Trust Standard Operating Procedure

University Hospitals Plymouth NHS Trust

Ionising Radiation Safety Policy: Managerial Responsibilities For Radiation Safety

Issue Date	Review Date	Version
December 2019	December 2022	2

Purpose

Details the managerial responsibilities for radiation safety

Who should read this document?

Managers responsible for areas in which ionising radiation is used

Key Messages

Managers have a legal responsibility for ensuring radiation safety. This document details these responsibilities.

Core accountabilities	
Owner	Nick Rowles & Ivor Jones
Review	Radiation Safety Committee
Ratification	Peter Wright – Director of Healthcare Science & Technology
Dissemination (Raising Awareness)	Radiation Safety Committee
Compliance	Radiation Safety Committee

Links to other policies and procedures
This is a subsidiary document of the Ionising Radiation Safety Policy (218) which contains full details of definitions, dissemination etc.

Version History		
1	April 2013	Document creation and approval
1	April 2015	Extended by Medical Director to August 2015
1	January 2016	Extended by Director of Corporate Business to January 2018
2	December 2019	Reviewed and Approved

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

University Hospitals Plymouth NHS Trust

Standard Operating Procedure (425)

Ionising Radiation Safety Policy:

Managerial Responsibilities For Radiation Safety

1 Introduction

1.1 This document is an appendix to Trust Policy No.218, the Ionising Radiation Safety Policy

1.2 It details the responsibilities of management with regard to radiation safety.

2 Definitions

2.1 See the Ionising Radiation Safety Policy (Trust Policy 218).

3 Regulatory Background

3.1 The purpose of this procedure is to ensure that senior managers are aware of their responsibilities under the various pieces of legislation relating to the use of ionising radiation.

4 Key Duties

The Trust	
General	• Ensuring that the Trust complies with its regulatory duties regarding protection of staff, patients, the public and the environment.
Risk Assessment	• Implement appropriate arrangements via its management structures to ensure risk assessments are undertaken and reviewed for activities involving ionising radiations.
Occupational and Environmental Monitoring	• Implement a programme of occupational and environmental monitoring in order to demonstrate ALARP, and take any action as necessary to reduce exposures which are not ALARP.
The Chief Executive	
General	• Ensuring implementation of the employer's legal duties surrounding the use of ionising radiations within the Trust. This responsibility is discharged through designated individuals
The Executive Director with Responsibility for Health & Safety	
General	• The delegated responsibility for the strategic management of radiation within the Trust

The Medical Director	
General	• The delegated responsibility for the Management of Risk within the Trust • The delegated responsibility for standards of Clinical Governance within the Trust
The Radiation Safety Committee	
General	• Reports to the Trust Board via the Trust committee structure on the Trust's responsibilities regarding compliance with legislation and best practice regarding the use of ionising radiations within the premises of the Trust. • Advises the Trust Board as to whether appropriate procedures and practices are in place across the organisation in support of the Trust radiation protection policies on the appropriate evidence required in order to assess compliance. • The full responsibilities of the Radiation Safety Committee are detailed in the Terms of Reference [Trust Procedure 430]
The Director of Healthcare Science and Technology	
General	• Ensuring that the Trust has adequate provision of specialist advisors for uses of ionising radiations, and for the provision of specialist radiation protection services • Ensuring that a programme of occupational and environmental monitoring is implemented. • Ensuring that a programme for the calibration of all relevant instrumentation is in place and is followed.
The Director of Planning & Estates	
General	• Ensuring that advice from specialist advisors is sought regarding plans for new or modified facilities. • Responsibility for the programme of environmental monitoring for workplace exposure to Radon, which is outside the scope of this procedure. • Responsibility for the collection of solid radioactive waste from user departments and its transfer to DWMS for incineration. • Ensuring that any proposal to change arrangements for collection or disposal of radioactive waste (including change of contractor) is notified to the RWAs well in advance as it may require notification to the Environment Agency and potentially a formal application for a variation to the Trust Permit.
The Head of Learning and Education	
General	• Ensuring that training programmes are available for staff working with ionising radiations, and where appropriate that this is provided to staff groups as part of induction and statutory update training.

