

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

Diagnostic Imaging Department,
Victoria Memorial Hospital,
Welshpool, Powys Teaching Health
Board

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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 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 Vision

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

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.



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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 inspection of the Diagnostic Imaging Department at Victoria Memorial Hospital, Welshpool, Powys Teaching Health Board on 23 and 24 June 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 Senior 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 29 questionnaires were completed by patients or their carers and 10 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 inspection found a caring, respectful and patient-focused service delivering positive experiences and high standards of care.

Feedback from patients, family members and carers was highly positive, with all but one respondent rating the service as ‘very good’ and the remaining respondent rating it as ‘good’. Patients consistently described the environment as clean, welcoming and efficient, with many praising the professionalism, friendliness and reassurance provided by staff. Several respondents highlighted the value of having accessible local services in Welshpool.

The inspection found strong evidence of person-centred care. Patients reported being treated with dignity and respect, receiving clear explanations about procedures and feeling listened to by staff. Privacy and confidentiality were maintained through appropriate facilities, including dedicated changing areas, private consultation space and measures to minimise unnecessary patient exposure. Staff survey responses reflected similar positive views, with all respondents confirming that patient dignity, involvement and informed decision-making were prioritised.

Care was generally delivered in a timely manner, with appointments running efficiently and patients being informed of any delays. Most respondents considered waiting times between referral and appointment to be reasonable and reported being kept informed about expected waiting times.

The department demonstrated a commitment to accessibility, communication and inclusion. Bilingual signage and patient information were widely available, along with access to interpretation services and British Sign Language support. Information on providing feedback and raising concerns was clearly displayed, supported by evidence of service improvements through a “You Said, We Did” initiative. Equality, diversity and inclusion were actively promoted through staff training and organisational policies.

Despite the positive findings, some areas for improvement were identified. Health promotion information, particularly regarding healthy lifestyles and smoking cessation, was limited within the department and should be expanded. The health board was also asked to consider introducing a hearing loop at reception and making large-print consent information available.

This is what we recommend the service can improve:

- Health promotion information on healthy lifestyles and smoking cessation
- Accessibility through consideration of a hearing loop at reception and the availability of large-print consent forms and patient information.

This is what the service did well:

- Patients consistently describing staff as friendly, professional, caring and reassuring
- Strong emphasis on dignity, respect and person-centred care
- Good communication and engagement arrangements, including bilingual signage and information, visible feedback mechanisms and evidence of service improvement.

Delivery of Safe and Effective Care

Overall summary:

The department generally provided safe, effective and patient-centred radiology services, supported by committed staff, governance arrangements and significant investment in equipment. Staff demonstrated good awareness of patient identification processes, pregnancy enquiry procedures, referral management, clinical evaluation processes and the reporting of accidental or unintended exposures. Medical Physics Expert (MPE) support was comprehensive, and quality assurance (QA) arrangements for equipment were well established.

The environment was clean, well maintained and supported effective infection prevention and control practices. Patients reported high levels of satisfaction with the information provided and care received.

However, several areas of improvement were identified. The department lacked a formal process to confirm that non-radiology duty holders had read and understood Employer's Procedures (EPs). Inconsistencies were also noted in staff understanding and use of Diagnostic Reference Levels (DRLs), including the display of unratified local DRLs. In addition, assurance of the training and competency of third-party operators, Everlight, was insufficient. Further improvement was required in radiation risk communication training for staff, while clinical audit arrangements lacked formalised procedures, clear governance and oversight, defined actions and evidence of action completion and re-audit.

Further improvements were needed in documentation practices, practitioner identification for walk-in examinations, use of standard IR(ME)R terminology and completion of the radiology equipment inventory.

Despite these shortcomings, staff demonstrated strong engagement with incident reporting, shared learning and patient safety processes and the department showed a clear commitment to continuous improvement.

Immediate assurances:

- Updated EPs reflecting the 2024 amendments to IR(ME)R had not been fully ratified or implemented at the time of inspection, limiting assurance that procedures were being systematically reviewed against current standards.

This is what we recommend the service can improve:

- Clinical audit and IR(ME)R audit oversight by developing a formal audit procedure covering the entire patient pathway, including defined compliance standards, action plans, timescales, responsible leads, evidence of completion

and re-audit arrangements

- Removing unratified DRLs from clinical areas and improve staff understanding of which DRLs to use, how to apply them and the actions required when DRLs are consistently exceeded
- Assurance of adequate training and competency of all duty holders. In particular, oversight of training assurance processes for third-party Everlight operators and radiation risk communication training for all operators
- Documentation and record-keeping by ensuring practitioner identification and authorisation were consistently recorded, standard IR(ME)R terminology was used and the equipment inventory contained all required information, including year of manufacture; plus all software, including supportive AI systems, to be included.

This is what the service did well:

- Robust patient identification and pregnancy enquiry processes that were clear, well understood and consistently applied by staff
- Strong incident reporting and shared learning culture, with detailed trend analysis, Datix audits and positive staff feedback regarding learning from incidents
- Equipment quality control testing and MPE involvement, supported by significant investment in modern radiology equipment and comprehensive quality assurance programmes.

Quality of Management and Leadership

Overall summary:

The department demonstrated a positive culture, strong leadership visibility and a commitment to patient care, while requiring further improvement in workforce planning, governance oversight and competency management.

The inspection found that leadership and governance arrangements within the radiology department were generally effective and supported the delivery of safe, patient-centred care. A clear governance structure was in place, supported by comprehensive documentation, defined responsibilities and active oversight through established committees and professional leadership. Senior managers demonstrated a commitment to compliance, learning and continuous improvement, with clear processes for policy development, staff communication and implementation of IR(ME)R requirements.

Staff described positive engagement with leadership and welcomed the accessibility of senior managers, particularly the Professional Head of Radiography (PHoR).

Communication arrangements were regarded as effective, supported by daily huddles, staff meetings and governance forums. Survey results reflected strong confidence in immediate and senior managers, with most staff reporting visible leadership, constructive feedback and involvement in decision-making processes. A strong culture of openness was evident, with staff feeling able to raise concerns and report incidents through established governance mechanisms.

Despite these strengths, workforce capacity and resilience were identified as significant challenges. Staff consistently raised concerns regarding staffing levels, skill mix and lone working arrangements. Half of survey respondents felt staffing levels were insufficient and management acknowledged the need for additional resources to improve resilience and maintain safe service delivery.

Mandatory training compliance was generally good, however weaknesses were identified in Basic Life Support (BLS) compliance.

Further improvements were identified within the management of competency, entitlement and training records. Procedures around entitlement and evidence of completed training lacked sufficient oversight, with many records not signed by an appropriate competency assessor. Clear links between training, competency assessment and entitlement documentation were lacking, creating a risk that competence could not always be clearly evidenced. The absence of a dedicated Quality and Safety Governance Radiographer role was also identified by senior management as a potential gap in governance oversight.

Immediate assurances:

- A review of training records identified that four of the seven substantive radiography staff had expired BLS training, since 31 May 2026. Staff cited difficulties accessing training due to course availability, timing and location.

This is what we recommend the service can improve:

- Address staffing and workforce resilience to ensure safe staffing, reduce lone working and maintain service sustainability
- Strengthen training and competency governance, ensuring all documentation is fit for purpose, completed by appropriate personnel, linked and regularly reviewed
- Enhance governance capacity is robust to improve oversight of compliance, training, quality assurance and governance activities.

This is what the service did well:

- Strong leadership and communication, visible, approachable and supportive leadership, with effective communication
- Positive safety and reporting culture, staff felt confident raising concerns and demonstrated good engagement with incident reporting and learning processes
- Commitment to high-quality patient care, consistently identified as the organisation's top priority, with staff expressing pride in the quality of care delivered.

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 at Victoria Memorial Hospital, Welshpool, for the inspection undertaken in June 2026. Patient responses were captured onsite via hard copy questionnaires and posters displaying the online survey link. In total, HIW received 29 questionnaire responses from patients, families or carers who had shared their views on the setting.

Patient survey responses should be interpreted as reflecting broader experiences of the service rather than experiences limited to the inspection period. Findings are therefore best used as contextual information and triangulated with other evidence sources.

Patient responses were mostly positive with all but one patient rating the service as 'very good', the other as 'good' and all patients described the premises as clean.

Patient comments included:

"The staff were extremely helpful and friendly and it was a very positive experience, they were a credit to the NHS. The facility was clean and well laid out and they saw me on time. I really could not fault my experience."

"First class service on all counts."

"The staff were very helpful, friendly and reassuring, giving me a clear timeline as to when my GP would have results. Great experience."

"Great service, seen extremely quickly."

"Signage in the reception area could be more prominent. If the receptionist is busy with another patient that would aid 'self-navigation'."

"Very happy with service Thank You."

"Good setting."

"Excellent staff, knowledgeable and caring."

