Inspections and enforcement activity in 2022/23

Using a graded approach to regulatory activity

We reviewed our approach to scheduling inspections in response to findings from the International Atomic Energy Agency's peer review in 2019. Along with the IR(ME)R enforcement authorities in Wales, Northern Ireland and Scotland, we take a graded approach to our work.

Our approach to the levels of analysis, frequency of inspection and actions we are required to take are proportionate to the extent of the radiological hazards posed by the modality or practice. In practice, we therefore focus more resources on those areas that pose a greater potential radiological risk to patients, such as radiotherapy and nuclear medicine therapies, and less on those such as dental and plain film X-ray.

Diagnostic imaging

Inspections during the year included:

- 7 diagnostic imaging centres
- 6 chiropractic inspections
- 2 dental inspections

Across the 7 inspections of diagnostic imaging centres, we found 12 cases of non-compliance with the regulations and we made 24 recommendations following inspection activity. Some more detailed examples are in the key themes section.

Regulations 6(1), 6(2) and 6(5)(b): As in previous years, the most common recommendations related to the employer's procedures. We made 12 recommendations to ensure that employers have a full set of procedures that clearly support staff when delivering care, and that reflect clinical practice.

Other recommendations related to regularly testing equipment performance and ensuring that training records for practitioners and operators are available and up-to-date.

We also issued 6 Improvement Notices, 2 of which were from chiropractic inspections. See further information on these in our enforcement register.

Nuclear medicine

We carried out 3 inspections and made 10 recommendations relating to:

- **Regulation 6, 6(1)(a), 6(2):** reviewing the employer's procedures to ensure they are reflective of current practice and contain sufficient detail to exclude pregnancy, and that duty holders can access them (3 recommendations)
- **Regulation 6(5)(a):** making referral guidelines available to both internal and external referrers (1 recommendation)
- **Regulation 6(5)(c):** ensuring diagnostic reference levels for the CT component of hybrid imaging studies are available to operators (1 recommendation)
- **Regulation 7:** planning and undertaking routine clinical audit (1 recommendation)
- **Regulation 12(1):** ensuring that patient doses are kept as low as reasonably practicable through an ongoing programme of optimisation (2 recommendations)

- **Regulation 15(2):** including all required fields in the equipment inventory (1 recommendation)
- **Regulation 17(4):** having clear and up-to-date training records for all practitioners and operators (1 recommendation)

We also issued one Improvement Notice relating to providing referral guidelines, quality-assuring written procedures and protocols, and establishing authorisation guidelines for practitioners without a licence.

Radiotherapy

We carried out 11 inspections, one of which was of a brachytherapy service. From these inspections, we issued 3 Improvement Notices and made 30 recommendations, which included:

- **Regulations 6(1) and 6(5)b:** reviewing the employer's procedures to ensure they reflect clinical practice, with an appropriate quality assurance process (11 recommendations)
- **Regulation 8(2):** ensuring that the study of risk relating to accidental and unintended exposures for all aspects of radiotherapy was present and reflective of practice (3 recommendations)
- **Regulation 8(4):** ensuring that there was a clear process relating to the management of clinically significant unintended and accidental exposures and overall management of incidents (7 recommendations)
- **Regulation 15(2) and 15(6)a:** ensuring that equipment QA processes are robust, and that the equipment inventory contains the correct information (2 recommendations)
- **Regulations 17, 17(2) and 17(4):** training records for duty holders, with particular focus on practitioners (7 recommendations)

We issued Improvement Notices against:

- **Regulations 6(1)b & 15(1)a**: where there was no documented process for commissioning new equipment and a subsequent failure to calibrate the machine effectively
- **Regulation 8(4):** where the service did not have an adequate process for incident management and therefore multiple incidents were not reported to the regulating authority in line with the regulations
- **Regulation 11(5):** where there were no authorisation guidelines to enable operators to authorise exposures in the practitioner's absence