The Emergency Continuity Planner

General	• Ensuring matters relating to the safe use of ionising radiations are considered in the Trust contingency arrangements for major incidents.
Service Line Clinical Directors (through the Chief Operating Officer), Service Line Group Managers and Departmental Heads	
General	• To provide assurance to the Radiation Safety Committee as to their Service line's compliance with radiation protection legislation via the Radiation Safety Assurance self-assessment pro forma. • Ensuring the safety of all staff, public and contractors in their Service Lines and Departments from exposure to ionising radiations. • Operational management of Radiation Safety for uses of ionising radiations in the areas for which they are responsible including implementation and review of relevant policies and procedures. This must be explicitly provided for within the directorate / department's governance arrangements. • Implementation of Departmental Operating Procedures concerning medical exposures in accordance with the Ionising Radiations (Medical Exposure) Regulations 2017 • Ensuring that sufficient time and resources are made available to those involved in the use of ionising radiation to ensure that all legislation is complied with • Management of equipment used in relation with work utilising ionising radiations • Cooperation with the Radiation Safety Assurance programme • To develop and implement action plans to remedy any failings in compliance.
Policies and Procedures	• Ensuring that all relevant procedures are regularly reviewed and in-date. • Ensuring that IRMER Employer's procedures and others as required are presented to the RSC for review at least once every two years. • Perform audits of compliance with the above procedures

Risk Assessment	• Risk management surrounding the use of ionising radiations. • Seeking the advice of an RPA and/or RWA on the nature, compliance and content of Risk Assessments • Involving the relevant RPS(s) in writing Risk Assessments relevant to the areas in which they are appointed • Ensuring that all risk assessments are “suitable and sufficient” and comply with the requirements of the ACoP. • Ensuring that the Register of Risk Assessments is accurate and updated. • Implement local arrangements for radiation risk assessment for any activity involving ionising radiation for which they are involved. These arrangements must clearly identify responsibility for undertaking such risk assessments, and ensure that those undertaking risk assessments are appropriately trained. • Ensuring that Prior Risk Assessments are performed when introducing new or modified equipment and techniques. • Ensuring that Risk Assessments are subject to appropriate review i.e. at regular intervals and when changes in procedures are made. These reviews must take into account performance and assurance data (monitoring results etc.), which must be referenced in the review. • Ensuring that actions resulting from such Risk Assessments are identified and appropriately implemented in order to ensure that exposures are ALARP • Documenting the outcome of the risk assessment in accordance with Trust requirements, and transferring the risk to the Directorate risk register in accordance with local Directorate procedures. • Ensuring that the outcomes of risk assessment are made available to staff • Reporting on the nature of Directorate risks via the risk register and risk management structure and to the Radiation Safety Committee
Local Rules	• Ensuring that Local Rules are in place for all areas in their Service Line where work with ionising radiation takes place and that these rules are current, ACoP compliant and regularly reviewed. • Ensuring that all staff who may enter a Controlled Area have read and acknowledged the Local Rules • Seeking the advice of an RPA and/or RWA on the nature and content of Local Rules • Involving the relevant RPS(s) in writing Local Rules relevant to the areas in which they are appointed

Incidents Involving Ionising Radiation	• Managing and investigating the incident as per Trust policy, and ensuring the involvement of the RPA/RPS/MPE as appropriate. • When reporting the incident on Datix managers must indicate that radiation was involved. • Ensuring that initial investigations are conducted commensurate with the need to report to external agencies as soon as possible. • That all such incidents whether reportable to an external agency or not, are appropriately managed and analysed via the Service Line Clinical Governance Committee and that appropriate action plans are developed and followed. Such action plans must be completed in a timely manner and reported to the Radiation Safety Committee. • Service Line managers in Radiotherapy (Oncology Directorate) and Radiotherapy Physics (Directorate of Healthcare Science and Technology) must ensure there are local procedures in place to ensure incidents are recorded and investigated in accordance with the report “Towards Safer Radiotherapy”
Radiation Protection Supervisors	• Ensuring that sufficient, suitably trained and updated individuals are appointed as Radiation Protection Supervisors (RPSs) for the Radiation Controlled Areas within their directorates. • Ensuring that RPSs are appointed in writing with a copy of the letter being sent to the RPA.
External Audits and Inspections	• Ensuring that actions resulting from relevant external inspections are being performed in an appropriate and timely manner
Training	• Ensuring all staff working with ionising radiations receive appropriate training, including update and refresher training, in the nature of the risks to which they may be exposed, and the necessary measures which they must take in accordance with Trust and DOPs to ensure their safety and the safety of others. Ensuring all such staff comply with Trust procedures and DOPs in relation to the safe use of ionising radiations. • Ensure that all staff receive appropriate training for the use of any equipment and in the performance of any techniques they may be required perform. • Ensure that training material is available for Outside Workers. • Ensure that adequate training records are maintained for all staff.