"Living in Welshpool, I really appreciate having this local hospital. My family have made use of the facilities on several occasions, from having hearing aids fitted, dressings changed, x-rays taken and physio sessions. It's so convenient and accessible, far easier than having to travel to Shrewsbury or Telford. The staff are friendly and professional, it's a great asset to Welshpool."

"All staff are really lovely."

Person-centred

Health promotion

Bilingual signage was displayed advising patients to inform staff if they were pregnant or breastfeeding, including posters in reception, the waiting area and the X-ray room, with additional multilingual information available at reception.

There was very limited health promotion information displayed within the department. Whilst some healthy lifestyle and smoking cessation materials were available in the corridor near the Minor Injuries Unit (MIU), which was adjacent to the department, no information was visible in the waiting area.

The health board must provide more information about healthy lifestyles and smoking cessation in the department

Dignified and respectful care

Staff consistently treated patients with respect, kindness and professionalism. A receptionist was observed supporting an elderly patient in a particularly caring and courteous manner. Patient confidentiality was maintained within the constraints of a small reception area, with a separate office available for private discussions when required.

X-ray room doors were closed during examinations and procedures to preserve privacy. There were dedicated changing facilities, including direct access between the X-ray room and changing area to avoid unnecessary exposure to the waiting room. Additional changing facilities, privacy screens and access to refreshments were also available.

All patients in the HIW questionnaire agreed they were treated with dignity and respect and staff explained what they were doing. They all said that staff listened and answered questions and measures were taken to protect their privacy. All respondents felt able to speak to staff without being overheard.

Staff reported positive views in the HIW questionnaire regarding patient care with 100% agreeing patients' privacy and dignity were maintained and all thought that patients were informed and involved in decisions.

Individualised care

All patient respondents in the questionnaire felt involved as much as they wanted in decision-making. All but one respondent felt they received sufficient aftercare information and that they were given information on how to care for themselves following their treatment.

In the staff survey all 10 respondents were satisfied with the care they provide and said that care of patients was the organisation's top priority. All but one member of staff said they were content with the efforts of the organisation to keep staff and patients safe.

Timely

Timely care

Positive arrangements were noted for communicating waiting times to patients within the department. During the inspection we noted that patients received treatment promptly. The department primarily operated through scheduled appointments, with occasional referrals from the adjacent MIU. Staff we spoke with said that any delays with appointments were communicated verbally to patients where necessary.

The majority of respondents to our questionnaire agreed that the wait between referral and appointment was reasonable. Almost all patients said that at the department, they were told how long they would likely have to wait to be seen.

Equitable

Communication and language

Information for patients and families on providing feedback was prominently displayed throughout the department. Bilingual posters, including quick response (QR) codes linking directly to an online feedback survey, were clearly visible within patient areas. Information on the complaints process was also readily available, with a bilingual poster at reception outlining how concerns could be raised and managed. Evidence of learning from patient feedback was demonstrated through a 'You Said, We Did' display in the waiting area, highlighting three examples of service improvements.

The department provided a range of accessible information, including pictorial signage and information on accessing British Sign Language (BSL) support. Most signage and patient information were available bilingually in English and Welsh, supporting compliance with Welsh language standards. Patients received verbal explanations of procedures and completed consent forms detailing risks and benefits, with staff also advising on next steps following examinations. Interpretation services were available through a language line for patients unable to communicate in English. However, no hearing loop or large-print patient information was available.

The health board must consider the need for a hearing loop at reception and large print consent forms.

Staff we spoke with were aware of the need to support patients with communication and accessibility needs. Bilingual consent documentation was available and staff reported adapting their approach according to individual patient requirements, including reading information aloud where necessary. Staff confirmed there were no Welsh-speaking team members within the department.

There was no routine system for identifying Welsh speaking patients or patients with additional communication needs prior to attendance, unless this information was included within the referral. Such needs could be recorded on departmental systems following patient attendance.

The health board must ensure arrangements are in place when a Welsh-speaking patient wants to receive care in Welsh.

Patient feedback about staff was very positive and interactions between staff and patients consistently demonstrated a high standard of communication and care. All patients in the feedback said they were able to find the department easily. A total of three patients said Welsh was their preferred language. No members of staff in the HIW questionnaire said they were a Welsh speaker.

Rights and equality

The department was accessible via lift access as well as an alternative entrance, with level access throughout, wide doorways, accessible changing and toilet facilities and seating designed to support patients with mobility needs. Appointment letters included safeguarding information for children and vulnerable adults who did not attend appointments.

Equality, diversity and inclusion (EDI) were promoted through mandatory training, specialist awareness training, organisational policies and staff support networks. Staff demonstrated an understanding of supporting transgender patients by asking individuals how they wished to be addressed, including their preferred name and pronouns. There were also protected characteristic groupings in the health board that staff could join.

Pregnancy-related signage in two changing rooms was not fully inclusive due to gender-specific language. This was raised during the inspection and promptly addressed, with the signage replaced by a gender-neutral version. **These concerns were escalated and resolved during the inspection and are detailed in [Appendix A](#) of this report.**

Most patients in the questionnaire felt they could access the right healthcare at the right time and no patients said they faced discrimination when accessing or using this health service.

Most staff in the questionnaire felt the workplace was supportive of EDI and believed staff have equal access to opportunities. Additionally, 80% of staff reported no discrimination at work within the last 12 months.

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

All staff were aware of where written procedures and protocols were located. Staff reported that written procedures were clear, easy to follow and that updates or amendments were communicated effectively. However, some uncertainty remained regarding the current approved versions and how staff could identify the most up-to-date documents.

The employer had implemented several measures to support compliance with the EPs. All duty holders were required to read and adhere to these procedures, which were available via the intranet and were provided during induction and upon entitlement. Understanding and compliance were reinforced through mandatory radiation safety training at induction and via biennial refresher training, supported by completion of induction checklists. In addition, all operators undertook an annual assessment audit to demonstrate their understanding.

The site currently followed Betsi Cadwaladr University Health Board (BCUHB) East general X-ray technique protocols. Operators demonstrated awareness of the applicable protocols for the site. We were told that Powys Teaching Health Board were in the process of developing local examination protocols for use across the health board.

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

All IR(ME)R documentation, including EPs and examination protocols, were developed in consultation with MPEs and underwent formal approval through the Therapies and Health Science Business Meeting and Radiation Protection Committee (RPC) prior to publication. Approved documents were published on the shared area and made accessible to staff.

The department obtained confirmation of staff reading and understanding of EPs through an electronic form for in-house staff. However, a similar assurance process was not currently in place for duty holders outside radiology.

The employer must ensure that confirmation of reading and understanding of EPs is in place for duty holders outside radiology.

The EP to ensure that quality assurance programmes in respect of written procedures, written protocols and equipment were followed, detailed and clear, was well written and an area of good practice.

The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024, effective from October 2024, introduced significant updates to enhance patient safety and align with current clinical practices. The requirements of these regulations had not been included in the EPs which were currently available to duty holders and in use. The revised EPs, which included updates to reflect the amendments, were currently in draft format and had not been put through the agreed ratification process prior to being signed by the Employer, the Chief Executive. However, they had been signed by the Deputy Chief Executive.

As a result we could not be assured of the safety of patients undergoing medical exposures through the requirement for systematic examination of the procedures used against agreed standards. **These concerns were addressed through our Immediate Assurance Process and were detailed in Appendix B of this report.**

Referral guidelines

The employer had established an employer's procedure that described the referral guidelines and arrangements for the making, amendment and cancellation of referrals, with these processes communicated to referrers. All referrals were reviewed as part of the justification process and any incomplete referral was returned to the referrer for clarification before the examination proceeded. The reason for the return was communicated to the referrer and recorded appropriately.

Any amendments to referrals were made following review and were documented within the Radiology Information System (RIS), ensuring a clear audit trail. Where

discrepancies or queries arose, these were resolved directly with the referrer and the outcome was recorded within RIS.

During inspection discussions, the department confirmed that referrals followed the standard referral pathway and were not assumed, including where the medical exposure formed part of a wider procedure. Referrers were able to contact the department directly to amend or cancel referrals and any related near misses were reported through the Datix incident management system.

The centralised booking hub in Newtown was responsible for placing referrals onto the list for authorisation by entitled operators, who subsequently accepted or rejected referrals. Cancellation requests were communicated directly to the department. The arrangements provided clear governance and oversight of referral management, supporting effective justification and maintaining an auditable record of referral decisions.

Diagnostic reference levels (DRLs)

Staff confirmed that DRLs were in place and that patient dose monitoring was undertaken. However, discussions with staff identified significant inconsistencies in understanding regarding which DRLs should be used, how they should be applied and the actions required when DRLs were consistently exceeded.

The employer's procedure described a robust process for establishing, reviewing and auditing DRLs. Local DRLs were developed using patient dose data collected from imaging equipment and analysed by the MPE in collaboration with lead radiographers. Following equipment installation a dose audit would be undertaken after a period of use. Local DRLs were approved through established governance processes and were subject to regular review. Instances where DRLs were consistently exceeded were intended to trigger investigation and corrective actions, with formal reviews undertaken at least every three years or sooner if required.

