Ionising Radiation Safety Policy

V2.5

6th July 2017
Summary.
See sections 1 & 2.
1. Introduction

1.1. Royal Cornwall Hospitals NHS Trust is a Radiation Employer.

1.2. 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.

1.3. 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.

1.4. 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.

1.5. 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.

1.6. 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 identified in departmental local rules, procedures & work instructions, quality manuals, and other radiation safety documentation 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 1999 (IRR 1999)
   2.4.2. Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) and 2006 and 2011 amendment regulations.
   2.4.3. The Medicines (Administration of Radioactive Substances) Regulations 1978 (The MARS Regulations 1978)
   2.4.4. Environmental Permitting Regulations.
   2.4.5. Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2010.

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 relates to medical exposures and non-medical exposures to ionising radiation.

3.2. 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.

3.3. 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.

3.4. The Scope of its practice includes:

3.5. **Royal Cornwall Hospitals NHS Trust:**
   - 3.5.1. Diagnostic Imaging,
   - 3.5.2. Cardiology
   - 3.5.3. Nuclear Medicine
   - 3.5.4. Clinical Oncology
   - 3.5.5. Bone Densitometry
   - 3.5.6. Restorative Dentistry
   - 3.5.7. Theatres
   - 3.5.8. Pharmacy

3.6. **Cornwall health community:**
   - 3.6.1. Newquay Hospital
   - 3.6.2. Stratton Hospital
   - 3.6.3. Bodmin Hospital
   - 3.6.4. St Austell Community Hospital
   - 3.6.5. Falmouth Hospital
   - 3.6.6. Camborne/Redruth Community Hospital
   - 3.6.7. St Mary’s Hospital, Isles of Scilly

3.7. 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 IRR99 Schedule 4.

4.2. **IRR99:** The Ionising Radiations Regulations 1999

4.3. **IR(ME)R:** The Ionising Radiation (Medical Exposure) Regulations 2000, including Ionising Radiation (Medical Exposure) (Amendment) Regulations 2006 and 2011.

4.4. **Medical exposure:** Exposure of a person to ionizing radiation for the purpose of his 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 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. Radiation Employer: Radiation employer means an employer who in the course of a trade, business or other undertaking carries out work with ionising radiation or intends to carry out such work.

4.7. Local Rules: Rules made in accordance with IRR99 Regulation 17.

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. The Radiation Protection Advisory Committee reports to the Chief Executive and Trust Board through the Divisional Quality Group.

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 to act as a duty holder under IRR99, provides expert advice on any radiation matters to ensure that the Employer is able to comply 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 the medical exposure.

5.8. **Divisional Manager / Service Manager**, under advice from the RPA & MPE, 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 2.

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. The implementation of Standard Operating Procedures concerning medical exposures in accordance with the Ionising Radiations (Medical Exposure) Regulations 2000.

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 in the nature of risks to which they may be exposed and the necessary measures which they must take to ensure their safety and the safety of others.

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

5.8.12. Undertaking audits to demonstrate compliance of clinical governance standards to support Trust assurance under that framework.

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 2.

5.12. **The Head of Procurement and Supplies** 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 2.
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. The Trust shall ensure that it is not reasonably foreseeable for an individual dose limit to be exceeded.

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 2.

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 4(1) regarding procedures – see appendix 1.
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
6.5.1. 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 within the premises of the Royal Cornwall Hospital and Cornwall & Isles of Scilly Primary Care Trusts. 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
- Clinical Director (where applicable) of each service, or their nominee(s)
- A Service Manager from each service
- A Radiation Protection Supervisor from each service
- Society of Radiographers/Union representative(s)

- Up to two co-opted members & invited members as required

6.6.4. The Radiation Protection Committee will be constituted in order to effect the managerial change and accountability required to implement the Trust policies. 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 Divisional Quality Group 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 Divisional Quality Group of any organisational concerns raised therein.
- Receive annual statements of compliance from clinical Imaging & Medical Physics regarding Divisions 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 Divisional Quality Group.

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
- The Medical Director
- Chairman of the Divisional Quality Group
- Divisional Managers

6.13. Communication with External Bodies: Minutes should also be circulated to the Chief Executives of the Cornwall and IOS Primary Care Trust, and Cornwall Partnership Trust.

7. **Dissemination and Implementation**

7.1. **Dissemination**

7.1.1. 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.

7.1.2. For significant revisions, staff will be notified via the daily email bulletin and notification cascaded to radiation users via RPAC.

7.1.3. The Trust shall maintain an archive of previous document versions.

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 Schedule 2.

