



Review of the Incident Learning Workshop for Clinical Imaging, MRI and Nuclear Medicine

On Tuesday 7th July 2026, the Medical Exposures Group (MEG) hosted the first National Incident Learning Workshop, in Birmingham. The event was well attended by radiographers, clinical scientists, governance leads, service managers, medical physics experts and quality assurance professionals, all with a shared commitment to learning from incidents and near-misses with an aim to improve patient safety.

The programme included presentations covering key aspects of incident learning, including safety culture, application of the coding, reporting quality and stakeholder engagement. Alongside these sessions, delegates participated in practical workshops where they applied the national coding taxonomy to scenarios, discussed coding decisions and explored local implementation challenges.

The interactive nature of the workshop generated lively discussion throughout the day, with attendees making full use of the opportunities to ask questions, share experiences and learn from colleagues working in diverse healthcare settings. Figure 1 summarises the top three actions attendees plan to take post-workshop.

Workshop Impact: The Top 3 Next Steps Identified by Attendees



Implement or expand taxonomy use (49 %)



Share learning and training (21 %)



Improve Reporting Quality (18 %)

"Roll out coding across all modalities and include learning points in our investigation templates."

"Form a working group and share good practice"

"Improve the quality of incident reports we receive."

Figure 1 What delegates told us they plan to do next

The MEG would like to express thanks to those who attended and took part in the workshop. For those unable to attend, recordings of the presentations delivered on the day can be found [here](#).

Spotlight on Coding

As shown in Figure 2, 59% of incidents occurring between January 2026 and July 2026 submitted to the national incident learning system (at the time of publication) are of Severity Level 2, which are locally reported non-notifiable incidents.

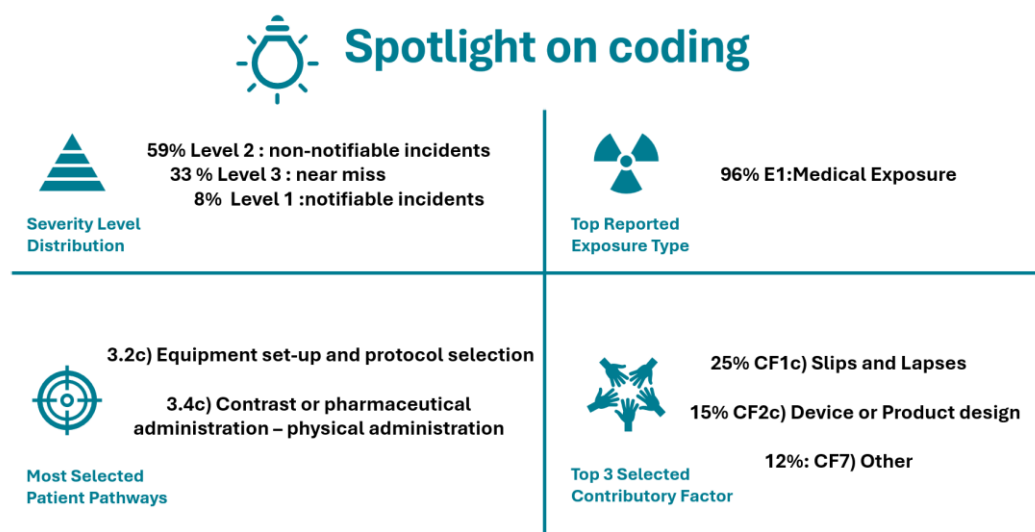


Figure 2 Analysis of incidents occurring between Jan 2026 and July 2026 inclusive, that were available for review at the time of publication

Furthermore, 96% are incidents that involve E1: Medical Exposures. The two most commonly identified patient pathways for incidents occur within the ‘practical aspects’ of the exposure, specifically 3.2c which relates to equipment set up and protocol selection and 3.4c which involve the physical administration of a contrast or pharmaceutical. The Contributory factor assigned to most incidents is that of CF1c: slips and lapses. Users are encouraged to use the 6 contributory factor codes as prompts when investigating an incident. The MEG welcome feedback where users have selected “CF7) Other”, to help support local investigations and shape future updates to the coding taxonomy.

Update to Webpages

The MEG would like to bring to your attention the recently updated [webpages](#) which are available to support involvement and contribution to the national incident learning system. Of note are updates to the [Data submission](#), [Frequently Asked Questions](#) and [Additional Resources](#) tabs.

Next Steps

As contributions to the National incident learning system increase, the focus of the MEG will move towards sharing learning from the data collated from January 2025 to December 2025. In order to ensure publications and guidance is beneficial to the clinical community; MEG will establish and chair a steering group that will help shape this work.