The department demonstrated comprehensive dose audit processes. This included continuous patient dose surveys which were thorough, documentation of doses exceeded within RIS and three-monthly data reviews to identify trends. No examples of consistently exceeded DRLs had been identified at the time of inspection.

Despite these strengths, inspection findings highlighted a lack of clarity surrounding DRL implementation. Two sets of DRLs were displayed within the examination room, comprising ratified national DRLs and unrated local DRLs. Site representatives confirmed that both were being used to monitor patient doses. Furthermore, staff provided differing explanations regarding the purpose of national and local DRLs and the actions required when DRLs were consistently exceeded, indicating that procedures were not consistently understood.

The employer must ensure:

- **Only ratified DRLs are displayed**
- **Staff are made aware of the correct DRLs to use**
- **Staff are aware of the actions to follow when DRLs are consistently exceeded.**

Medical research

The department did not participate in research involving medical exposures.

Entitlement

All staff confirmed that, following completion of the required training and competency, they received a formal entitlement letter from the PHoR that clearly defined their scope of practice and authorised duties.

The employer had established a comprehensive entitlement process for operators, referrers and practitioners. Entitlement was delegated to the PHoR, who was responsible for ensuring that all training, competency and governance requirements were met before entitlement was granted. Once competence had been demonstrated, written confirmation of entitlement was issued with an agreed scope of practice, individuals were added to entitlement matrix and access to relevant EPs and referral guidance was provided. Referrers from outside the health board followed the same process, including formal written entitlement and inclusion within the entitlement matrix. External referrers were provided with the EPs upon entitlement.

The process for entitling practitioners was clearly described, including arrangements for practitioners working outside Radiology, who were required to complete procedure-specific training and work within a defined scope of practice. Non-medical referrers and non-medically qualified practitioners were only entitled following completion of relevant IR(ME)R training and formal written authorisation.

Inspection discussions identified that newly qualified radiographers were not considered competent practitioners until completion of their preceptorship and formal sign-off. However, the site confirmed that it was not currently operating in accordance with the practitioner entitlement arrangements for radiographers as described in EP for the identification of referrers, practitioners and operators. Instead, processes outlined within newly drafted, but as yet unratified, procedures had been implemented, with

operators authorising referrals against agreed authorisation guidelines. Consequently, entitlement documentation for radiographers acting as practitioners was not available.

Processes for the entitlement checks performed were discussed with the senior staff on site which confirmed that the employer did not have assurance of individual duty holder training, competency and scope of practice for Everlight, a third party contractor, operators. Training and competency was assumed from the All Wales Everlight contract.

The employer must ensure assurances are attained for the training and competency of Everlight operators.

The relevant EP relating to identifying individuals entitled to act as referrer or practitioner or operator within a specified scope of practice was very detailed and clear.

Patient identification

Patient identification arrangements were found to be clear and consistently understood by staff. A standard three-point identification check was undertaken, with additional confirmation of the examination, anatomy, laterality and relevant clinical information.

We reviewed the EP for the correct identification of the individual to be exposed to ionising radiation. Staff we spoke with were aware of the procedure to identify correctly individuals as well as the procedure to identify correctly individuals who may not be able to identify themselves. This aligned to the processes described in the procedure. Procedures in place for correctly identifying the patient were clear and well understood by staff.

Staff confirmed that previous imaging from other health boards and NHS Trusts in England could be accessed to reduce unnecessary repeat exposures.

Where more than one operator was involved, a formal handover was undertaken and the operator performing the exposure was documented. Inspection findings confirmed that staff practice aligned with the EPs and information provided within the SAF.

Individuals of childbearing potential (pregnancy enquiries)

Pregnancy enquiry arrangements were found to be clear, robust and well understood by staff. Individuals of childbearing potential were routinely asked pregnancy-related questions, with procedures adapted appropriately for younger patients. Pregnancy status was documented on both consent forms and RIS, providing an auditable record.

Where pregnancy could not be excluded, the examination was deferred and a radiologist consulted to assess justification, with decisions documented on RIS. Pregnancy tests were available, where required and if doubt remained the examination did not proceed. A pregnancy enquiry flowchart was available in examination rooms and compliance was monitored through regular audits. Staff we spoke with were able to confirm the procedures that they followed for correctly identifying individuals and performing pregnancy enquiries of appropriate individuals. Staff were also able to confirm the procedures followed for carers and comforters.

Bilingual appointment letters included advice for patients to contact the department if they were, or may be, pregnant.

The EP in place for pregnancy enquiries was clear and well understood by staff.

Benefits and risks

Information regarding the benefits and risks of radiation exposure was routinely provided to patients through appointment letters, consent forms and departmental posters, with additional patient-friendly reference materials available within examination rooms. Staff encouraged patients to ask questions and could access supporting dose comparison information when required. Information was also available via QR codes included in patient communications.

Arrangements for carers and comforters were clearly defined, requiring practitioner justification, provision of benefit and risk information, informed consent, appropriate radiation protection measures and dose monitoring.

The process for communicating benefits and risks was well established and supported by clear EPs. However, staff reported that they had not received recent formal training or refresher training specifically relating to radiation risk communication. Consideration should be given to implementing regular training for operators and practitioners to strengthen confidence and consistency when discussing radiation benefits and risks with patients, carers and comforters.

The employer must ensure relevant training is regularly provided to staff on radiation risk communication in the form of delivering benefits and risk information to patients.

All bar one patient in the HIW questionnaire were satisfied with information provided about benefits and risks of relevant procedures.

Clinical evaluation

Clinical evaluation arrangements were clearly defined and operated in accordance with IR(ME)R requirements. Clinical evaluations were undertaken by entitled, trained and competent operators, including consultant radiologists and reporting radiographers and were recorded as formal radiology reports within the RIS.

For plain film examinations, particularly within the MIU, radiographers may record a Preliminary Clinical Evaluation (PCE) on the Picture Archiving and Communication System (PACS). The PCE functioned as an initial alert for the operator performing clinical evaluation and did not replace the formal clinical evaluation. A definitive clinical evaluation was typically completed within hours of the examination by either an on-site reporting radiographer or a third-party reporting provider (Everlight). Staff clearly described this process and demonstrated a good understanding of the distinction between PCEs and formal clinical evaluations, ensuring prompt and effective patient care.

Non-medical imaging exposures

Similar processes were in place for non-medical imaging (NMI) examinations as for standard radiographic examinations. Referrals were received from GPs and were authorised by radiographers in accordance with Delegated Authorisation Guidelines (DAGs).

Appropriate patient identification checks were undertaken prior to exposure, alongside reviews of previous imaging. Clinical evaluation arrangements mirrored those for standard X-ray examinations, with evaluations undertaken and documented in line with established departmental procedures.

Employer's duties - clinical audit

The Self-Assessment Form (SAF) outlined processes for both clinical audit and IR(ME)R audit, including the identification, communication and monitoring of follow-up actions. Clinical audit findings were reviewed to identify areas of non-compliance or variation, with actions typically involving targeted training, procedural reviews, amendments to protocols, or changes to clinical practice.

Audit outcomes were communicated through team meetings and governance forums, with progress monitored via governance structures such as radiology governance meetings. Re-audits were undertaken to confirm improvements and sustained compliance. Clinical audit topics were generally selected in response to current themes, incidents and patient feedback. However, no formal procedure for the oversight of conducting clinical audits was in place.

IR(ME)R audits formed part of the departmental audit programme and included key compliance areas such as patient identification, pregnancy checks, justification and authorisation, dose recording and PCE. Audits were undertaken by radiographers and departmental leads, with findings reviewed by senior staff and reported through governance structures, including the RPC. Audit outcomes and associated actions were communicated to staff to support shared learning.

The IR(ME)R audit process lacked clarity regarding coverage of the entire patient pathway, compliance targets, follow-up actions and re-audit arrangements. Audit documentation did not specify expected compliance rates and staff were unclear regarding appropriate audit thresholds, particularly the expectation of 100% compliance for IR(ME)R audits. Although actions were frequently identified, records lacked defined timescales, named leads and evidence of re-audit to assess effectiveness. Furthermore, whilst audit findings were reportedly discussed at meetings, evidence demonstrating completion of resulting actions was not available. Overall, the clinical audit programme appeared reactive rather than planned, with limited formal oversight of audit activity, outcomes and assurance processes.

This absence of formal oversight of the clinical audit processes was reflected in process weaknesses, including unclear timeframes for completion, an absence of responsible individual and limited evidence of action being taken in response to audit findings.

The employer must ensure:

- **There is a formal procedure for conducting both clinical audits and IR(ME)R audits including; defining compliance targets for the audit, timescales, results and actions, and sharing learning**
- **The programme includes all areas of the patient pathway and includes proactive areas within the programme**
- **There is formal oversight of the audit process.**

Employer's duties - accidental or unintended exposures

No significant accidental or unintended exposures requiring notification to HIW under IR(ME)R had occurred at the department during the previous two years.