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 the Medicines (Administration of Radioactive Substances) Regulations 1978.

7.2.4. All drivers of vehicles carrying radioactive material must receive adequate training in accordance with the Environmental Permitting Regulations 2010.

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 that use ionising radiation shall audit compliance with training requirements.

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

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<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with requirement for IR(ME)R Procedures</th>
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<tbody>
<tr>
<td>Lead</td>
<td>Head of Department in Conjunction with respective Medical Physics Expert</td>
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<tr>
<td>Tool</td>
<td>As applicable:</td>
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<td></td>
<td>Audit of Diagnostic Reference Levels.</td>
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<td>Audit of reported adverse events.</td>
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<td></td>
<td>Individual departmental inspection/review of IR(ME)R procedures</td>
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<tr>
<td>Frequency</td>
<td>Annually or sooner if indicated by RPA/MPE.</td>
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<tr>
<td>Reporting arrangements</td>
<td>Report to Radiation Protection Advisory Committee.</td>
</tr>
<tr>
<td>Acting on</td>
<td>Actions identified by RPAC to be acted upon by Head of</td>
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<tr>
<td>Element to be monitored</td>
<td>Effectiveness of Policy</td>
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<tr>
<td>Lead</td>
<td>Radiation Protection Advisory Committee</td>
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<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>
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<tr>
<td>Frequency</td>
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<td>Reporting arrangements</td>
<td>Summary Minutes to Medical Director</td>
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<tr>
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<td>Actions identified by RPAC to be acted upon by respective Heads of Department.</td>
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<tr>
<td>Change in practice and lessons to be shared</td>
<td>Changes in practice will be fed back to RPAC.</td>
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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. Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age,
gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.3. *Equality Impact Assessment*

10.4. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Employer’s IR(ME)R Procedures

1. These procedures set out the employer’s arrangements to fulfill the requirements set out in Schedule 1 of the Ionising Radiation (Medical Exposure) Regulations 2000. These procedures apply to all medical exposures carried out within the organisation.

2. Definitions of Legal Duty Holders Under IR(ME)R

2.1. An individual may perform one or many roles dependent upon their qualifications and position within the organisation. For example, a dentist might act as a Referrer, Practitioner and Operator as well.

2.2. **Referrer:** The referrer is responsible for working within the organisation’s referral criteria and for providing adequate written clinical information to enable the patient to be correctly identified and to enable the practitioner to justify the medical exposure(s) requested.

2.3. **Practitioner:** The practitioner is responsible for justifying medical exposures and, within the extent of their involvement, keeping the dose to the patient as low as reasonable practicable consistent with the intended purpose.

2.4. **Operator:** The operator is any person who carries out practical aspects of a medical exposure and is responsible for ensuring that, within the extent of their involvement, they keep the dose to the patient as low as reasonable practicable consistent with the intended purpose.

2.5. **Medical Physics Expert:** A Medical Physics Expert will be appointed by the organisation and be available for consultation and support as appropriate for; justification, dose optimisation, patient dosimetry, equipment quality assurance relating to the development and use of new techniques and equipment, and other radiation protection matters concerning medical exposures.

2.6. **Employer:** The employer is responsible for compliance with IR(ME)R. The employer must establish procedures, diagnostic reference levels, appoint duty holders, provide training, maintain records et cetera as required by the legislation.

3. Procedure for the Correct Identification of the Patient

3.1. It is the responsibility of the Operator administering the ionising radiation to establish the correct identity of the patient undergoing examination or treatment. Where a number of operators are involved written procedures must identify which operator has this responsibility.

3.2. A standard procedure is in place throughout the Trust which must be observed at all times.

4. Procedure to Identify Individuals entitled to act as a Referrer, Practitioner or Operator

4.1. After receiving a request from an authorised Referrer, the exposure will be justified by a suitably trained Practitioner, following agreed written guidelines and protocols laid down by Royal Cornwall Hospitals NHS Trust. Medical Exposures will then be undertaken by suitably trained Operators. The RPA & MPE will advise the Trust if there is any doubt as to whether a Practitioner or
Operator has had sufficient training to carry out their role.

Referrer

4.2. Requests for Medical Exposures can only be made by an authorised Referrer:

4.2.1. Any medical or dental practitioner appointed to Royal Cornwall Hospitals NHS Trust, the Cornwall Health Community or General Practitioners working in Cornwall.
4.2.2. Other Health Care Professionals acting under agreed Standard Operating Procedures (SOPs).

