Summary.
See sections 1 & 2.
1. Introduction

1.1. The Trust has numerous sources of ionising radiation under its control, including x-ray-generating equipment, both diagnostic and therapeutic, together with both sealed and unsealed radioactive sources. These sources are used to benefit patients directly through Medical Exposures and indirectly through the maintenance and calibration of associated equipment and research and development activities.

1.2. Medical Exposures are used within the Trust for the purposes of medical diagnosis, treatment, research, occupational health surveillance, health screening and as a medico-legal procedure.

1.3. This policy addresses ionising radiation. Laser and non-laser optical radiation sources (i.e. infra-red, visible, ultraviolet) are addressed in the Non-Ionising (Laser and Optical) Radiation Safety Policy, accessible via the document library.

1.4. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. It is the policy of Royal Cornwall Hospitals NHS Trust, to ensure that staff, patients, visitors, contractors, members of the public and the environment are not exposed unnecessarily to ionising radiation in order to minimise the health risks arising from the Trust’s use of ionising radiation.

2.2. All usage of ionising radiation must be justified and controlled such that any exposure received by any person is as low as reasonably practicable, social and economic factors being taken into account. More detailed safety rules and guidance are identified in departmental quality systems, local rules, procedures, and other radiation safety documentation which support this policy.

2.3. The Trust will fully co-operate with any inspections by statutory bodies and furnish any information requested. The Trust will respond expeditiously to requirements and comments raised by an inspector.

2.4. Royal Cornwall Hospitals NHS Trust accepts its responsibility to comply with the requirements of the relevant UK legislation, including:

   2.4.1. Ionising Radiations Regulations 2017 (IRR 2017)
   2.4.2. Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R).
   2.4.3. Environmental Permitting Regulations (EPR).
   2.4.4. Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (CDG)

2.5. Failure to comply with this policy may lead to disciplinary action and/or prosecution of the Trust or individual.

3. Scope

3.1. This policy applies to all individuals employed by or providing a service on behalf of the Trust including contractors, voluntary workers, supernumerary staff, students, locum and agency staff and to individuals holding honorary employment contracts.
3.2. This policy covers all sites owned by Royal Cornwall Hospitals NHS Trust and those areas on other Employer’s sites where RCHT staff work with ionising radiation (including community hospitals).

3.3. These procedures will be enforced and amplified in these areas by written Standard Operating Procedures, which are the responsibility of Clinical Directors/ Head of Departments.

4. **Definitions / Glossary**

4.1. Dose: Dose means, in relation to ionising radiation, any measure of cumulative exposure to ionising radiation that may be compared with the limit values specified in IRR2017 Schedule 3.

4.2. IRR2017: The Ionising Radiations Regulations 2017

4.3. IR(ME)R: The Ionising Radiation (Medical Exposure) Regulations 2017

4.4. Medical exposure: Exposure of a person to ionising radiation for the purpose of medical or dental examination or treatment which is conducted under the direction of a suitably qualified person and includes any such examination for legal purposes and any such examination or treatment solely for the purposes of research.

4.5. Radiation Protection Adviser: Radiation Protection Adviser means an individual who, or a body which, meets such criteria of competence as may from time to time be specified in writing by the Health and Safety Executive.

4.6. Local Rules: Rules made in accordance with the Ionising Radiations Regulations
5. Ownership and Responsibilities

5.1. **The Trust Board** - retains overall responsibility for the health, safety, and welfare of employees and non-employees.

5.2. **The Chief Executive** - as the ‘Employer’, is identified as the person having overall responsibility for ensuring that the Trust complies with the requirements of the relevant legislation. This responsibility cannot be delegated.

5.3. **The Medical Director** is identified as the Trust Board member with operational responsibility for radiation safety.

5.4. **The Radiation Protection Advisory Committee**, which meets twice annually, reviews and advises on the implementation of the relevant radiation protection legislation and on other Health & Safety matters in connection with both ionising and non-ionising radiations. The Committee will inform the Trust, via the governance structure, of the state of protection arrangements in force. The full responsibilities of the committee are detailed in the terms of reference.

5.5. **The Radiation Protection Adviser (RPA)**, formally appointed by the Employer under IRR17, provides expert advice on radiation matters to assist the Employer with compliance with the requirements of the relevant legislation. They must be consulted on all matters required by the legislation.

5.6. **The Radioactive Waste Adviser (RWA)**, formally appointed by the Employer to provide qualified expert advice in respect to legislation pertaining to the...
accumulation and disposal of radioactive waste, particularly the Environmental Permitting Regulations 2010. They must be consulted on all matters required by the legislation.

5.7. **Medical Physics Expert(s) (MPE)**, formally appointed by the Employer to act as a duty holder under IR(ME)R in the areas of Diagnostic Radiology, Radiotherapy and Nuclear Medicine to provide advice on quality assurance, optimisation and radiation protection relating to medical exposures.