The service demonstrated a well-established process for the identification, management and investigation of accidental and unintended exposures (AUEs). Staff consistently described the actions required, including informing the patient, recording relevant information and informing appropriate duty holders. Staff also confirmed that Duty of Candour principles were applied throughout the process.

The SAF outlined a comprehensive approach to the management of clinically significant accidental or unintended exposures (CSAUEs). Following investigation, the PHoR was responsible for informing the referrer, practitioner and patient (or their representative) of the incident and investigation outcome, supported by MPE dose and risk assessments and relevant clinical advice. Reflective practice was undertaken where staff were involved and learning was shared both within radiology and across wider Therapies and Health Sciences teams.

The EP relating to significant accidental and unintended exposures, was detailed, clear and well understood by staff, representing an area of good practice.

The PHOR undertook regular analysis of incidents and near-miss data through a Radiology Datix Audit programme, identifying trends and implementing improvements. For example, an increase in referrals containing incorrect patient details, anatomical regions or laterality resulted in reminders being issued to referrers regarding IR(ME)R requirements and pause-and-check processes.

Quarterly incident trend reports and presentations were shared with staff via meetings and shared systems, alongside anonymised reflective "seven-minute briefing" documents. The trend analysis and quality of incident reporting was an area of good practice, with staff providing positive feedback regarding the quality of shared learning. Some staff, however, expressed concerns regarding broader governance oversight and the extent to which responsibility for audits, incident review, documentation and training assurance sat with the PHoR.

All staff we spoke with were able to confirm the procedures that they followed for identifying and reporting AUEs. They believed shared learning, particularly regarding incidents, was of very good quality.

All staff respondents to the questionnaire said their organisation encouraged them to report errors, near misses or incidents. However, only 90% felt staff who were involved were treated fairly, when errors, near misses or incidents were reported. All staff indicated the organisation took action to ensure this did not happen again and they all agreed they were given feedback about changes made in response to reported errors, near misses and incidents. Additionally, all staff felt encouraged to report incidents and

knew how to raise concerns. All staff who had an opinion felt secure raising concerns about unsafe clinical practice and 80% were confident these concerns would be addressed.

Duties of referrer, practitioner and operator

The SAF described the arrangements to ensure practitioners and operators were appropriately trained and competent for their scope of practice. Staff were required to hold relevant professional qualifications and complete local induction, role-specific training, supervised practice and competency assessments before being entitled to undertake IR(ME)R duties. Training included the safe use of equipment and was delivered through clinical application specialists or supervised departmental training. Ongoing competence was maintained through mandatory IR(ME)R and radiation safety training, undertaken at least every two years, alongside continuing professional development and professional registration requirements. Compliance was monitored through the electronic staff record (ESR), departmental records, appraisal, audit and governance processes overseen by the PHoR.

We were told that new staff were observed during their induction period and undertook a period of preceptorship, which included a review of EPs and radiation safety training. A separate matrix was maintained to document completion of radiation safety requirements. There was an induction template for competency checking (which included minimal IR(ME)R compliance aspects). However the template had not been put into practice for every member of staff.

Justification of individual exposures

Staff demonstrated a good understanding of the practical aspects of justification and authorisation. When assessing referrals, staff described the actions to determine whether an examination was appropriate. Unjustified referrals were rejected and returned to the referrer with an explanation. Staff also confirmed that previous imaging and prior clinical evaluations were considered where relevant.

The authorisation process was undertaken by radiographers using locally agreed DAGs, although these were consistently referred to by staff as “protocols”. Further discussion highlighted the importance of consistent IR(ME)R terminology. The site frequently uses terms such as “vetting”, “protocolling” and “image reading”, which could create ambiguity. The standard IR(ME)R terminology, including “justification”, “authorisation” and “clinical evaluation”, should be used to provide greater clarity and consistency.

The employer must ensure that standard IR(ME)R terminology is used to provide clarity and consistency.

During inspection discussions, the site confirmed that it was not currently operating in accordance with the practitioner entitlement arrangements described within the existing EPs. Instead, operators authorised referrals against DAGs issued by a named practitioner, following processes outlined within newly drafted, but currently unratified, EPs. These have now been ratified and put into use at the health board.

Staff described clear arrangements for the exposure of carers and comforters. However, differing responses were provided regarding the use and positioning of the dose monitoring badge in relation to protective clothing, indicating a need for greater consistency in staff understanding and compliance with the EP.

Documentation within the SAF described justification and authorisation as being recorded within RIS and linked to the individual undertaking the action. However, inspection findings identified a discrepancy between the arrangements described in the EPs and those being followed in practice. Procedures for identifying the practitioner and recording authorisation for walk-in examinations were not being followed in accordance with EP for the identification of entitled referrers, practitioners and operators. There was no consistent use of signatures, initials or equivalent electronic identification within the designated justification sections, as required by the EPs. While staff clearly understood the justification process, documentation and recording practices must fully align with IR(ME)R requirements and local procedures.

The employer must ensure:

- **Justification and authorisation practices fully align with IR(ME)R requirements and local procedures**
- **Procedures for identifying the practitioner and recording authorisation for walk-in examinations are followed.**

Optimisation

The SAF described how practitioners and operators demonstrated an understanding of radiation optimisation principles. This included how exposures were tailored to ensure doses were kept as low as reasonably practicable (ALARP) while achieving the required diagnostic outcome.

Optimisation was supported using appropriate exposure factors, adherence to written protocols and the application of DRLs. Additional safeguards were applied for children, with age and size specific imaging protocols used to minimise radiation doses. For individuals of childbearing potential, pregnancy enquiries were undertaken at multiple stages of the patient pathway, with exposures reviewed or alternative imaging considered where pregnancy could not be excluded. Exposures involving carers and comforters were undertaken only where necessary, justified by an entitled practitioner, supported by informed consent processes and subject to appropriate dose monitoring and recording arrangements.

Paediatrics

Patient appointment letters advised individuals to notify the department if they were unable to attend their scheduled appointment. Where a child or vulnerable adult did not attend an appointment without prior notification, a risk assessment was undertaken to determine any potential impact on the individual's health and wellbeing and whether further safeguarding or follow-up actions were required.

There was a very low volume of paediatric imaging described as taking place at the department. As a result, the site had not established local paediatric DRLs.

To support radiation optimisation, imaging equipment was configured to automatically select age-appropriate paediatric exposure parameters using demographic information imported from RIS. These settings could be adjusted by the operator where clinically indicated.

Staff reported that paediatric-specific training and support were provided by a reporting radiographer as required, ensuring that operators maintained the necessary knowledge and skills to safely image paediatric patients.

Carers or comforters

Exposures involving carers or comforters were justified by an appropriately entitled practitioner, who ensured that the anticipated benefit of the exposure outweighed the associated radiation risk. The SAF explained that in reaching this decision, the practitioner considered the clinical circumstances, applied relevant dose constraints and ensured that the exposure was optimised ALARP.

Prior to the exposure, carers and comforters were provided with appropriate information regarding the potential benefits and risks to support informed decision-making and consent was obtained. Details of the justification and exposure were recorded within the patient record, RIS and the departmental record maintained within the examination room.

Staff were able to describe the process for justifying exposures involving carers and comforters. However, there was currently no formal training programme or refresher training in place for operators relating to communicating the benefits and risks of the radiation exposure to carers and comforters. A regular training programme or updates in this area is required to support consistent practice and ensure staff remain competent and confident in providing this information.

Expert advice

There was evidence of full involvement with MPEs across all diagnostic practices on site, in accordance with IR(ME)R requirements. MPE support was provided through a Service Level Agreement (SLA) with BCUHB, covering expert advice, Radiation Protection Supervisor (RPS) support and participation in key governance arrangements.

Senior staff advised that radiation protection training for clinical staff was provided annually by MPEs, with additional training for non-clinical staff delivered as required following issues identified through governance processes, including RPC meetings. Staff confirmed that MPE advice was readily accessible via email and telephone, with contact details displayed within the department and staff described receiving timely responses when advice was required.

MPEs were actively involved in patient dose assessment, optimisation and the establishment, review and auditing of DRLs. Through access to a central patient dose management system, they monitored patient doses, analysed exposure factors and provided annual reports to the Radiology Improvement and Optimisation Team (RIOT). Work was ongoing to explore the development of standardised local DRLs across Powys.

The MPEs contributed to quality assurance programmes, equipment commissioning, acceptance testing and protocol development. They provided advice on remedial and suspension levels, supported QC training for staff and reviewed proposed changes to radiation-related documentation. QA and radiation protection were standing agenda items at RIOT and RPC meetings, ensuring ongoing oversight.

MPE involvement extended to the investigation of accidental and unintended exposures, equipment specification and procurement, as well as advising the employer on compliance with IR(ME)R. MPEs also worked closely with the Radiation Protection Adviser (RPA) and provided assurance through regular SLA review processes, ensuring appropriately recognised and competent experts remained available to support the service.