4.3. The Referrer shall complete radiation protection/IR(ME)R training as directed by the Employer.

4.4. It is the responsibility of the referrer to provide sufficient accurate written information when requesting an exposure to:

4.4.1. Correctly identify the patient
4.4.2. Allow the practitioner to justify the exposure.

Practitioner

4.5. A Practitioner is a registered medical or dental practitioner appointed to the Trust entitled by Job Description to take responsibility for the justification of an individual medical exposure.

4.6. Other Health Care Professionals with appropriate training may, working within agreed SOPs, act as a Practitioner to justify exposures as specified within the scope and practice of those SOPs.

Operator

4.7. The Operator is any person who is entitled in accordance with the written Standard Operating Procedures, to carry out practical aspects of the medical exposure.

4.8. The following may be entitled to act as operators:

4.8.1. Radiologists, having undergone adequate and appropriate training on the equipment concerned.
4.8.2. Consultant physicians or surgeons with POPUMET and appropriate experience appointed before May 2000 to Royal Cornwall Hospitals NHS Trust.
4.8.3. Health Professions Council registered radiographers.
4.8.4. Medical Technical Officers with adequate training in ionising radiation under a written SOP.
4.8.5. Registered dental practitioners and dental nurses, subject to adequate training, may be entitled to operate dental x-ray machines.
4.8.6. Medical physicists subject to adequate training are authorised to operate all equipment for testing and QA purposes. They may be authorised for medical exposures by written SOP.
4.8.7. Nurses, subject to appropriate training giving radionuclide injections under a written SOP.
4.8.8. Medical Practitioners subject to appropriate training are authorised to use Image Intensifier machines while a radiographer is present.
4.8.9. Other healthcare practitioners who following adequate training are given written permission within an approved scope of practice to carry out specific practical aspects of Medical exposures (e.g. assistant practitioners).
4.8.10. ARSAC licence holders for examinations or treatments defined in their ARSAC license and persons acting under the written instruction of the licence holder.

5. **Procedure for Justification of Exposures**

5.1. All exposures must be individually authorised by a recognised medical practitioner or radiographer as detailed in the local procedures, and initialled, signed or authorised electronically as proof of justification and thereby authorisation to carry out the medical exposure.

5.2. Operators may carry out exposures on a verbal request from a medical practitioner only if the clinical need of the patient is such that it would be detrimental for that patient if the operator were to wait for a request form or electronic request to be completed. The patient identification protocol must still be followed.

5.3. All radionuclide examinations will be individually authorised by an ARSAC licence holder. If they are not available, other named staff as designated by SOP may perform this.

5.4. In the instance of a Major Incident being declared, operators may carry out exposures on patients who are identified only by their Major Incident Hospital Identification Number (HIN). The operator must check that the number on the patient and that of the request form, tally, and this number must be recorded on the radiograph. Exposures may only be carried out without a request forms if under the criteria in point 5.2, above.

6. **Procedures to be Observed in the Case of Medico-Legal Exposures**

6.1. This refers to an examination performed for insurance or legal purposes without a medical indication. This category of exposure will include those undertaken to support legal action of any kind e.g. those required to support a court action or for emigration purposes.

6.2. All requests for Medico-Legal exposures will be evaluated as to their appropriateness and justified by a practitioner who is a medical specialist or dental practitioner appointed to the Trust.

6.3. The referrer must state on the request that the examination is for medico-legal purposes.

6.4. The operator must check with the patient that the referring doctor has explained that the X-ray is for medico-legal purposes.

6.5. A Medical Specialist or Dental Practitioner must report all medico-legal exposures.

7. **Procedures for Making Enquiries of Females of Childbearing Age to Establish Whether the Individual is or may be Pregnant or Breast-feeding**

7.1. Before all high dose exposures, it is the operator’s responsibility to enquire whether a female may be pregnant or breast-feeding before any exposure to ionising radiation. Written Standard Operating Procedures will identify which
exposures are high dose and give details of the procedure to be followed.

8. Procedures to Ensure That Quality Assurance Programmes for Standard Operating Procedures Are Followed

8.1. Standard Operating Procedures will identify a quality manager responsible for the maintenance and regular audit of Standard Operating Procedures.

9. Procedures for the Assessment of Patient Dose and Administered Activity

9.1. In Nuclear Medicine the ARSAC licence holder is responsible for ensuring that all administered activities fall within the ARSAC DRLs.
9.2. In Radiotherapy all treatment doses will be recorded using appropriate quality controlled systems.
9.3. For Diagnostic Radiology factors relevant to estimating patient dose will be recorded. For standard examinations these may be defined by written protocol.