5.8. **Service Managers/Department Heads** are responsible within their area for:

5.8.1. Operational management of radiation protection in the areas for which they are responsible.

5.8.2. Ensuring that the RPA (& MPE, where applicable) is fully aware of all existing and proposed uses of ionising radiation within their area and for seeking advice from specialist advisers on safety and compliance, in particular risk management.

5.8.3. Risk management surrounding the use of ionising radiations, including ensuring that Prior Risk Assessments are performed when introducing new or modified equipment and techniques, and that these are subject to review.

5.8.4. Ensuring that the RPA (& MPE where applicable) are involved in the planning and purchase of all new and replacement facilities and equipment that utilise ionising radiation – see Appendix 4.

5.8.5. Identifying suitably trained candidates to be formally appointed by the Employer as Radiation Protection Supervisors for each area where work with ionising radiation is undertaken.

5.8.6. Maintaining quality systems as required by the regulations, including the implementation of written procedures concerning medical exposures in accordance with the Ionising Radiation (Medical Exposure) Regulations 2017.

5.8.7. The safe management of radioactive sources and disposal of radioactive waste.

5.8.8. Management of equipment used in relation to work with ionising radiations.

5.8.9. Ensuring that equipment is added to the Trust’s equipment replacement programme where there are safety concerns or where cost-benefit analysis demonstrates that exposure arising from the equipment is no longer as low as reasonably practicable, social and economic factors being taken into account.

5.8.10. Ensuring that all staff working with ionising radiations receive appropriate training and records of training are maintained.

5.8.11. Ensuring that staff comply with Trust procedures and SOPs relating to radiation.

5.8.12. Undertaking a programme of clinical audit

5.9. **The Radiation Protection Supervisors**, formally appointed by the Employer, will supervise all work practices using ionising radiation, within their defined area of responsibility, to ensure that they are undertaken in accordance with the Local Rules.
5.10. **All Employees** have a duty to take reasonable care, when carrying out their work, to protect themselves, their colleagues, and any other person. They must:

5.10.1. Exercise reasonable care in carrying out their duties and work in accordance with the Local Rules and Standard Operating Procedures.

5.10.2. Comply with the employer’s procedures and protocols for medical exposures.

5.10.3. Attend training programmes as required by the Trust and provide the Radiation Employer with documentation of continuing education, if required.

5.10.4. Only undertake work for which they have been authorised and adequately trained.

5.10.5. Use as instructed any protective equipment provided by the employer.

5.10.6. Wear as directed (and return as required) any personal dose meter issued.

5.10.7. Report any faults in equipment, facilities or procedures that may adversely affect the health and safety of any person, or cause untoward radiation exposure of an individual.

5.10.8. Report any incident in which a patient or member of staff may have received a radiation exposure much greater than intended, to include incidents where a radiation exposure was not intended.

5.11. **The Head of Planning and Projects** is responsible for ensuring that advice from specialist advisers is sought regarding the plans for new or modified facilities and that final plans for new or modified facilities utilising ionising radiation have the approval of the RPA prior to commissioning – see appendix 4.

5.12. **The Head of Procurement** is responsible for ensuring that specifications for radiation sources and equipment used in connection with medical exposure are approved by the respective MPE and RPA prior to equipment purchase/issue of invitations for tender – see appendix 4.

6. **Standards and Practice**

6.1. **Overview**

6.1.1. The Trust is committed to minimising risks arising from the Trust’s use of ionising radiations.

6.1.2. The Trust will ensure that structures and systems are in place and regularly reviewed in order to ensure that:

6.1.2.1. A radiation protection management structure is developed and maintained to ensure that the Trust complies with current legislation.

6.1.2.2. Any new practice involving the use of ionising radiation shall undergo prior risk assessment.

6.1.2.3. The risk resulting from any exposure to radiation shall be exceeded by the individual or societal benefit it produces, i.e.
practices shall only be undertaken where they are justified.

6.1.2.4. The dose from any diagnostic medical exposure is kept as low as is reasonably practicable (ALARP) social and economic factors being taken into account, consistent with the required clinical purpose.

6.1.2.5. All exposures of target volumes for external beam radiotherapy shall be individually planned, taking into account that doses to non-target tissues/critical organs shall be kept ALARP, consistent with the intended therapeutic purpose.

6.1.2.6. All exposures to members of the public, staff and contractors, and the environment will be ALARP and constrained in accordance with best practice standards and guidance.

6.1.2.7. It is not reasonably foreseeable for an individual dose limit to be exceeded (or alternatively register the individual as a classified worker).

6.1.2.8. Employees are appropriately trained and undergo relevant continuous training and development.

6.2. Medical Exposures

6.2.1. Any equipment or apparatus used in connection with medical exposures will be selected, installed and maintained so as to restrict, as far as reasonably practicable, the exposure of the patient consistent with the intended clinical purpose. See Appendix 4.