Equipment: general duties of the employer

The site had benefited from significant health board investment through the equipment replacement programme, which had modernised diagnostic imaging services and enhanced patient care.

Staff were able to describe the process for assessing patient radiation dose and all radiology procedures undertaken within the department. Equipment performance was monitored through a comprehensive QA programme, with faults identified through routine quality control (QC) testing, user checks, servicing arrangements and incident reporting. The site lead and RPS oversaw QC processes, reviewed trends and escalated issues as required.

QC testing was undertaken within agreed timeframes and staff had access to documented remedial and suspension levels within departmental QC folders. Training and oversight was provided by the RPS. During the inspection, it was noted that the radiology equipment inventory did not include the year of manufacture, as required under IR(ME)R. It was also highlighted that artificial intelligence (AI) and other assistive software systems were not included within the equipment inventory. Whilst the site advised these were recorded separately, this was not evidenced during the inspection.

The employer must ensure that the radiology equipment inventory contains all the relevant information required, including the year of manufacture.

Safe

Managing risk and health and safety

The department was found to be accessible, well maintained, fit for purpose and safe. There was clear signage to the department and accessibility arrangements were in place for patients with mobility needs. All areas observed were clean, tidy, free from clutter and maintained to a high standard, with furniture, fixtures and fittings in good condition.

The environment was appropriate for service delivery, with sufficient waiting area seating and adequate space to accommodate patients comfortably. No environmental hazards, blocked access routes, or trip risks were identified during the inspection.

Senior staff we spoke with said that, in the event of an accidental or unintended exposure, the exposure would be stopped immediately, relevant information recorded and senior staff informed.

Incidents were reported through Datix, reviewed with the MPE, escalated through the quality and safety governance processes and managed in line with local procedures, taking into account Duty of Candour requirements. Learning from incidents, including

IR(ME)R incidents, was shared through team discussions, governance meetings and Datix audits. Safety notices, alerts and other communications were received via the quality and safety team and disseminated to staff through departmental communication channels, including infection prevention and control reports where appropriate.

Infection prevention and control (IPC) and decontamination

The department and equipment were observed to be in a very good state of repair, with no visible defects that would impact effective cleaning. Suitable handwashing and drying facilities were available and appropriate personal protective equipment (PPE) was readily accessible and stored appropriately.

Staff described robust IPC arrangements, including cleaning equipment and treatment couches between patients using appropriate cleaning wipes and replacing paper couch rolls after each use. Daily cleaning checklists were completed and uploaded to a document control system. For patients with suspected or confirmed infections, appointments would be arranged at quieter times, where possible towards the end of the day, to allow enhanced cleaning. Staff confirmed they had access to sufficient PPE and could access IPC policies and procedures.

All patients who expressed an opinion in the questionnaire said that IPC measures were being followed and agreed infection control arrangements were effective. All staff respondents thought the organisation implemented an effective infection control policy and that there was appropriate PPE supplied and used. All staff 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 interviewed demonstrated an awareness of safeguarding responsibilities and the processes to follow if they had concerns regarding children or adults at risk. Staff reported completing mandatory safeguarding training, including online learning, regular updates and face-to-face sessions delivered during continuous professional development (CPD) events.

Staff were able to identify appropriate escalation routes, including informing their manager and seeking advice from the health board safeguarding team, with contact details readily available within the department. Staff were aware that safeguarding policies and procedures were accessible via the organisation's intranet.

Appointment letters advised patients to notify the service of cancellations, with risk assessments undertaken where children or vulnerable adults did not attend appointments, to consider the impact of the non-attendance.

Effective

Patient records

A random sample of 10 patient referrals were reviewed, comprising five current and five retrospective records. The referral documentation was available in both electronic and paper formats and was clearly structured. All records reviewed contained three unique patient identifiers and were appropriately completed by an identifiable referrer with sufficient clinical information to justify the examination. Referrals were made by appropriately entitled referrers and were in accordance with referral requirements detailed within EP for the making of a referral.

Evidence confirmed that patient identity was checked prior to the exposure and that dose information, including relevant exposure parameters, was recorded for each record reviewed. Clear evidence of clinical evaluation was also identified within the records sampled.

Efficient

Efficient

There was one X-ray machine and one ultrasound machine on the site. They provided an appointment-based service, which could be same day appointments, for GP referrals and outpatient referrals, as well as a 'walk-in' service for the MIU patients and in-patients.

The service had implemented several measures to support efficiency, patient flow and timely access to imaging. Appointment booking had been centralised through a dedicated booking hub, removing the need for individual radiographers across the health board to manage their own bookings. Referrals were categorised according to clinical priority, ensuring patients were allocated appropriately and resources used effectively.

The site utilised an AI software package, to support the chest imaging pathway. The system duplicated the original image and automatically provided location mapping (heatmaps/outlines) together with an abnormality score indicating the probability of a finding. This acted as a computer-assisted detection tool, highlighting changes in image density that may warrant prioritisation for clinical review. The AI-generated image was used solely as a supportive flagging mechanism to the operator performing the

examination and was not sent for clinical evaluation.

For patients who had not been pre-booked but required urgent assessment, such as those referred from the MIU, staff prioritised these examinations appropriately. In addition, demand and capacity planning work had been undertaken to inform appointment scheduling and workforce deployment. These measures helped ensure that capacity was aligned with demand and support the delivery of a responsive and efficient service.

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 June 2026. Staff responses were captured onsite via posters displaying the online survey link. In total, HIW received 10 survey responses from staff who had shared their views on the setting. Staff comments were generally positive including highly positive comments regarding care quality and all staff agreed patient care was the organisation's top priority. Although 50% (five respondents) disagreed that staffing levels were sufficient.

Staff comments included:

"My immediate manager is fantastic however other line managers were quite the opposite and do not help or take on board concerns when they were voiced."

"Short staffed regularly for last twelve months, service during this period not as efficient."

"The team successfully managed a phased implementation of a Radiology Informatics System (RIS) and a capital replacement programme that ran side by side."

"Real emphasis from all staff at every level to put patients' needs and safety above and beyond."

"More Staff needed."

Leadership

Governance and leadership

There was a clear governance and management structure demonstrated within the SAF, which was completed comprehensively. The SAF was also completed, with all supporting documents in a timely manner. The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements, where needed.

The Chief Executive was designated as the 'employer' in relation to IR(ME)R 2017. Whilst they had overall responsibility for ensuring the regulations were complied with, where appropriate the employer had delegated tasks to other appropriately entitled professionals working in the health board to implement IR(ME)R. Governance was also provided via the RPC and appointed MPEs.

Responsibilities were implemented through written procedures, training, audit, quality assurance and incident management systems, with oversight from the PHoR. IR(ME)R duties were delegated through a formal entitlement process, with responsibility for entitlement delegated to the PHoR.

Staff we spoke with spoke well and were aware of where to find procedures and what to do in the event of any issues. They described good levels of engagement and communication with senior management. Daily huddles were held across sites, this was a recorded morning session to discuss staffing, equipment, operational issues and any matters requiring escalation. Staff also highlighted regular meetings attended by the PHoR. They stated information was shared with them through a range of mechanisms.

Senior staff we spoke with reported maintaining an open and accessible management approach, including a daily open-door session with the PHoR and ongoing online availability. Updates were also communicated through the quarterly Radiology Governance Oversight Group, with meeting minutes available to all staff. They also outlined a structured process for the development, review and approval of departmental policies, EPs and DAGs, including consultation with staff and governance groups before final approval and publication.

Clear arrangements were in place to ensure staff read and understand IR(ME)R-related procedures. Updated procedures were circulated to staff, who were required to complete an online assessment, with completion monitored by management. Senior managers we spoke with stated the employer was not included within this sign off process to confirm that duty holders had read and understood the procedures.

The staff feedback regarding immediate managers showed 90% felt their manager supported them with difficult tasks and gave clear feedback on their work. The same number said they asked staff opinions before making decisions that affected their work.

Perceptions of senior leadership in the staff questionnaires showed 90% said senior managers were visible. In addition, 80% of staff felt communication was effective and 90% believed senior managers were committed to patient care.

Workforce

Skilled and enabled workforce

Staff and senior staff raised concerns regarding workforce capacity and resilience within the department. Staff felt that current staffing levels and skill mix were not always sufficient, particularly when individuals were required to work alone during some shifts. We were told that where staff were required to work on their own, without the support of a healthcare worker, appointments were typically booked for 20 minutes instead of the normal 10 minutes. However, lone working was described by staff as isolating and could impact the ability to manage workloads effectively as well as any associated risks. Senior staff acknowledged these concerns, stating that, ideally, two members of staff would always be on duty. They reported ongoing efforts to secure additional staffing resources and highlighted concerns about the sustainability of operating short appointment slots with limited staffing. In the HIW questionnaire 80% of staff agreed they could manage workload demands.

The health board must review the staffing levels within the department to ensure there are always two members of staff on duty.