10. Procedures for the Use of Diagnostic Reference Levels

10.1. In Nuclear Medicine, DRLs will be observed within the national ARSAC limits.
10.2. In Diagnostic Radiology, DRLs will be established for procedures, due heed will be given to National guidance and Health Protection Agency recommendations.
10.3. Audit of DRLs will be the responsibility of the Departmental Head.
10.4. An investigation of doses consistently exceeding DRL will be undertaken and the Trust will take all steps to achieve dose reduction.

11. Biomedical and Medical Research Programmes

11.1. Exposures shall only be undertaken with the prior approval of a research ethics committee (REC), it is the responsibility of the investigator to ensure this is granted before commencing the study.
11.2. The investigator shall submit the trial study protocol, otherwise completed IRAS form and site-specific form (where applicable) to the appropriate (diagnostic radiology/nuclear medicine/radiotherapy) Medical Physics Expert (MPE).
11.3. The MPE shall undertake an assessment of radiation doses arising from local practice and determine a research protocol total dose constraint (or for site-specific assessments, whether the constraint set by the lead site will be met) and estimate risks to the patient arising from any exposures additional to normal patient care.
11.4. The Investigator, under guidance from the MPE, shall identify a suitable Clinical Radiation Expert (CRE) (clinician) to evaluate, on the basis of the trial study protocol and the MPE assessment, the risks to the patient against the merits of the study and formulate the CRE’s report.
11.5. Upon REC approval being subsequently obtained, the Investigator shall ensure a copy of the final IRAS form & REC approval are supplied to the Medical Physics Expert.
11.6. REC approval notwithstanding, the Employer recognises the legal requirement that exposures shall only be undertaken where:
   11.6.1. The individual concerned participates voluntarily in the research programme.
   11.6.2. The individuals concerned are informed in advance about the risks of the exposure.
   11.6.3. The dose constraint set down in the employer’s procedures for
individuals for whom no direct medical benefit is expected from the exposure is adhered to.

11.7. The researcher(s) will ensure that the practitioner and operator are aware that the patient is taking part in a research project by written documentation accompanying the patient.

12. Procedures for the Giving of Information and Written Instructions to Patients Receiving Radioactive Substances

12.1. It will be the responsibility of the Operator administering any therapeutic radiopharmaceutical dose to give written information to the patient or an appropriate responsible adult, detailing steps to be taken to limit the radiation dose to other members of the public.

13. Procedures for the Carrying Out and Recording of an Evaluation for Each Medical Exposure

13.1. All diagnostic medical exposures must be evaluated by a suitably trained healthcare professional.
13.2. SOP will identify which examinations will be evaluated by other trained Health Care Professionals.
13.3. All therapeutic procedures will be followed up to evaluate the outcome of the exposure.
13.4. Audit will measure compliance.

14. Procedures to Ensure that the Probability and Magnitude of Accidental or Unintended Doses to Patients from Radiological Practices are Reduced so far as Reasonably Practicable

14.1. Protocols and Quality systems are intended to try to ensure the exposure of patients is undertaken with the minimum radiation dose consistent with clinical need.
14.2. Policies will be in place to ensure that all practical aspects will be conducted with due regard to minimising unintended doses to patients.
14.3. The Radiation Protection Adviser will instigate an immediate investigation if any report is made of a possible incident resulting in an exposure much greater than intended involving defects in radiation equipment or operating procedures and protocols.

15. Procedure for Quality Assurance Programmes

15.1. Quality assurance programmes will be implemented in all areas
15.2. The effectiveness of such programmes will be audited and the results presented annually to a Clinical Imaging Audit Meeting.
Appendix 2. 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 which 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), computerised radiotherapy treatment planning systems, 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 IRR99 Regulation 13 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 IRR 99 Regulation 32 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 the radiation protection service 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.

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

2.6.1. Assist in the equipment selection/facility design process for the designated areas to which they are appointed, particularly with respect to matters relating to radiation protection.

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

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

2.6.4. 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 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 (see section 5) 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

Recommendations from MPE

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

Identify preferred option from above.

Pass final plans to RPA for approval (legal requirement)

Approval of Radiation Protection

Recommendations from RPA

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

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 arrangements

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

Installer’s/erector’s Critical Examination of equipment

RPA approval of critical exam?