6.2.2. Quality Assurance tests will be carried out at regular intervals in accordance with legislation or recommended standards on all equipment or apparatus involved in medical exposures.

6.2.3. Each department conducting medical exposures shall develop (in conjunction with the Medical Physics Expert):

6.2.3.1. A set of Standard Operating Procedures (SOP) to address the requirements of IR(ME)R Regulation 6(1) regarding procedures – see appendix 3.

6.2.3.2. Written protocols for every standard radiological practice (exposure charts/programmes)

6.2.3.3. Diagnostic Reference Levels for diagnostic examinations

6.2.3.4. Referral criteria

6.2.3.5. QA procedures together with measures for review and clinical audit.

6.2.3.6. A register of practitioners and operators in their area of work that includes name, dates and nature of training and the extent of their duties under IR(ME)R.
6.3. Adverse Event Reporting

6.3.1. All adverse events shall be recorded in accordance with standard Trust procedures (DATIX). For radiation, this shall include breaches of the local rules, events in which a patient or member of staff may have received an exposure much greater than intended (or where no exposure was intended).

6.3.2. An investigation shall be undertaken by the Head of Department in conjunction with the RPA (& MPE, as appropriate).

6.3.3. The RPA/MPE shall report the event as may be required to the appropriate external regulatory agencies.

6.4. Pregnant or Breastfeeding Staff

6.4.1. Anyone working with ionising radiation who becomes pregnant should inform their manager in writing immediately, so that an individual risk assessment can be performed and a dose assessment undertaken if necessary.

6.4.2. Before returning to work with unsealed radioactive materials staff should inform their manager if they are intending to breastfeed so that arrangements can be made for a risk assessment to be undertaken.

6.5. Co-operation Between Employers

The Trust will establish good communication and co-operation with those employers whose staff may be occupationally exposed by the Trust's radiation work.

6.6. RCHT Radiation Protection Advisory Committee - Terms of Reference

6.6.1. The Trust Radiation Protection Advisory Committee reports to the Trust on the Trust’s responsibilities in implementing legislation and best practice regarding the use of ionising and non-ionising radiations. The committee will consider the interests of:-

- Employees of the Trust
- Patients under the care of the Trust
- The general public
- The environment

6.6.2. Undertaking this role the Committee will have the remit to advise the Trust Board as to whether appropriate procedures and practices are in place across the organisation in support of the Trust Radiation Protection policies and will advise on the appropriate evidence required in order to assess compliance.

6.6.3. The Committee will be composed of:-

- Medical Director of the Trust or their nominee
- Trust Radiation Protection Adviser/Radioactive Waste Adviser/Laser Protection Adviser
- A representative of each service – e.g. Clinical Director or consultant or
service manager, or their nominee(s)
- Training & Radiation Safety Lead Radiographer
- Co-opted Radiation Protection Supervisors & Medical Physics staff
- Society of Radiographers/Union representative(s)
- Co-opted members & invited members as required

6.6.4. The Radiation Protection Committee will be constituted in order to ensure safe uses of radiation and the implementation of Trust policy. Minutes of this committee are circulated to all senior Clinical Managers with responsibility for the use of ionising and non-ionising radiations. These Managers may be asked to attend for specific issues.

6.6.5. THE COMMITTEE WILL:-
- Draft and review the Trust radiation protection policies.
- Accept annual reports from the Trust Radiation Protection Advisers and non-ionising radiation Adviser(s) and advise the Trust of any organisational risks raised therein.
- This report will highlight any proposed or actual changes to the Ionising Radiations Regulations, Ionising Radiation (Medical Exposure) Regulations and other relevant legislation.
- Receive evidence that Radiation Protection Supervisors, Laser Protection Supervisors and other appropriate local radiation safety supervisors are appointed within the Trust and its premises, and that they have received appropriate training.
- Accept annual reports from the Trust Radiation and Laser & Non-Ionising Protection Supervisors and non-ionising radiation supervisors and to advise the Trust of any organisational concerns raised therein.
- Receive reports from services who use ionising and non-ionising radiations so that the Committee may advise the Trust on compliance. These statements should include the following evidence of compliance:
  -(a) Quality assurance programmes for radiation equipment in their areas and evidence in support of meeting agreed standards
  -(b) Training programmes for staff working in areas using radiation equipment or sources.
- Receive reports from the RPA and LPA regarding incidents involving the use of radiation and the extent to which Clinical Specialities have managed such incidents.
- To initiate projects or changes in working practices designed to reduce occupational, medical and public exposure to ionising and non-ionising radiations.
- Monitor that the Trust fulfils all legal obligations relating to the safe use of ionising and non-ionising radiations

6.7. Quorum: The Committee will only be quorate when attended by six members.

6.8. Officers: The Chairman will be elected by the committee members and will serve for three years. The retiring Chairman will be eligible for re-election.
6.9. Secretariat facilities will be provided by the Department of Medical Physics.