Overall compliance with mandatory training was good, including IPC and safeguarding training. However, a review of training records identified that four of the seven substantive radiography staff had expired BLS training, since 31 May 2026, leaving only three staff with up-to-date certification. This created a risk that shifts could be covered by staff without current BLS training. Staff cited difficulties accessing training due to course availability, timing and location. **These concerns were addressed through our Immediate Assurance Process and are detailed in [Appendix B](#) of this report.**

Training compliance was monitored through ESR by the PHoR, although we were told that bank staff were not included within standard ESR reporting processes. One bank radiographer reported not having received an appraisal within the previous 12 months because of not appearing on ESR reports.

Staff advised they felt able to raise concerns and described a positive reporting culture. Senior staff outlined several mechanisms for escalation, including the open-door approach from the PHoR, whistleblowing arrangements, escalation through management structures and Datix reporting systems.

A review of staff training and entitlement records identified concerns regarding competency assessment and documentation. Evidence was available demonstrating that practitioners, operators and referrers had completed relevant radiation protection and role-specific training. However, records did not consistently demonstrate competency assessments, review dates or clear links between training, competency and entitlement processes. Scope of practice was generally identifiable, but documentation lacked sufficient detail and oversight.

The radiography competency framework reviewed during the inspection provided limited evidence of assessment against key IR(ME)R-related competencies. There was insufficient documentation relating to competency sign-off for radiographers performing practitioner and operator duties. Operator responsibilities included pregnancy enquiries, emergency procedures and additional duties including equipment quality control testing and clinical evaluation. Applications specialists provided in-house training for all new staff and completed an equipment competency sign-off. However, these various forms and records were not cross-referenced or clearly linked. The equipment training form was also not signed by an entitled duty holder who was authorised to perform competency assessments within the health board. The site used a crib sheet which listed elements of equipment training. However, 'sign-off' only included a tick next to each sentence or topic with no signatures or dates from trainer or trainee to agree the training had been completed.

There was no central oversight over training and entitlement matrices held within the department, with the responsibility for updating training records lying with the individual duty holder. This was also not checked by a designated responsible individual to ensure it was up to date and accurately reflected the areas that duty holders were trained in.

The employer must ensure:

- **Training and competency records clearly include sufficient detail and oversight to demonstrate competency assessment, review dates and clear links between entitlement being underpinned by training and competency**
- **Independent central oversight over the training and entitlement matrices to ensure they are accurate, up to date and reflect current scopes of practice**

- **Training records are signed by the trainee and competent assessor and clear links are made throughout documentation.**

Appraisal compliance was generally strong, with 90% of staff stating in the questionnaire that they had received an appraisal within the previous 12 months.

It was also noted that the health board did not have a dedicated Quality and Safety Governance Radiographer role. These responsibilities were undertaken by the PHoR who had recently been supported by a bank radiographer. Senior staff discussed the absence of a dedicated governance role was identified as a potential gap, particularly in relation to oversight of training, competency assessment, compliance monitoring and quality assurance activities.

The health board must consider the value of a Quality and Safety Governance Radiographer role to support the coordination and delivery of governance activities across all radiology.

In the staff questionnaire, regarding their health and wellbeing at work, 90% of staff agreed that, in general, their job was not detrimental to their health and that the organisation took positive action on health and wellbeing. All staff, stated that their current working pattern and off duty allowed for a good work-life balance and were aware of the occupational health support available to them. All staff agreed they were involved in decisions affecting their work and they had received appropriate training for their role.

Culture

People engagement, feedback and learning

Information about providing feedback on care was displayed throughout the department, including posters with QR codes linking to online patient surveys. A clear bilingual complaints poster was displayed in reception, outlining the complaints process and expected timescales. However, there was no readily available information for patients or families to take away. Staff advised that the complaints poster could be photocopied on request, but there were no dedicated leaflets available.

The information displayed did not reference the 'Listening to People' framework or advocacy services such as Llais. Improvements were required to ensure patients could easily access information, including 'Listening to People' and Llais leaflets or printed resources sourced from the health board or other appropriate sources.

The health board must ensure that information is prominent displayed and available for patients to take away, relating to ‘Listening to People’ and Llais.

Feedback arrangements were supported by effective systems for capturing and learning from complaints and incidents. Staff reported that verbal and informal concerns were recorded on Datix and that learning was shared through team huddles, emails and staff meetings. Senior staff confirmed that complaints, compliments and concerns were standing agenda items at team meetings, with information escalated to the Patient Experience Quality Group. Patient feedback was also reviewed through questionnaires and audits, with lessons learned shared across the department.

Staff demonstrated a good understanding of the Duty of Candour, having received training and were able to describe their responsibilities and previous application of the duty in practice.

The majority of patients (71%) in the HIW questionnaire understood how to complain.

In the staff questionnaire, all staff said they knew and understood the Duty of Candour and understood their role in meeting the Duty of Candour Standards. Additionally, all staff said their organisation encouraged them to raise concerns when something had gone wrong and to share this with the patient. Also all staff agreed that patient or service user experience feedback was collected within the department and they received regular updates on patient or service user experience feedback. All bar one member of staff said that feedback from patients or service users was used to make informed decisions within the department.

In total 90% of staff felt their organisation was supportive, but less, 70% felt the organisation took swift action to improve. All staff were satisfied with the quality of care and support they gave to patients and said they would be happy with the standard of care provided by their department for themselves or for friends and family and all would recommend their organisation as a place to work.

Other responses in the staff questionnaire were as follows:

- They were able to meet the conflicting demands on their time at work - 100%
- They were able to access ICT systems needed to provide good care and support for patients – 90%
- They had adequate materials, supplies and equipment to do their job – 100%
- Staff knew who to report concerns of unsafe practice to - 100%
- The organisation supported staff to identify and solve problems – 90%.

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
Pregnancy-related signage in two changing rooms was not fully inclusive due to gender-specific language.	Language not gender neutral or inclusive.	This was raised with management during the inspection and promptly addressed.	Signage replaced with a gender-neutral version.

Appendix B – Immediate improvement plan

Service: Diagnostic Imaging Department at Victoria Memorial Hospital (Welshpool)

Date of inspection: 23 and 24 June 2026

Findings	The Ionising Radiation (Medical Exposure) (Amendment) Regulations 2024, effective from October 2024, introduced significant updates to enhance patient safety and align with current clinical practices. The requirements of these regulations had not been included in the Employer’s Procedures which were currently available to duty holders and in use. The revised Employer’s Procedures, which included updates to reflect the amendments, were currently in draft format and had not been put through the agreed ratification process prior to being signed by the Employer, the Chief Executive. However, they had been signed by the Deputy Chief Executive. The Employer’s Procedures that were being used by the department did not reflect the amendments to the regulations. This included additional Employer’s Procedures relating to Employer’s Procedure O (Clinical Audit) and Employer’s Procedures P (for the making, amending and cancellation of referrals). The absence of framework for procedures to outline the appropriate action to be taken in accordance with Regulation 7 and Employer’s Procedure O highlighted a lack of robustness within the audit process. Early identification of gaps may not be identified to ensure appropriate measures are in place to mitigate against patient safety risks. Assurances could not be evidenced to ensure that the audit cycle was consistently completed by the implementation of appropriate actions identified from the analysis of audit findings. Actions were often identified; however we did not find adequate assurance that these actions were being acted upon, were proven to be effective or completed in a timely manner.
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As a result we could not be assured of the safety of patients undergoing medical exposures through the requirement for systematic examination of the procedures used against agreed standards.				
Improvement needed			Standard / Regulation	
1.	The employer must ensure: • The draft Employer’s Procedures are ratified in accordance with the agreed process, before being signed by the Employer and put into immediate use • They provide HIW with a copy of the signed procedure page • The Employer’s Procedures are sent to all relevant staff including those external to the health board • Relevant training is provided to ensure staff are aware of the changes and of any changes to practice required.		IRMER 2017 Regulation 6(1), Regulation7, Schedule 2 and Schedule 3	
Service Action:			Responsible officer	Timescale
The draft Employer’s Procedures have been ratified in accordance with the agreed governance process and formally signed by the Chief Executive Officer on 30 th June 2026. A copy of the signed procedure page is attached as evidence.			CEO	Completed
Following ratification, the procedures were implemented with immediate effect. The finalised Employer’s Procedures (Version 8) were distributed to all duty holders under IRMER, including those external to the Health Board, via email on Tuesday 30th June 2026. Delivery and read receipts were requested to provide assurance of dissemination. The accompanying email outlined the purpose of the updated procedures and the rationale for the assurance processes introduced.			Professional Head of Radiography	Completed