Radioactive Substances	• Safe management of radioactive sources and disposal of radioactive waste. • Ensuring that, prior to commencing any work with ionising radiation, or any change in practice, a radiation prior risk assessment has been carried out and submitted for review to the RWAs along with the BAT case. A Radiological Assessment may also be required. This must be prepared in conjunction with the RWAs. • Preparation of written procedures for the procurement, security, holding and use of radioactive sources, and the accumulation and disposal of radioactive waste, including record keeping, which will ensure compliance with the Environment Agency permits and Trust procedures; • Presenting periodic returns indicating their current holdings of radioactive sources and waste disposals in the previous period, to the RWAs • Performing regular audits of the presence of all sealed sources for which they are responsible. • Performing regular leakage tests on all sealed sources that they hold. • Ensuring that contingency plans are in place for all reasonably foreseeable incidents.
Audit	• Performance of audits to demonstrate compliance in support of clinical governance standards and to support Trust assurance under CQC Regulations. Providing evidence and reports of such audits to the Radiation Safety Committee and other Trust bodies as required. These are to be recorded on the Trust audit register and compliance can be demonstrated via the register. • Providing assurance as required to demonstrate compliance as part of the Radiation Safety Assurance programme. • Audit of clinical evaluation of exposures. • Where required by the results of an audit, to ensure that appropriate remedial action plans have been developed and followed.

Occupational and Environmental Monitoring	• Identify via risk assessment those areas where ionising radiations are used and ensure appropriate monitoring arrangements are in place for occupational monitoring of staff, and of the environment. • Ensuring that occupational exposures are as low as reasonably practicable • Inform the Radiation Protection Service of requirements for monitoring of individual staff. • The management of employees' occupational exposure, including ensuring employees are subject to appropriate monitoring, that employee monitors are worn, that dose records are reviewed and any required action in response to these records. They must also facilitate programmes of environmental monitoring in areas for which they are responsible • Ensure any staff who require occupational monitors receive appropriate instructions regarding wear of the monitors, and procedures for issue and return. • Ensure monitors are stored in a suitable secure location when not in use, including between shifts • Implement a local procedure which will ensure timely issuing and return of dosimeters • Ensure procedures are in place for employees undertaking work with ionising radiation at other employers' premises, to ensure co-operation between employers on relevant matters including personal dosimetry. • Perform regular monthly audits to ensure staff wear the monitors issued to them, and take appropriate action where this is not the case. The results of such audits must be made available to the radiation safety assurance programme • Take any actions that are required to alleviate late returns of dosimeters by staff identified in reports provided by the radiation protection service. • Review dose reports for staff and disseminate this information to those monitored • Initiate investigations to identify the reason for any extraordinary readings, in liaison with the RPA, and implement any remedial actions that are required. • Facilitate and cooperate with programmes of environmental monitoring
Contracting Services to Another Provider	• Ensuring that the Trust has assurance that adequate procedures are in place for the protection of patients under the regulations, • Ensuring that all processes and pathways are reviewed, • Ensuring that detailed and adequate governance arrangements are in place in any contracts • Ensuring that this is done before the service is commenced.

Medical Exposures	• Ensuring that procedures and protocols in compliance with the regulations are written, implemented and reviewed and that staff adhere to them. • Ensuring that Departmental Operating Procedures (DOPs) are implemented to comply with the regulations. These DOPs must be appropriate to each range of medical exposures of their service line and must, as a minimum, include those listed in Schedule 1 of the Regulations and listed in the Procedure for Medical Exposures • Ensuring that DOPs are implemented to ensure that all registered Healthcare Professionals who are entitled to act as a referrer are individually identifiable. • Ensuring that Practitioners and Operators are able to identify requests made from individuals who are entitled referrers. • Ensuring that all duty holders under the regulations are appropriately qualified and trained, and ensure records of such training (including practical training on equipment) are maintained within the directorate. Training must include appropriate update training in relevant matters concerning the individual's role in medical exposures. • Ensuring a clinical evaluation is recorded for every medical exposure • Ensuring that appropriate governance arrangements exist for research exposures • Ensuring that all incidents involving medical exposures, or procedural errors, are investigated in accordance with the Procedure for Incidents Involving Ionising Radiation. • Ensuring that an optimisation strategy for medical exposures is in place. • Ensuring (where appropriate) that diagnostic reference levels are implemented, reviewed and appropriate action is taken when they are consistently exceeded. This must include a formal process for adoption and review. • Ensuring that Local DRLs are in place for all exposures and that compliance with these LDRLs is audited and action taken where they are regularly exceeded. In addition, where these DRLs are not within National and European DRLs that these have been approved by the Service Line Clinical Governance Committee. • Ensuring that audits of Clinical Evaluation of exposures have been performed. These are to be recorded on the Trust audit register and compliance can be demonstrated via the register.

5 Procedure to Follow

5.1 The responsibilities of managers under the various pieces of legislation relating to the use of ionising radiation are listed in section 4 above.

5.2 The relevant legislation is detailed in the Ionising Radiation Safety Policy (Trust Policy 218).

6 Document Ratification Process

6.1 See the Ionising Radiation Safety Policy (Trust Policy 218).

7 Dissemination and Implementation

7.1 See the Ionising Radiation Safety Policy (Trust Policy 218).

8 Monitoring and Assurance

8.1 See the Ionising Radiation Safety Policy (Trust Policy 218).

9 Reference Material

9.1 See the Ionising Radiation Safety Policy (Trust Policy 218).