# IR(ME)R annual report 2024/25

## CQC is the relevant enforcing authority of IR(ME)R in England.

We enforce the regulations through on-site inspections and by reviewing statutory notifications from healthcare services about significant accidental or unintended exposures to patients.

Every day, tens of thousands of patients undergo planned exposures to ionising radiation as part of their medical care. Inevitably in some cases, things can go wrong. It is imperative that these events are monitored and that learning is shared to help avoid the same mistakes happening again and to lessen the impact.

As part of our annual programme for assessing compliance with IR(ME)R, we review statutory notifications of significant accidental or unintended exposures (SAUE notifications) that providers have submitted to us. This report covers the period between 1 April 2024 and 31 March 2025.

# Notifications received

In 2024/25, we received 842 SAUE notifications that met the defined thresholds of notifiable incidents across the modalities of:

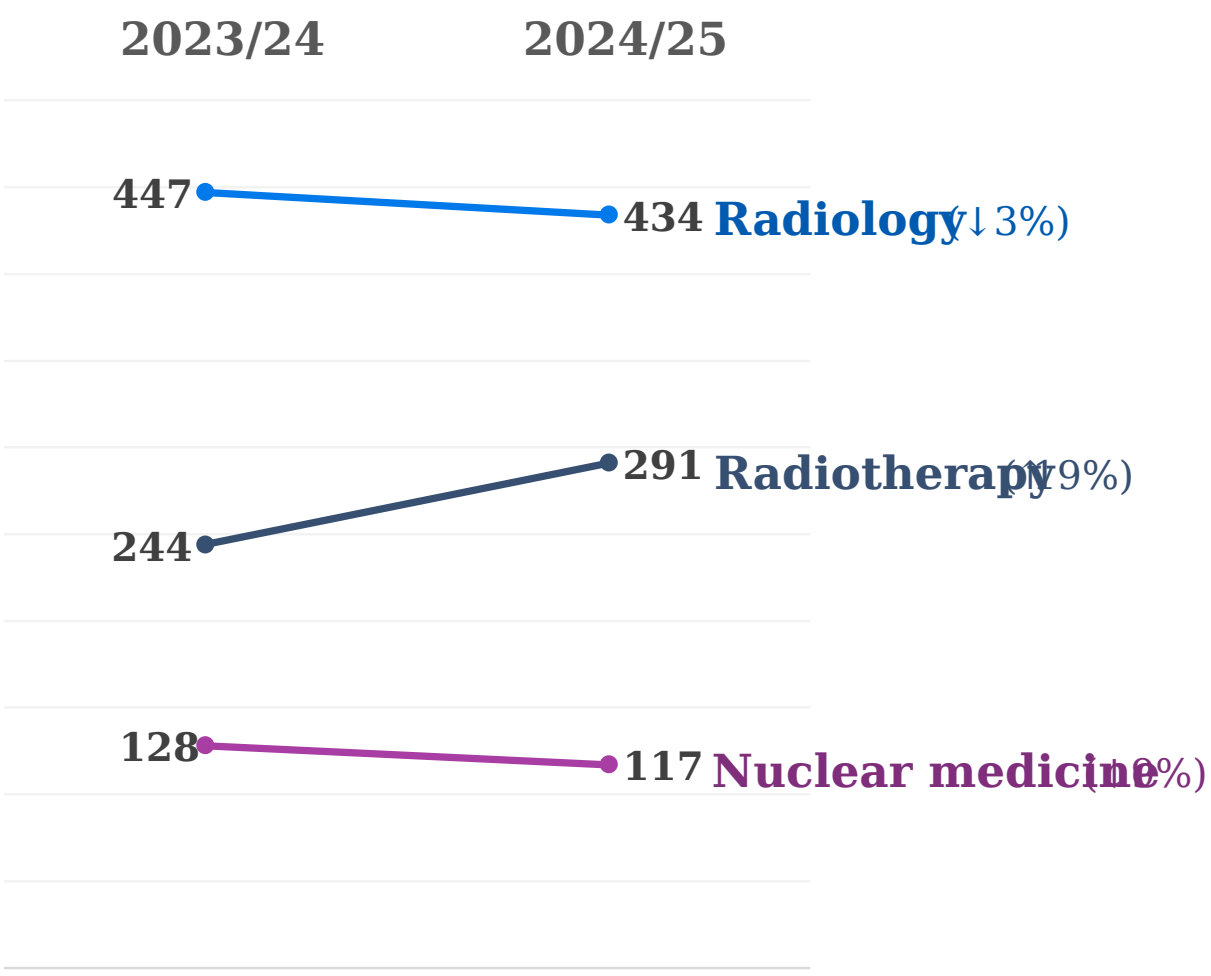
- Diagnostic and interventional radiology: 434 notifications (447 in 2023/24)
- Radiotherapy: 291 notifications (244 in 2023/24)