6.10. Frequency of Meetings: Twice a year.

6.11. Reporting Pathways
   6.11.1. The Trust Radiation Protection Committee will report to the Trust Board through the organizational governance structure.
   6.11.2. The RPA will produce an annual report in consultation with the Chairman to the above Committee.
   6.11.3. The Radiation Protection Adviser will report to the Chairman of the Radiation Protection Committee and to the Chief Executive of the Trust.

6.12. Minutes: To be circulated to:
   - Members of the Committee

7. Dissemination and Implementation

7.1. Dissemination
   Upon ratification by the Radiation Protection Advisory Committee & authorisation by the Medical Director, this policy shall be disseminated by storage on the electronic document library.

7.2. Training
   7.2.1. The Trust will ensure that staff working with ionising radiation will be trained to a level commensurate with the work being performed and the degree of hazard involved.

   7.2.2. All IR(ME)R practitioners and operators must have received adequate training as defined in IR(ME)R 17.1-17.6

   7.2.3. Staff acting as practitioners for the clinical administration of radiopharmaceuticals or the clinical use of sealed radioactive sources must hold an appropriate certificate from the Administration of Radioactive Substances Advisory Committee (ARSAC) as required by IRMER 2017.

   7.2.4. All drivers of vehicles carrying radioactive material must receive adequate training in accordance with the ADR / Carriage of Dangerous Goods Act

   7.2.5. The Training Needs Analysis for Radiation Protection is contained within the Trust Core Training Policy. This specifies the training needs of various staff groups & the training routes available to them.

   7.2.6. For staff whose regular duties involve work with ionising radiation, role specific training shall be provided at local departmental induction.

   7.2.7. It is the responsibility of the local Head of Department to liaise with the RPA/MPE regarding the scope, content and suitability of the training programme provided.
7.2.8. Heads of Departments shall ensure that audit of compliance with training requirements is carried out.

7.2.9. For staff whose role requires professional registration, they shall undertake suitable CPD activities and maintain that registration.

7.2.10. Trust-wide standards of radiation protection training shall be monitored by the Radiation Protection Advisory Committee.

7.2.11. Training routes and materials shall be reviewed at least 3 yearly.

7.2.12. The RPA/MPE shall continuously monitor for changes in legislation or best practice standards or guidance that may present a further training need.

8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with requirement for IR(ME)R Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Head of Department supported by respective Medical Physics Expert</td>
</tr>
<tr>
<td>Tool</td>
<td>As applicable: Audit of Diagnostic Reference Levels. Audit of reported adverse events. Individual departmental inspection/review of IR(ME)R procedures</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually or sooner if indicated by RPA/MPE.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Report to Radiation Protection Advisory Committee.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Actions identified by RPAC to be acted upon by Head of Department.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Changes in practice will be fed back to RPAC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Effectiveness of Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Radiation Protection Advisory Committee</td>
</tr>
<tr>
<td>Tool</td>
<td>Reports of Expert Advisers. Reports of Committee members. Correspondence from staff. Reports of adverse events. Reports of external inspections or assessments</td>
</tr>
<tr>
<td>Frequency</td>
<td>Six Monthly</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Summary Minutes to Medical Director</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Actions identified by RPAC to be acted upon by respective Heads of Department.</td>
</tr>
</tbody>
</table>
9. Updating and Review

9.1. The Radiation Protection Advisory Committee shall review this policy at least once every three years.

9.2. Heads of Departments shall provide feedback to the RPAC Chair any arising need for changes to this policy.

9.3. The expert advisers (RPA & MPE) shall continuously monitor for changes in legislation or current best practice standards and guidance. Upon their recommendation a full review of this policy shall be commenced.

9.4. Any revision activity is to be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Diversity & Human Rights Policy’ or the Equality and Diversity website.

10.2. Equality Impact Assessment

10.3. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Ionising Radiation Safety Policy V3.0</th>
</tr>
</thead>
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<tr>
<td>Date Issued/Approved:</td>
<td>08/01/2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>May 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>May 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Trevelyan Foy (Radiation Protection Adviser/Radioactive Waste Adviser)</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252495</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Policy and procedures to ensure the health, safety and welfare of staff, patients and members of public who may be exposed to hazards arising from the use of ionising radiations on the Trust's premises and areas on other sites where Trust staff work.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Radiation, x-ray, xray, safety.</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
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<td>✓</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>08/01/19</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Ionising Radiation Safety Policy v2.5</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Radiation Protection Advisory Committee</td>
</tr>
<tr>
<td>Care Group General Manager confirming approval processes</td>
<td>Robin Jones (CS)</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>John Hancock, Chair Radiation Protection Advisory Committee</td>
</tr>
<tr>
<td>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name:</td>
<td>Kevin Wright</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
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Links to key external standards

- The Ionising Radiations Regulations 2017
- The Ionising Radiation (Medical Exposure) Regulations 2017
- The Health and Safety at Work Act, 1974
- The Environmental Permitting Regulations 2010
- Fitness of Equipment Used For Medical Exposure to Ionising Radiation – Guidance Note PM 77.

