EP includes reference as to	IR(ME)R regulation 6 (5) (d)(ii), 6 (6),	EP-23 will be reviewed and updated to include reference to	Deputy Head of Radiology	30th November 2026

	X-ray and guidance for the exposures of carers and comforters for the department. The EP would benefit from including reference as to the modalities the dose constraint applies.	the modalities to which the dose constraint applies.	and Schedule 2 1 (n)	the modalities and which the specific dose constraint applies.		
16.	The frequency of testing required was not being complied with as set out by the MPE's instructions. Current paper-based recording methods were inconsistent, making oversight difficult and introducing risk. Additionally, it was reported as being difficult for senior staff and MPE to have overarching insight on QC testing due to no central recording of results. Consideration should be given to the establishment of a centralised electronic	The employer must ensure: • The frequency of QC testing complies with that set out by the MPEs • There is central recording of the audit results to allow for overarching management insight • Additional staff are trained to carry out QC testing.	IR(ME)R regulation 15 (1) (a) and Schedule 1 (d)	Reinforcement and review of the MPE's QC schedule will be undertaken with all relevant staff. A central shared spreadsheet will be created to record the QC and audit results. (This will be an interim measure until a document management system is purchased) A review of trained staff to undertake QC will be undertaken with additional staff trained where required to include Assistant Practitioners (when appropriate).	WGH Deputy Site Lead Radiographer WGH Deputy Site Lead Radiographer GGH Deputy Site Lead Radiographer	30th November 2026 31st January 2027 31st January 2027

	system for recording QC data, expand staff training and work with the MPE to develop a more robust and sustainable QA framework with strengthened senior management oversight.					
17.	Remote access by engineers was possible for certain modalities, but only when enabled by radiographers. However, a formalised handover process for such access is not yet fully established.	The employer must ensure a formal written handover process is established for remote access with external engineers for access and repairs. This process should follow the same process as if the engineer was on site to ensure that equipment is accepted and put back into clinical practice in a safe way.	IR(ME)R regulation 15 (3) and Schedule 1 (d)	Edit handover document to include remote access.	BGH Site Lead Radiographer	30th November 2026
18.	Dose information was also recorded on patient referral forms, including for mobile fluoroscopy in non-radiology settings (e.g. theatres). Despite	The employer must ensure there is regular timely re-audit until the compliance is reached and then at regular intervals thereafter.	IR(ME)R regulation 7	Ensure compliance with EP10 is included within audit schedule.	GGH Site Lead Radiographer	31st January 2027

	these systems, audit findings had identified inconsistent compliance with dose recording requirements (ranging from 25–55%) and evidence of limited follow-up action to address these gaps.					
19.	Fault records were not centrally collated, limiting senior management oversight. Additionally, the equipment inventory currently had gaps, including missing key information such as the year of manufacture and required updating to fully meet IR(ME)R requirements.	The employer must ensure: • Fault records are centrally managed and reviewed regularly by management and signed to that effect to ensure management oversight and to avoid any relevant actions being missed • The equipment inventory is updated to include all the information required by IR(ME)R. •	IR(ME)R regulation 15 (2)	A central shared spreadsheet will be created to record equipment faults. (This will be an interim measure until a document management system is purchased) EP-14 and the equipment inventory will be reviewed and updated to ensure that all information required by IR(ME)Ris included.	BGH Deputy Site Lead Radiographer PPH Deputy Site Lead Radiographer	30th November 2026 30th November 2026

20.	The age of the equipment restricted available imaging views. Additionally, formal clinical reporting was not consistently undertaken, with reliance on technical output only, representing a breach of IR(ME)R requirements.	The employer must ensure that there is formal clinical reporting on all DXA scans.	IR(ME)R regulation 12 (9)	The Health Board will advertise for a trained DXA reporter.	Deputy Head of Radiology	31st October 2026
21.	An operator's chair in a general X-ray room containing the resuscitation trolley was noted to have torn upholstery, which would prevent effective cleaning and needed to be replaced.	The health board must ensure the ripped chair in the general X-Ray room is replaced and that all equipment is suitable for its use and can be effectively cleaned.	H&CQS -Risk and IPC	A replacement operators chair will be sourced which is IP&C compliant	BGH Deputy Site Lead Radiographer	30th September 2026
22.	There was no clear evidence of authorisation in some cases. Although relevant information was present on paper forms, it was not consistently transferred to the patient's	The employer must ensure patient records comply with the requirements of IR(ME)R including:	IR(ME)R regulation 6 (2), and 11(1) (c) and 11 (5)	Standardise Radiology referral documentation across paper and electronic systems to ensure full clinical detail, identifiable authorisation, pregnancy enquiries (aligned with action 10), safety checks and clinical	Deputy Head of Radiology	31st March 2027