- Nuclear medicine: 117 notifications (128 in 2023/24).

This is broadly similar to 2023/24 (819 notifications), an increase of 3%.

Diagnostic radiology made up the largest proportion of total notifications (52%). This likely reflects the greater volume of diagnostic examinations performed compared with radiotherapy (35%) and nuclear medicine (14%).

**Figure 1: Total number of SAUE notifications, 2023/24 and 2024/25, by modality**




# Key themes

We believe the numbers of notifications received is generally a positive indicator of a good patient safety culture in medical exposures. However, as in previous years, we have identified some persistent themes and patient safety incidents:

- Referral incidents continue to make up a significant proportion of notifiable incidents, most notably with incorrect patient referrals and failure to cancel referrals that are no longer required.

  **Action for employers:**
  There is now a legal requirement to have an IR(ME)R Schedule 2 Employer Procedure that details how to make, amend and cancel a referral. You also need to consider referral PAUSE and check guidance and other mechanisms that could minimise the risk.

- Errors in the practical aspects of an exposure remain prevalent, mostly in the pre-exposure checks.

  **Action for employers:**
  Ongoing training and education to support clinical staff should include IR(ME)R relevant training, so that staff understand their responsibilities as entitled IR(ME)R operators.

- Notifiable incidents directly related to equipment continued to increase during 2024/25.

  **Action for employers:**
  Although we accept there will always be a risk of equipment failures, you must have robust quality assurance programmes in place for equipment, and access to the right expert advice and support through your medical physics experts and manufacturer contracts.

As well as the persistent themes, we are aware that a number of medical radiological services carrying out high levels of activity have not reported a patient safety event for several years. These services operate across a range of imaging modalities and provide complex medical procedures. During 2024/25, we prioritised these services for inspection, and where we found breaches of regulations and gaps in compliance, we issued enforcement notices and quality improvement recommendations related to incident investigations, as required under IR(ME)R.

We will continue to prioritise these services in our inspection planning to determine compliance with the regulations, to promote radiation protection and improve the quality and safety of medical exposures for people.

# Inspection activity

During this reporting period, we carried out 71 regulatory IR(ME)R inspections across all modalities. Of these:

- 68 were planned proactive inspections as part of our rolling risk-based graded inspection programme
- 3 were reactive inspections in response to information of concern shared with us.

We inspected:

- 22 diagnostic radiology services
- 28 nuclear medicine services
- 21 radiotherapy services.

Medical radiological practice continues to evolve, with technological advances, adoption of new techniques and changes to working practices. Clinical demand is also placing extensive pressure on services, stretching capacity to its limits, and we recognise that there are associated pressures within the clinical professional workforce. The community continues to work in an extremely fast-paced and challenging clinical environment and the opportunity for errors and mistakes is ever present.

We recognise that the risk of a notifiable significant accidental or unintended exposure remains relatively low in relation to the number of individual medical exposures to ionising radiation in a year. However, we know that in reality a high number of incidents, including near misses and 'good catches' across all types of service, do not meet the defined threshold for notification to the relevant enforcing authority.

The importance of having a strong safety culture, proactive risk management and systems-based approaches to analysing patient safety events must not be overlooked. A strong safety culture that encourages and supports staff to identify and report all patient safety events is how we can maximise learning and implement positive changes that continually improve patient safety.