Training has been provided to ensure staff awareness and understanding of the updated procedures and any associated changes to practice. The Radiography team received formal training on 25th June 2026 via a PowerPoint presentation; this has been submitted as supporting evidence. The session was recorded. There were 3 Radiographers not present on 25th June. Another training session has been arranged to go through V8 when they have returned from leave.	Professional Head of Radiography	Complete Additional training session by 31/7/26
To further strengthen assurance, a Microsoft Form has been developed and issued to duty holders. This requires individuals to confirm that they have read the Employer's Procedures and to complete a structured assessment consisting of 31 questions based on the content of Version 8. A minimum pass mark of 95% has been set to demonstrate satisfactory understanding. This is included as a QR code on the last slide of the presentation but also included in the email to all duty holders.	Professional Head of Radiography	Documentation - complete
Where an individual does not achieve the required pass mark, they are required to revisit the procedures and undertake reassessment. The form clearly outlines that failure to complete the process, or demonstrate competency, may result in temporary suspension of entitlement until such time as competence and understanding are assured. This will be monitored by the Professional Head of Radiography weekly to monitor compliance.	Professional Head of Radiography	Full compliance by 31/7/26

Findings	A review of the mandatory training and other training at the department identified low compliance levels for staff with Resuscitation Level Two Adult Basic Life Support training, with only three of the seven staff appropriately qualified. Staff compliance with the training had only been out of date since 30 May 2026 and feedback from senior staff suggested there were issues around course availability and logistics, such as the location of the training. Additionally, we were told that whilst management had taken steps to book staff onto the next available training courses, a course due on 24 June 2026 had been cancelled because of the hot weather. However, the risk remained present at the time of the inspection.
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		This low compliance rate meant that assurance could not be provided that enough 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.	
Improvement needed		Standard / Regulation	
2.	The employer must ensure: • Staff receive appropriate training on resuscitation 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 • These requirements are also put in place across the whole health board for relevant staff.	Health and Care Quality Standards – Skilled and Enabled Workforce	
Service Action:		Responsible officer	Timescale
All staff requiring Resuscitation Level 2 Adult Basic Life Support (BLS) training have been prioritised and booked onto the earliest available training courses. Access to training has been escalated through the Health Board's education and resuscitation services to ensure staff can achieve and maintain compliance in a timely manner.		Professional Head of Radiography	Complete
To address organisational capacity constraints, the Health Board has utilised additional staff to support the delivery of BLS training. As an interim measure, suitably qualified trainers from Llanidloes Hospital are delivering additional training sessions to increase course availability and reduce delays in access to training. The Radiology team have been made a priority.		Head of Organisational Development	Complete
In addition, a substantive member of the Radiology team has been identified to undertake accredited BLS cascade trainer training. Once completed, this will enable the department to deliver approved in-house		Professional Head of Radiography	Cascade training

BLS training, providing increased local training capacity, improving accessibility for staff and supporting ongoing compliance. Robust interim mitigation measures have been implemented to ensure appropriately trained staff are available on every shift while compliance levels are being restored. Staffing rotas are reviewed regularly to maintain safe cover and ensure a suitable response in the event of a medical emergency. Staff have been formally instructed to book training immediately upon receipt of the automated training notification issued three months in advance of expiry. Departmental managers will monitor compliance proactively through regular performance meetings to ensure training remains current and any risks are identified and addressed at the earliest opportunity. Regarding the staff in Welshpool, since inspection, two staff members have received their training and two are booked for 10th July 2026. These arrangements are being implemented across the Health Board for all relevant staff groups to strengthen access to resuscitation training, improve compliance rates and provide assurance that staff have the knowledge and skills required to respond effectively in a medical emergency.		to be completed by 02/10/26
	Professional Head of Radiography	Complete
	Head of Organisational Development	Full compliance by 31/07/26
		Complete

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

Service representative:

Name (print): Claire Madsen

Job role: Executive Director of AHP, Health Science & Digital

Date: 02/07/2026

Appendix C – Improvement plan

Service: Diagnostic Imaging Department at Victoria Memorial Hospital (Welshpool)

Date of inspection: 23 and 24 June 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.	There was very limited health promotion information displayed within the department. Whilst some healthy lifestyle and smoking cessation materials were available in the corridor near the Minor Injuries Unit (MIU), which was adjacent to the department, no information was visible in the waiting area.	The health board must provide more information about healthy lifestyles and smoking cessation in the department.	Health and Care Quality Standards – Health Promotion	Review the waiting area and departmental patient information display. Add current healthy lifestyle, smoking cessation and Making Every Contact Count resources in accessible bilingual formats, with a named check to ensure materials remain current and available. Evidence to include photographs of the display and dated review record.	Professional Head of Radiography	Within 4 weeks

2.	There was no hearing loop or large-print patient information was available.	The health board must consider the need for a hearing loop at reception and large print consent forms.	H&CQS – Communication and Language	Confirm whether a fixed or portable hearing loop is required at reception through Estates/Facilities assessment and Equality access advice. In the interim, ensure staff know how to access communication support and provide large-print versions of key patient information and consent forms. Additional information required: availability, cost and installation timescale for hearing loop provision.	Deputy Director, Primary Care, Community & Mental Health	Interim controls within 4 weeks; hearing loop decision and implementation plan within 12 months
3.	There was no routine system for identifying Welsh speaking patients or patients with additional communication needs prior to attendance, unless this information was included within the referral. Such needs could be recorded on departmental systems	The health board must ensure arrangements are in place when a Welsh-speaking patient wants to receive care in Welsh.	H&CQS – Communication and Language	Introduce a pre-attendance check within booking or referral triage to identify Welsh language preference and additional communication needs where recorded. Update appointment letters and local SOPs to signpost	Professional Head of Radiography	SOP and staff briefing within 12 weeks; system change subject to RIS capability within 24 weeks

	following patient attendance.			patients to request Welsh language or communication support, and brief staff on how to access Welsh-speaking staff or translation support when required. Additional information required: whether RIS/booking fields can reliably capture language and communication preferences before attendance.		
4.	The department obtained confirmation of staff reading and understanding of EPs through an electronic form for in-house staff. However, a similar assurance process was not currently in place for duty holders outside radiology.	The employer must ensure that confirmation of reading and understanding of EPs is in place for duty holders outside radiology.	Ionisation Radiation (Medical Exposures) Regulations (IR(ME)R) Regulation 6(2) and 10(1)	Identify all non-radiology duty holders who are required to work under the Employer's Procedures. Issue the relevant EPs and obtain recorded confirmation of reading and understanding through the same electronic assurance process used for radiology staff. Maintain a central tracker	Professional Head of Radiography	Duty holder list within 4 weeks; confirmations completed within 8 weeks

				and escalate non-completion through the IR(ME)R governance route. Additional information required: confirmed list of external duty holders and their line managers.		
5.	Despite these strengths, inspection findings highlighted a lack of clarity surrounding DRL implementation. Two sets of DRLs were displayed within the examination room, comprising ratified national DRLs and unratified local DRLs. Site representatives confirmed that both were being used to monitor patient doses. Furthermore, staff provided differing explanations regarding the purpose of national and local DRLs and the actions required when DRLs were consistently exceeded,	The employer must ensure: • Only ratified DRLs are displayed • Staff are made aware of the correct DRLs to use • Staff are aware of the actions to follow when DRLs are consistently exceeded.	IR(ME)R Regulation 6 (5) and Schedule 2 (1) (f)	Remove unratified local DRLs from display immediately and replace with the current ratified DRLs only. Review the DRL procedure with the MPE and Radiology leadership team, then deliver a focused staff briefing explaining which DRLs to use, when escalation is required and how repeated exceedances are investigated and recorded. Evidence to include updated display, briefing record and staff sign-off.	Professional Head of Radiography	Unratified DRLs removed immediately; procedure review and staff briefing within 4 weeks

	indicating that procedures were not consistently understood.					
6.	Processes for the entitlement checks performed were discussed with the senior staff on site which confirmed that the employer did not have assurance of individual duty holder training, competency and scope of practice for Everlight, a third party contractor, operators. Training and competency was assumed from the All Wales Everlight contract.	The employer must ensure assurances are attained for the training and competency of Everlight operators.	IR(ME)R Regulation 17, Schedule 3	Seek formal written assurance from the All Wales contract lead and Everlight confirming the training, competency, entitlement and scope of practice arrangements for operators undertaking work for the health board. Review the assurance against local IR(ME)R employer requirements and retain evidence within the entitlement governance file. Additional information required: named contract lead, current assurance documentation and process for periodic reassurance.	Professional Head of Radiography	Request assurance within 4 weeks; review and file evidence within 12 weeks, subject to external response