	electronic record. Additionally, tick-box confirmations were noted without accompanying initials or signatures to demonstrate accountability. Important clinical details were not always captured at the point of referral. For example, a patient's post–caesarean section status was only identified within the report and not clearly documented on the referral form or electronic system. In one mammography referral, the GP was listed on the form whereas the referral appeared to originate from a breast surgeon. No supporting documentation from the breast surgeon was available, resulting in	• A robust system for referrals is established and implemented that eliminates variation and reduce risk • Referrals are completed in full with sufficient clinical detail • Authorisation of the exposure is being recorded • Pregnancy enquiries are consistently completed and clearly documented • There is evidence of clear clinical evaluation in all cases • Information is consistently recorded on every occasion • The various forms are standardised for every modality • The CT DAG includes the necessary detail for such as orthopaedic requests and		evaluation are consistently recorded. The CT DAG will be updated for orthopaedic and major trauma requests. Compliance will be monitored through IR(ME)R audit, with gaps reported through Radiology governance until assurance is achieved.	WGH Site Lead Radiographer	30th November 2026

	ambiguity regarding the responsible referrer. Documentation practices were inconsistent, with variability in how and where information was recorded. Some records were incomplete, particularly in relation to key safety checks. Pregnancy status checks were not consistently documented and differed across modalities due to the use of multiple forms. Regarding DAGs in CT, some referral categories, including orthopaedic and major trauma requests, lacked sufficient detail to enable operators to appropriately authorise exposures under delegated authority.	major trauma to allow operators to authorise under the DAG.				

23.	It was identified that the health board did not have a document management system to improve the handling of paper-based records including EPs. The department and the wider health board would benefit from the implementation of a document management. Such a system would support better version control, tracking of review dates and confirmation of staff engagement with documents. It is noted positively that this has been recognised as an area for development, with plans already identified by the Head of Radiology.	The employer should invest in an electronic document management system to support better version control, tracking of review dates and confirmation of staff engagement with documents.	H&CQS – Efficient	Following recruitment to the Quality Lead Radiographer role, an appropriate document control system will be procured, implemented and embedded to support the effective management, review and control of documentation.	Head of Radiology	31st March 2028
24.	We were told that the Head of Radiation Physics employed from Swansea Bay and the Head of Radiology had been	The employer should consider the establishment of a dedicated Governance Radiographer (Quality	H&CQS – Leadership and Governance	Progress the proposal for a dedicated Health Board-wide Quality Lead Radiographer role through the OCP process and, subject to approval, implement the role to support standardised	Head of Radiology	31st March 2027

	advocating for the establishment of a dedicated Governance Radiographer (Quality and Safety role) across Hywel Dda University Health Board. This role would provide central coordination of clinical audit activity, incident learning and follow-up to promote a more integrated, standardised approach to governance, supporting compliance with IR(ME)R. A formal proposal had been developed, with identified investment and was currently under consideration at executive level as part of the organisational change process. This role was considered essential in addressing the current fragmented approach to governance arrangements.	and Safety role). This role would include addressing some of the areas requiring improvement in this report including providing clinical audit activity, incident learning and follow-up and to standardise the approach to governance, supporting compliance with IR(ME)R.		governance, quality assurance and sustained compliance across Radiology services.		

	In addition, there were plans to progress radiology accreditation, which this role would help support and strengthen.					
25.	There were also inconsistencies identified within the records. For example, dates relating to equipment training and competency sign-off did not align. In one case, records indicated sign-off in January 2026 with no additional supporting training documentation available. Training and competency documentation should be completed progressively over time, with competencies signed off at the point they are achieved. Furthermore, there was no clear mechanism within the documentation to record	The employer must ensure training and competency records are appropriately assessed over time and each element is signed off once deemed competent.	IR(ME)R regulation 6 (3) (b), 17 and Schedule 3	Review of Radiology training and competency records to ensure competencies are assessed progressively, dated and signed off when achieved. A standardised entitlement record will be introduced to capture assessor sign-off, staff acknowledgement, review dates and changes to scope of practice.	PPH Site Lead Radiographer PPH Site Lead Radiographer	30th November 2026 31st January 2027

	changes in scope of practice, such as adding or removing competencies. The records gave the impression of being retrospectively completed and did not provide sufficient assurance that they accurately reflect ongoing training, competency development, or current scope of practice.					
26.	Staff reported generally positive views on patient care, safety and professional standards. However, the survey identified significant challenges related to staffing levels, leadership visibility, communication and staff engagement in decision-making. This was reflected within the	The health board is required to reflect on some of the less favourable responses from staff throughout this report and inform HIW of the actions they will take to address these issues.	H&CQS – Leadership	Review themes arising from staff feedback and NHS Wales Staff Survey results, identifying three priority themes for improvement. Develop and implement an action plan to address the identified themes and report progress through the Clinical Care Group governance structure.	Head of Radiology	30th November 2026

	comments where some staff reported the need for improvements in permanent senior leadership posts whilst also reflecting positive management through periods of change.					

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: **Gail Roberts-Davies**

Name (print): **Gail Roberts-Davies**

Job role: **Head of Radiology**

Date: **23/07/2026**