Related Documents:
- Non-Ionising (Laser and Optical) Radiation Safety Policy
- Core Training Policy

Training Need Identified?
- Yes, in conjunction with Learning and Development

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
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<td>01.07.2002</td>
<td>V2.0</td>
<td>Original</td>
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<tr>
<td>01.07.2007</td>
<td>V2.1</td>
<td>Minor amendments</td>
<td>Richard Cranage (Radiation Protection Adviser)</td>
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<tr>
<td>22.10.2009</td>
<td>V2.2</td>
<td>Minor amendments, changes to TOR of RP Advisory Committee.</td>
<td>Richard Cranage (RPA)</td>
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<td>11.07.2011</td>
<td>V2.3</td>
<td>Changes in structure to reflect policy on policies. Revision of appendices. ‘Ionising’ added to title for clarity.</td>
<td>Richard Cranage (RPA) / Trevelyan Foy (MPE)</td>
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<td>18.02.2013</td>
<td>V2.4</td>
<td>Appendix 3 – Radioactive Materials added. Role of RWA added.</td>
<td>Trevelyan Foy (RPA)</td>
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<tr>
<td>06.07.2017</td>
<td>V2.5</td>
<td>Interim revision pending new legislation – policy version 2.4 transcribed onto new Trust policy template.</td>
<td>Trevelyan Foy (RPA)</td>
</tr>
<tr>
<td>08/01/2019</td>
<td>V3.0</td>
<td>Updated to reflect new legislation. Appendix regarding transport of radioactive materials added.</td>
<td>Trevelyan Foy (RPA/RWA) / Tracy Cayton-Smith (MPE) / Chloe Trevail</td>
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</table>
All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

**Name of the strategy / policy / proposal / service function to be assessed**
Ionising Radiation Safety Policy V3.0

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>New or existing document:</th>
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<tr>
<td>Medical Physics</td>
<td>Existing</td>
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<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trevelyan Foy</td>
<td>01872 252495</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. <strong>Policy Aim</strong>*</th>
<th>Minimise the risk posed by exposure to ionising radiations</th>
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</thead>
<tbody>
<tr>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
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<table>
<thead>
<tr>
<th>2. <strong>Policy Objectives</strong>*</th>
<th>Ensure exposures (except exposure of radiotherapy target volumes) are maintained as low as reasonably practicable, social and economic factors being taken into account.</th>
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<tr>
<td></td>
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|-----------------------------------------|--------------------------------------------------------------------------|

<table>
<thead>
<tr>
<th>4. *How will you measure the outcome?</th>
<th>Monitoring of patient radiation doses, staff doses, results of environmental monitoring, monitoring of adverse events (DATIX).</th>
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<table>
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<tr>
<th>5. Who is intended to benefit from the policy?</th>
<th>Staff, patients, visitors, volunteers, contractors and the environment.</th>
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</table>

<table>
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<th>6a Who did you consult with</th>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
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<tbody>
<tr>
<td>b). Please identify the groups who have been consulted about this procedure.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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**Please record specific names of groups**
Radiation Protection Advisory Committee (RPAC)

| What was the outcome of the consultation?   | Re-ratification of existing policy. |
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td></td>
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<tr>
<td>Race / Ethnic communities / groups</td>
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<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and Civil partnership</td>
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<td>Pregnancy and maternity</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No X

9. If you are not recommending a Full Impact assessment please explain why.

Does not meet criteria above.
This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.
Appendix 3. Design of New or Modified Facilities and/or Procurement of Equipment Used in Connection with Medical Exposure

1. Definition of Equipment Used In Connection With Medical Exposure
   1.1. ‘Equipment used in connection with medical exposure’ includes all equipment whose design, construction, installation or maintenance can affect the magnitude or distribution of the dose of the person undergoing medical exposure. It includes:
      1.1.1. Radiation equipment: equipment that delivers ionising radiation to the person undergoing a medical exposure AND equipment that directly controls the extent of that exposure
      1.1.2. Ancillary equipment: such as computed radiology (CR) plates, CR readers, digital imaging systems, couches, anti-scatter grids, beam modifiers (filters, wedges, applicators), computerised radiotherapy treatment planning systems, radioisotope dose calibrators, film processors, image recording systems such as digital detectors