Y

Remedial action based on recommendations from RPA

N

Acceptance Testing of Equipment by Medical Physics Expert(s)

MPE approval of acceptan

Y

Handover of equipment to clinical use

N

Remedial action based on recommendations from MPE

Purchaser’s Acceptance Testing

Clinical Commissioning by User & Medical Physics Expert & Supplier’s Applications Specialist (applications training)

Clinical Commissioning by User & Medical Physics Expert & Supplier’s Applications Specialist (applications training)

Establishment of diagnostic reference levels in conjunction with MPE

Operator Training

MPE to advise on requirements of quality assurance programme

Full Clinical Use

Building/Installation Phase

(Following handover of the location/room) INSTALLATION OF EQUIPMENT

Installer’s Testing (May be undertaken by Physics on installer’s behalf)
Appendix 3. 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 displayed within the Nuclear Medicine Hot Lab and Pharmacy Technical Services areas.

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. Current all work with radioactive materials is undertaken by the Diagnostics, Therapies and Cancer Division. 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.

7.4.

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. Supply of Radioactive Open Sources to Other Organisations
9.1. Where another organisation (e.g. another NHS hospital) requests supply of an open source (e.g. Tc99m), they shall supply evidence of having a permit to keep or use such material before it is supplied by RCHT.

10. Disposal of Radioactive Sources/Waste
10.1. All disposals of radioactive sources/waste shall be in accordance with a written procedure agreed by the RWA/RPA.
<table>
<thead>
<tr>
<th>Document Title</th>
<th>Ionising Radiation Safety Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>06/07/2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>06/07/2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>01/01/2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Trevelyan Foy (Radiation Protection Adviser/Radioactive Waste Adviser/Laser Protection 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>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>6th July 2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Ionising Radiation Safety Policy v2.4</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Radiation Protection Advisory Committee</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Karen Jarvill (CSCS)</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Trevelyan Foy (Radiation Protection Adviser/Radioactive Waste Adviser)</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: John Hancock, Chair Radiation Protection Advisory Committee</td>
<td></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>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical/MedicalPhysics</td>
</tr>
</tbody>
</table>
Links to key external standards

The Ionising Radiations Regulations 1999
The Ionising Radiation (Medical Exposure) Regulations 2000
The Health and Safety at Work Act, 1974
The Environmental Permitting Regulations 2010
The Medicines (Administration of Radioactive Substances) Regulations 1978
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>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01.07.2002</td>
<td>V2.0</td>
<td>Original</td>
<td></td>
</tr>
<tr>
<td>01.07.2007</td>
<td>V2.1</td>
<td>Minor amendments</td>
<td>Richard Cranage (Radiation Protection Adviser)</td>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<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>
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</table>
## Appendix 5. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of service, strategy, policy or project (hereafter referred to as policy) to be assessed:</th>
<th>Ionising Radiation Safety Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Corporate</td>
</tr>
<tr>
<td><strong>Is this a new or existing Policy?</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Trevelyan Foy</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252495</td>
</tr>
</tbody>
</table>

### 1. Policy Aim*

Minimise the risk posed by exposure to ionising radiations

### 2. Policy Objectives*

Ensure exposures (except exposure of radiotherapy target volumes) are maintained as low as reasonably practicable, social and economic factors being taken into account.

### 3. Policy – intended Outcomes*

High standards of regulatory compliance
Minimisation of health detriment.

### 4. *How will you measure the outcome?*

Monitoring of patient radiation doses, staff doses, results of environmental monitoring, monitoring of adverse events (DATIX).

### 5. Who is intended to benefit from the policy?

Staff, patients, visitors, volunteers, contractors and the environment.

### 6a Who did you consult with b). Please identify the groups who have been consulted about this procedure.

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

**Please record specific names of groups**

Radiation Protection Advisory Committee (RPAC)

### 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.**

What was the outcome of the consultation?

Re-ratification of existing policy.
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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to age</td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to sex</td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to race/ethnicity</td>
</tr>
<tr>
<td><strong>Disability</strong> - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to disability</td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to religion</td>
</tr>
<tr>
<td><strong>Marriage and Civil partnership</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to marital state</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>Positive impact on protection of pregnant persons in accordance with statutory requirements.</td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td></td>
<td>X</td>
<td></td>
<td>All measures unrelated to sexual orientation</td>
</tr>
</tbody>
</table>

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.**

**Signature of policy developer / lead manager / director**  
**Trevelyan Foy**

**Date of completion and submission**  
06/07/2017

**Names and signatures of members carrying out the**

1. Trevelyan Foy
2. Human Rights, Equality & Inclusion Lead
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the
Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed __ ________________

Date ________________