7.	The process for communicating benefits and risks was well established and supported by clear EPs. However, staff reported that they had not received recent formal training or refresher training specifically relating to radiation risk communication. Consideration should be given to implementing regular training for operators and practitioners to strengthen confidence and consistency when discussing radiation benefits and risks with patients, carers and comforters.	The employer must ensure relevant training is regularly provided to staff on radiation risk communication in the form of delivering benefits and risk information to patients.	IR(ME)R Schedule 2 (1) (i) and Schedule 3	Develop and implement a short refresher training package on communicating radiation benefits and risks to patients, carers and comforters. Include examples of common patient questions, documentation expectations and escalation routes for complex queries. Record completion for all relevant operators and practitioners and add the training to the annual refresher programme.	Professional Head of Radiography	Training package developed within 8 weeks; staff completion within 16 weeks
8.	The IR(ME)R audit process lacked clarity regarding coverage of the entire patient pathway, compliance targets, follow-up actions and re-audit	The employer must ensure: There is a formal procedure for conducting both clinical audits and	IR(ME)R Regulation 7 and Schedule 2 (1) (o)	Create a formal annual clinical and IR(ME)R audit programme covering the full patient pathway, including referral, justification,	Professional Head of Radiography	Audit procedure and programme approved within 12 weeks; first

arrangements. Audit documentation did not specify expected compliance rates and staff were unclear regarding appropriate audit thresholds, particularly the expectation of 100% compliance for IR(ME)R audits. Although actions were frequently identified, records lacked defined timescales, named leads and evidence of re-audit to assess effectiveness. Furthermore, whilst audit findings were reportedly discussed at meetings, evidence demonstrating completion of resulting actions was not available. Overall, the clinical audit programme appeared reactive rather than planned, with limited formal oversight of audit activity, outcomes and assurance processes.	IR(ME)R audits including; defining compliance targets for the audit, timescales, results and actions, and sharing learning • The programme includes all areas of the patient pathway and includes proactive areas within the programme • There is formal oversight of the audit process.		authorisation, optimisation, clinical evaluation, reporting and recordkeeping. Each audit will include defined standards, expected compliance thresholds, named lead, completion date, action plan, learning dissemination and re-audit date. Oversight will be through the Radiology governance meeting with exception reporting to the appropriate quality and safety route.		audit cycle completed within 6 months
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	This absence of formal oversight of the clinical audit processes was reflected in process weaknesses, including unclear timeframes for completion, an absence of responsible individual and limited evidence of action being taken in response to audit findings.					
9.	The site frequently uses terms such as “vetting”, “protocolling” and “image reading”, which could create ambiguity. The standard IR(ME)R terminology, including “justification”, “authorisation” and “clinical evaluation”, should be used to provide greater clarity and consistency.	The employer must ensure that standard IR(ME)R terminology is used to provide clarity and consistency.	IR(ME)R Regulation 2	Review local procedures, SOPs, audit tools and staff guidance to replace ambiguous terminology with standard IR(ME)R terminology, including justification, authorisation and clinical evaluation. Deliver a staff briefing and include terminology checks in future audit and induction materials to support consistent use.	Professional Head of Radiography	Document review and staff briefing within 8 weeks

10.	Documentation within the SAF described justification and authorisation as being recorded within RIS and linked to the individual undertaking the action. However, inspection findings identified a discrepancy between the arrangements described in the EPs and those being followed in practice. Procedures for identifying the practitioner and recording authorisation for walk-in examinations were not being followed in accordance with EP for the identification of entitled referrers, practitioners and operators. There was no consistent use of signatures, initials or equivalent electronic identification within the designated justification sections, as required by the EPs. While staff clearly	The employer must ensure: • Justification and authorisation practices fully align with IR(ME)R requirements and local procedures • Procedures for identifying the practitioner and recording authorisation for walk-in examinations are followed.	IR(ME)R Regulations 11(1)(b) and (c), 12 (5)	Undertake a process review of walk-in examinations to confirm how practitioners are identified and how justification and authorisation are recorded. Update the local SOP and RIS/workflow guidance so practice aligns with the Employer's Procedures, including clear use of signatures, initials or electronic identifiers. Complete a sample audit after implementation to confirm compliance and take corrective action where gaps remain.	Professional Head of Radiography	Process review and SOP update within 8 weeks; sample audit within 12 weeks
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	understood the justification process, documentation and recording practices must fully align with IR(ME)R requirements and local procedures.					
11.	During the inspection, it was noted that the radiology equipment inventory did not include the year of manufacture, as required under IR(ME)R. It was also highlighted that artificial intelligence (AI) and other assistive software systems were not included within the equipment inventory. Whilst the site advised these were recorded separately, this was not evidenced during the inspection.	The employer must ensure that the radiology equipment inventory contains all the relevant information required, including the year of manufacture.	IR(ME)R Regulation 15 (1) (b), (2) and (2A)	Update the radiology equipment inventory to include all information required by IR(ME)R, including year of manufacture, equipment identifier, location and status. Confirm whether AI and other assistive software systems should be incorporated within the main equipment inventory or held in a clearly cross-referenced register, and retain evidence of review. Additional information required: full list of AI/assistive software in use and ownership of the software register.	Professional Head of Radiography	Inventory updated within 8 weeks; AI/software register position confirmed within 12 weeks

12.	We were told that where staff were required to work on their own, without the support of a healthcare worker, appointments were typically booked for 20 minutes instead of the normal 10 minutes. However, lone working was described by staff as isolating and could impact the ability to manage workloads effectively as well as any associated risks. Senior staff acknowledged these concerns, stating that, ideally, two members of staff would always be on duty. They reported ongoing efforts to secure additional staffing resources and highlighted concerns about the sustainability of operating short appointment slots with limited staffing. In the HIW questionnaire 80% of staff	The health board must review the staffing levels within the department to ensure there are always two members of staff on duty.	H&CQS – Skilled and enabled workforce	Complete a staffing review for the department, including demand, appointment length, lone-working episodes, skill mix and ability to maintain two members of staff on duty. Where two-person staffing cannot be achieved immediately, document interim controls including extended appointment times, escalation arrangements, lone-worker support and risk assessment. Additional information required: current rota baseline, vacancy position, activity profile and funded establishment.	Professional Head of Radiography	Staffing review within 12 weeks; interim risk controls implemented within 4 weeks; longer-term workforce actions subject to approval
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	agreed they could manage workload demands.					
13.	However, these various forms and records were not cross-referenced or clearly linked. The equipment training form was also not signed by an entitled duty holder who was authorised to perform competency assessments within the health board. The site used a crib sheet which listed elements of equipment training. However, 'sign-off' only included a tick next to each sentence or topic with no signatures or dates from trainer or trainee to agree the training had been completed. There was no central oversight over training and entitlement matrices held within the department, with the responsibility for	The employer must ensure: • Training and competency records clearly include sufficient detail and oversight to demonstrate competency assessment, review dates and clear links between entitlement being underpinned by training and competency • Independent central oversight over the training and entitlement matrices to ensure they are accurate, up to date and reflect current scopes of practice	H&CQS - Skilled and enabled workforce	Implement a central training, competency and entitlement matrix with named ownership and routine review. Update training documentation so each competency record is signed and dated by the trainee and an authorised competent assessor, with clear links to scope of practice and entitlement. Introduce periodic independent review of the matrix and retain evidence of completed checks and corrective actions.	Professional Head of Radiography	Matrix and ownership agreed within 8 weeks; records reviewed and updated within 16 weeks

	updating training records lying with the individual duty holder. This was also not checked by a designated responsible individual to ensure it was up to date and accurately reflected the areas that duty holders were trained in.	Training records are signed by the trainee and competent assessor and clear links are made throughout documentation.				
14.	It was also noted that the health board did not have a dedicated Quality and Safety Governance Radiographer role. These responsibilities were undertaken by the PHoR who had recently been supported by a bank radiographer. Senior staff discussed the absence of a dedicated governance role was identified as a potential gap, particularly in relation to oversight of training, competency assessment, compliance monitoring and quality assurance activities.	The health board must consider the value of a Quality and Safety Governance Radiographer role to support the coordination and delivery of governance activities across all radiology.	H&CQS - Skilled and enabled workforce	Prepare an options appraisal for Radiology governance capacity, including the potential Quality and Safety Governance Radiographer role, alternative use of existing roles, bank support or shared governance resource. The appraisal should define responsibilities for training oversight, competency assurance, audit coordination, compliance monitoring and quality improvement,	Deputy Director, Primary Care, Community & Mental Health	Options appraisal completed within 12 weeks; implementation timescale subject to approval and funding decision

				and identify the preferred sustainable model for approval through the relevant management and governance route. Additional information required: available funding, workforce options and preferred governance structure.		
15.	The information displayed did not reference the 'Listening to People' framework or advocacy services such as Llais. Improvements were required to ensure patients could easily access information, including 'Listening to People' and Llais leaflets or printed resources sourced from the health board or other appropriate sources.	The health board must ensure that information is prominent displayed and available for patients to take away, relating to 'Listening to People' and Llais.	H&CQS – Culture and Health and Social Care (Quality and Engagement) (Wales) Act 2020 Regulation 10	Update the waiting area and departmental information points to include prominent bilingual information on Listening to People and Llais, with printed take-away leaflets available for patients. Add the information display to a local environmental checklist so availability and currency are checked routinely. Evidence to include photographs of the display and completed checklist.	Professional Head of Radiography	Within 4 weeks

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

Service representative:

Name (print): Claire Madsen

Job role: Executive Director of AHPs, Health Sciences and Digital

Date: 18/08/2026