2. Operational Implementation
   2.1. N.B. A diagrammatic representation of these arrangements is shown below.
   2.2. The Trust will:
      2.2.1. Implement appropriate arrangements via its management structures to ensure that consultation with an RPA in accordance with IRR2017 is undertaken with respect to any new or modified sources of radiation, or new or modified radiation facilities.
      2.2.2. Implement appropriate arrangements via its management structures to ensure that consultation with an RPA/MPE in accordance with IRR2017 is undertaken regarding the selection & use of equipment used in connection with medical exposure.
   2.3. Heads of Department, in conjunction with the nominated Project Manager (where applicable) must implement this procedure within their area regarding proposed:
      2.3.1. New or second-hand radiation sources or equipment used in connection with medical exposure.
      2.3.2. Replacement radiation sources or equipment used in connection with medical exposure
      2.3.3. Modified radiation sources or equipment used in connection with medical exposure
      2.3.4. Use of loan, hire or demonstration sources or equipment used in connection with medical exposure
      2.3.5. New or replacement facilities
      2.3.6. Modifications to existing facilities
   2.4. They shall:
      2.4.1. Ensure that radiation risk assessments are undertaken, in accordance with the radiation risk assessment procedure.
      2.4.2. During development of the equipment and or facility specification, consult with the Radiation Protection Adviser(s) (RPA).
      2.4.3. For equipment used in connection with medical exposure, during development of the equipment specification, engage in consultation with the Medical Physics Expert(s) (MPE) regarding the specification and suitability of
equipment.

2.4.4. Supply such information as may be required by the RPA or MPE to
make an assessment – e.g. equipment specifications, floor plans, description
and scope of intended work.

2.4.5. Ensure, in conjunction with the Head of Planning and Projects, that
RPA approval of the plans for new facilities is obtained.

2.4.6. Ensure, in conjunction with the Head of Procurement and Supplies,
that RPA, and where appropriate MPE, approval of the equipment specification
is obtained.

2.4.7. Ensure, in conjunction with the Head of Procurement and Supplies,
that the RPA/MPE ensures appropriate technical details are included within
tender specification documents.

2.4.8. Ensure that the RPA is given access to inspect/test shielding during
any building works.

2.4.9. Where applicable, ensure that the installer undertakes a critical
examination the equipment & consults with the Trust RPA regarding the
outcomes of that examination, addressing any recommendations of the RPA.

2.4.10. For equipment used in connection with medical exposure, ensure the
equipment is acceptance tested by Clinical and Radiation Physics prior to clinical
use & that recommendations from the MPE regarding the outcomes of that
examination are addressed.

2.4.11. Ensure that operators are given adequate training; as advised by the
RPA/MPE.

2.4.12. For diagnostic imaging equipment & techniques, ensure that diagnostic
reference levels (DRLs) are established in conjunction with the MPE.

2.4.13. Under advice from the RPA/MPE, ensure that a suitable quality
assurance programme is implemented.

2.5. Employees must ensure that any new or modified source of radiation which they
wish to introduce, or modification to their facility/use of new facilities, has been
appropriately identified via the Head of Department and has been subject to the
appropriate approvals and acceptance testing.

2.6. Radiation Protection Supervisors (where appointed for existing facilities) will:

2.6.1. Identify to the appropriate manager matters which need to be
considered in the risk assessment, or require the risk assessment to be
reviewed.

2.6.2. Monitor the adequacy of training and standards of competence.

2.6.3. Monitor to ensure that the quality assurance programme is
implemented.

2.7. The Radiation Protection Adviser(s) shall provide specialist radiation
protection advice regarding compliance with the regulations, to include but not limited
to:-

2.7.1. The implementation of requirements as to controlled and supervised
areas

2.7.2. The prior examination of plans for installations and the acceptance into
service of new or modified sources of ionising radiation in relation to any
engineering controls, design features, safety features and warning devices
provided to restrict exposure to ionising radiation.

2.7.3. The regular calibration of equipment provided for monitoring levels of
ionising radiation and the regular checking that such equipment is serviceable and correctly used.

2.7.4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation

2.8. The **Medical Physics Expert**(s) shall, in respect of equipment used in connection with medical exposure, advise on radiation protection, patient dosimetry (including the establishment of diagnostic reference levels), quality assurance and optimisation programmes (including acceptance testing) of that equipment.

2.9. The **Head of Planning and Projects** will:

2.9.1. Ensure that the RPA and MPE are consulted at the facility design stage as subject matter experts to advise on radiation protection and equipment selection.

2.9.2. Ensure that the final plans for new or modified facilities have the approval and sign-off of the RPA prior to commissioning.

2.10. The **Head of Procurement and Supplies** will:

2.10.1. Ensure that the specifications for new/replacement radiation sources and equipment used in connection with medical exposure are approved by the MPE and RPA prior to the purchase order of new/replacement radiation equipment.

2.10.2. Ensure that tender specifications for new/replacement radiation equipment and equipment used in connection with medical exposure are approved by the MPE and RPA prior to issuing the invitation to tender.

