Trust Policy

University Hospitals Plymouth NHS Trust

Ionising Radiation Safety Policy: SOP for Radiation Risk Assessment

Issue Date	Review Date	Version
February 2019	February 2024	5

Purpose

This procedure sets out the framework for radiation risk assessments within Plymouth Hospitals NHS Trust. It is a supporting document for Trust Policy No. 218, the Ionising Radiation Safety Policy.

Who should read this document?

All persons involved in the use of ionising radiations within PHNT.

Key messages

All uses of ionising radiation require a radiation risk assessment. These risk assessments must be regularly reviewed and action taken to minimise the risks involved.

Accountabilities

Production	Radiation Safety Committee
Review and approval	Radiation Safety Committee
Ratification	Peter Wright Director of Healthcare Science and technology
Dissemination	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	01/04/2010	Creation of document
2	20/08/2010	Approved by Radiation Protection Committee
3	April 2013	Reviewed and approved by RPC
3	April 2015	Extended by the Medical Director to August 2015
3	January 2016	Extended by Director of Corporate Business to January 2017
4	February 2019	Reviewed and approved by RPC

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it 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 the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request.

1 Introduction

1.1. The Trust has a duty to restrict any exposure to ionising radiations of patients, visitors and staff in accordance with the requirements of the regulations, and in seeking to do so, follows the ALARP principle (exposures As Low as Reasonably Practicable).

1.2. Prior to any new or modified activity involving the use of ionising radiations, a suitable and sufficient radiation risk assessment must be performed to identify if existing controls are sufficient to ensure exposures are ALARP, or identify the necessary further measures required.

1.3. Such risk assessments must be regularly reviewed – at period not exceeding two years.

2 Purpose, including legal or regulatory background

2.1. This procedure applies to all areas of the Trust that employ ionising radiations.

2.2. Radiation risk assessments are required under

2.2.1. The Ionising Radiations Regulations 2017 (IRR17) for staff and the public

2.2.2. The Environmental Permitting (England and Wales) Regulations 2016 (EPR2016) for environmental impact

3 Definitions

3.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

4 Duties

4.1. Managerial responsibilities are detailed in Trust Procedure 425: Managerial Responsibilities for Radiation Safety.

4.2. Additional, specific responsibilities are detailed below.

Employees
• Ensuring that any new or modified procedure which they wish to introduce has been appropriately identified via the Directorate management, been subject to appropriate risk assessment and approval.
Radiation Protection Supervisors (RPS)
• Assistance in undertaking radiation risk assessments for the designated areas to which they are appointed. • Identification to the appropriate manager of matters which need to be considered in the risk assessment, or which require the risk assessment to be reviewed. • Assistance in the implementation of action plans following risk assessments including writing and reviewing of Local Rules for the designated areas to

which they are appointed.
Radiation Protection Advisers (RPA)
• Advice on the nature and content of radiation risk assessments and assist in undertaking such risk assessments where required. • Inform the Trusts where he/she believes any activity involving the use of ionising radiations in being conducted with unnecessary risk and/or in breach of the regulations.

5 Key elements (determined from guidance, templates, exemplars etc)

5.1 All risk assessments performed under IRR 17 must meet the standards detailed in the Approved Code of Practice (paragraphs 70 and 71).

Advice should be sought from a RPA, and a standard template is available.

5.2 Service Lines are recommended to consult an RPA when any change in activity requires review of an existing risk assessment.

6 Overall Responsibility for the Document

6.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

7 Consultation and Ratification

7.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

8 Dissemination and Implementation

8.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

9 Monitoring Compliance and Effectiveness

9.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

10 References and Associated Documentation

10.1. See Trust Policy No.218, The Ionising Radiations Safety Policy.

Dissemination Plan | Appendix 1

Core Information	
Document Title	RADIATION SAFETY POLICY Radiation Risk Assessment
Date Finalised	February 2019
Dissemination Lead	Trust document controller
Previous Documents	
Previous document in use?	Trust documents, Q Pulse
Action to retrieve old copies.	Trust document controller, update on Q Pulse

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff		Email	Document Control	

Review and Approval Checklist — Appendix 2

Review		
Title	Is the title clear and unambiguous?	✓
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	✓
	Does the style & format comply?	✓
Rationale	Are reasons for development of the document stated?	✓
Development Process	Is the method described in brief?	✓
	Are people involved in the development identified?	✓
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	✓
	Is there evidence of consultation with stakeholders and users?	✓
Content	Is the objective of the document clear?	✓
	Is the target population clear and unambiguous?	✓
	Are the intended outcomes described?	✓
	Are the statements clear and unambiguous?	✓
Evidence Base	Is the type of evidence to support the document identified explicitly?	✓
	Are key references cited and in full?	✓
	Are supporting documents referenced?	✓
Approval	Does the document identify which committee/group will review it?	✓
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	✓
	Does the document identify which Executive Director will ratify it?	✓
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	✓
	Does the plan include the necessary training/support to ensure compliance?	✓
Document Control	Does the document identify where it will be held?	✓
	Have archiving arrangements for superseded documents been addressed?	✓
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	✓
	Is there a plan to review or audit compliance with the document?	✓
Review Date	Is the review date identified?	✓
	Is the frequency of review identified? If so is it acceptable?	✓
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	✓