2.11. **Process Diagram**
Decision to purchase new or replacement radiation source or equipment used in connection with medical exposure (see section 5 for list)

Purchaser to identify & evaluate equipment options, seek technical specifications

Purchaser to discuss suitability with Medical Physics Expert(s) (MPE)

Approval of Medical Physics Expert

Recommendations from MPE

Y

Establish physical needs of equipment. Identify possible location options. Prepare schematic drawings & details of services

Identify preferred option from above.

Pass final plans to RPA for approval (legal requirement)

Approval of Radiation Protection Adviser

Recommendations from RPA

Y

Supplies to verify technical details within proposed tender spec/contract with

Supplies to verify with MPE that equipment has been approved, then procure equipment.

Installation timeplan drawn up by Planning & Projects Contact Med Phys regarding timings for equipment testing.

Planning and Projects to check RPA has approved final plans & authorise works.

Med Physics to contact installers regarding critical exam

BUILDING WORK BEGIN
During building works RPA will test to ensure that shielding is in accordance with specification.

**Installer’s Testing**

(May be undertaken by Physics on installer’s behalf)

- Installer’s/erector’s Critical Examination of equipment
  - RPA approval of critical exam? (Y)
    - Acceptance Testing of Equipment by Medical Physics Expert(s)
      - MPE approval of acceptance test? (Y)
        - Handover of equipment to clinical use
        - Clinical Commissioning by User & Medical Physics Expert & Supplier’s Applications Specialist (applications)
          - Operator Training
            - Full Clinical Use
          - MPE to advise on requirements of quality assurance programme
    - Remedial action based on recommendations from RPA (N)

- Remedial action based on recommendations from RPA (N)

**Purchaser’s Acceptance Testing**

- Acceptance Testing of Equipment by Medical Physics Expert(s)
  - MPE approval of acceptance test? (N)
    - Remedial action based on recommendations from MPE
  - Remedial action based on recommendations from MPE (Y)

**Clinical Commissioning**

- Clinical Commissioning by User & Medical Physics Expert & Supplier’s Applications Specialist (applications)
  - Operator Training
  - MPE to advise on requirements of quality assurance programme
  - Establishment of diagnostic reference levels in conjunction with MPE
Appendix 4. Management of Radioactive Materials

1. Management Arrangements
   1.1. Work with radioactive materials shall only be carried out in accordance with RCHT policy and standard operating procedures, which address the requirements of the Environmental Permitting Regulations.
   1.2. The permit(s) shall be made available to relevant staff via the electronic quality management systems.

2. Authorisation of Practices
   2.1. Any member of staff seeking to introduce a new practice involving the use of new or existing radioactive materials shall first consult with the RWA/RPA and head of department
   2.2. All new practices shall be subject to prior radiation risk assessment.

3. Location of Work With Radioactive Materials
   3.1. Work with radioactive materials shall only be conducted in the agreed locations; work activities with sources shall not be conducted outside the main hospital site.

4. Source Security
   4.1. All sources must be kept in their approved locations when not in use.
   4.2. All sources must be continuously supervised when removed from their approved locations.

5. Organisational Structure & Duty Holders
   5.1. The organisational structure for the management of radioactive sources and wastes is within the Trust Radiation Safety Policy. Currently all work with radioactive materials is undertaken by the Clinical Support Care Group. Duties are described in the Trust Radiation Safety Policy.
   5.2. Workforce Changes
      5.2.1. When an existing post holder plans to leave the organisation or is otherwise unable to perform their duties (e.g. on a period of extended leave), the respective Head of Department shall consult with the RPA/RWA with regard to appropriate arrangements to ensure service continuity.
      5.2.2. Under the advice of the RWA/RPA, the Head of Department shall ensure all staff are given appropriate training & continuing professional development advice in order to perform their duties

6. Organisational Change
   6.1. The Trust will inform the EA of changes to its name, cessation of the use of radioactive materials on the premises.

7. Requests From the Environment Agency
   7.1. The EA may request a sample of any radioactive waste. The Trust will:
      7.1.1. Take and analyse such samples of waste and conduct such other tests and surveys as the Agency may require
      7.1.2. Make and keep a record of each such analysis, test or survey; and
      7.1.3. Retain such samples as may be directed by the Agency
   7.2. If required, the Trust will:
      7.2.1. Provide samples as directed
7.2.2. Dispatch samples for tests at a laboratory and ensure that the samples and residues thereof are collected from the laboratory within three months of receiving written notification that testing and repackaging in accordance with the appropriate transport regulations are complete.

7.3. The EA may request other information, e.g. inventories of solid sources, open sources, waste pertaining to various dates in time. The Trust will supply all such information as may reasonably be required without charge.

8. National Arrangements for Incidents Involving Radioactivity
8.1. The site participates in the NAIR scheme as a level 1 responder. As any major event would require the attendance of a level 2 responder, it is not anticipated significant quantities of material will be brought back to site.
8.2. Notwithstanding, if material is brought back to site the following shall apply:
   8.2.1. without delay the Environment Agency shall be informed
   8.2.2. as soon as practicable provide available details in writing to the EA of the nature of the accumulated waste, the radionuclides present and their activities
   8.2.3. Any transfer of the waste shall be to a person whom the EA has agreed in writing may receive that waste; and
   8.2.4. as soon as practicable provides available details in writing of the nature of the radioactive waste, the radionuclides present, their activities and the manner and date of disposal.

9. Disposal of Radioactive Sources/Waste
9.1. All disposals of radioactive sources/waste shall be in accordance with a written procedure agreed by the RWA/RPA.
Appendix 5. Transport of Radioactive Materials

1. **Authorisation**
   1.1. Transport of radioactive materials shall only be carried out by authorised departments, to ensure compliance with the Carriage of Dangerous Goods Regulations.
   1.2. Any member of staff seeking to introduce a new transport activity shall first consult with the RWA/RPA and head of department for authorisation.
   1.3. All new practices shall be subject to prior radiation risk assessment. The risk assessment shall indicate other measures which must be put in place before the activity commences, e.g.
   - appropriate transport containers
   - packaging/consignor/transport/receipt etc. procedures
   - consignment notes
   - contingency plans
   - emergency equipment
   - audit procedures
   - staff training
   1.4. Transport shall only be undertaken as set out in the risk assessment, i.e. of the agreed sources between the agreed locations using the agreed equipment, vehicles and personnel.
   1.5. For any changes in practice (including changes to procedures and work instructions), the head of department and RWA/RPA must be consulted for approval.

2. **Oversight of Transport Activities**
   2.1. The organisational structure for the management of radioactive sources and wastes is within the Trust Radiation Safety Policy Section 5.
   2.2. The respective **Service Manager/Head of Department** shall ensure that:
       2.2.1. Systems & procedures are in place for the safe and legislatively compliant transport of radioactive materials as required by the work routinely carried out.
       2.2.2. The RPA (and MPE where applicable) is fully aware of all situations in which sources of ionising radiation are transported on public roads (within the scope of the departmental work) and advice is sought from these, and other specialist advisers on safety and compliance.
       2.2.3. A suitable risk assessment (Prior Radiation Risk Assessment) is performed when introducing new or modified activities involving the transport of ionising radiation.
       2.2.4. Suitable procedures and record keeping is in place for transport activities, as advised by the RPA / RWA / other advisers.
       2.2.5. Any consignors, drivers or consignees of radioactive packages receive suitable training, commensurate with their role records or training are maintained.
       2.2.6. Records are maintained to demonstrate compliance with transport regulations (e.g. training records, consignment paperwork, transport audits etc.).
       2.2.7. Any vehicle used for transport of radioactive materials is subject to regular maintenance and checks and is suitably equipped.
       2.2.8. Compliance with relevant Trust procedures and SOPs.
       2.2.9. Regular (e.g. annual) audit of transport procedures.
2.3. The Estates Service shall be responsible for ensuring that the Trust appoints a suitable DGSA to advise on transport of radioactive materials and that periodic DGSA audits/reports are undertaken.

2.4. The RPA report to RPAC shall include information pertaining to transport activities.

3. Workforce Changes
3.1. When an existing post holder plans to leave the organisation or is otherwise unable to perform their duties (e.g. on a period of extended leave), the respective Head of Department shall consult with the RPA/RWA with regard to appropriate arrangements to ensure service continuity.
3.2. Under the advice of the RWA/RPA, the Head of Department shall ensure all staff are given appropriate training & continuing professional development advice in order to perform their duties.

4. Monitoring of Staff and Vehicles
4.1. Personal monitoring of staff shall be carried out where indicated by risk assessment.
4.2. As an alternative, where indicated, environmental monitoring of vehicles may be carried out in order to demonstrate that doses are acceptably low as to not require personal monitoring.
4.3. Such monitoring will be scheduled and recorded on the personal monitoring/environmental monitoring database held by Clinical and Radiation Physics.

5. Audit
5.1. Services undertaking transport activities shall undertake periodic audit of their activities. This shall include:

- Identification of package type
- Determination of Transport Index
- Package category labelling
- Package UN marking
- Quality assurance of packaging
- Vehicle preparation and safety equipment
- Driver training and preparation (e.g. completion of training, correct ID etc)
- Shipment paperwork / recording
- Vehicle contamination check

6. National Arrangements for Incidents Involving Radioactivity
6.1. The site participates in the NAIR scheme as a level 1 responder. As any major event would require the attendance of a level 2 responder, it is not anticipated significant quantities of material will be brought back to site. Notwithstanding, if material is to be brought back to site it must be transported in accordance with regulatory requirements.