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This policy supersedes all previous issues
## Version Control

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Radiation Protection Policy

1. Introduction

Techniques using various types of radiation can provide great diagnostic or therapeutic benefits to patients, but radiation can also be hazardous and even at low levels of exposure there may be long-term risks to health. This Trust will ensure, as far as reasonably practicable, the health and safety of its employees, contractors working on its premises and members of the public who may be exposed to radiation. The Trust needs to put in place appropriate systems of work in order to consistently achieve optimum benefit from such techniques whilst minimising deleterious consequences.

2. Policy Scope

2.1 This policy covers all types of radiation both ionising and non-ionising.

2.2 This policy will also cover situations where hazards to human health may arise due to electro-magnetic (e/m) fields. The hazard may arise directly or indirectly and may be due to high field strength or the context in which the e/m field arises¹.

2.3 The policy covers any situation where a person may be exposed, either intentionally or unintentionally, to radiation due to its use in the Trust, other than where the exposure is outside the control of the Trust, its employees, or other staff working under the Trust’s Policies².

2.4 Planned exposure to radiation may occur under one of the following general circumstances;

2.4.1 the exposure of patients (and under certain circumstances, their comforters and carers) as part of their own medical diagnosis or treatment;
2.4.2 the exposure of individuals as part of occupational health surveillance;
2.4.3 the exposure of individuals as part of health screening programmes;
2.4.4 the exposure of patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes;
2.4.5 the exposure of individuals as part of medico-legal procedures;
2.4.6 exposure to individuals through the use of radiation for quality assurance or calibration of equipment and
2.4.7 the unavoidable exposure of staff due to the nature of some procedures.

2.5 The policy also covers circumstances where unplanned exposure may occur following receipt of contaminated casualties / patients / objects from an external radiation incident; for example, an accident at a nuclear establishment (henceforth an ‘external contamination incident’)

2.6 The policy covers the point at which any technique involving radiation is considered through to the point at which the outcome of the procedure is used³.

¹ - Henceforth, “e/m field” is taken to mean a context where an e/m field gives rise to a recognised hazard to human health.
² - The policy, for example, does not extend to the protection of staff involved in the manufacture of radioactive material in an external commercial laboratory (although it would cover internal quality control of the manufactured agent given to a trust patient).
³ - A clinician, for example, considering a chest x-ray would need to be affected by this policy and the enactment of the clinician’s management decision based on the chest x-ray result would also come into its scope, i.e. all planned exposures to radiation must have a purpose that is realised in practice.
3. **Aim of the policy**

3.1 A fundamental aim of this policy is to ensure the Trust’s compliance with the recommendations of the International Commission of Radiological Protection (ICRP), as enacted in UK legislation, which can be described by the three key principles of radiation protection of ionising radiation.

3.1.1 Justification - exposure to radiation must produce sufficient benefit to the exposed individuals or society to offset the potential radiation detriment.

3.1.2 Optimisation - implementing procedures and techniques to keep all exposures as low as reasonably practicable (ref. 1), economic and social factors being taken into account.

3.1.3 Dose Limitation - keeping all radiation doses received within specified limits.

3.2 These principles also apply to radiotherapy in terms of non-target tissue, where all therapies must be individually planned taking into account the intended therapeutic radiation dose required to target volumes and conformance with employer’s procedures and protocols.

3.3 To ensure compliance with the relevant statutory legislation and accompanying guidance relating to the use of radiation for medical purposes.

3.4 There will inevitably be overlap into other areas of trust policy (e.g MAJAX plan) and this must be managed appropriately.

4. **Duties (Roles and responsibilities)**

4.1 **Chief Executive**

4.1.1 The Chief Executive will establish the management structure appropriate to the policy. He/she will nominate a member of the Trust board to implement radiation protection policy throughout the Trust (the Executive Contact) on his/her behalf.

4.1.2 To make final decisions and recommendations in this regard at the request of the Executive Contact.

4.2 **Executive Contact**

4.2.1 To provide leadership in radiation protection and demonstrate the executive’s commitment to dose reduction.

4.2.2 Monitor, review and implement the Radiation Protection Policy throughout the Trust.

4.2.3 Appoint Radiation Protection Advisers (RPA) and, if appropriate, Laser Protection Advisers (LPA) in writing ensuring that they have been adequately trained and are in possession of a recognised Certificate of Competence to act as RPA/LPA in the appropriate fields.

4.2.4 Ensure that the RPA/LPA will be given sufficient resources to carry out their duties (see 4.7 & 4.8).

4.2.5 Ensure that the RPA/LPA will be given appropriate powers to inspect and perform tests that they consider appropriate.

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*4 - The Trust’s major incident plan.*
4.2.6 To ensure that the appropriate procedures are in place for informing the relevant authorities of any radiation incident occurring within the Trust (see 4.5.7).

4.2.7 Chair the Radiation Protection Committee (RPC) (or appoint a deputy to chair), at least annually,

4.2.8 To ensure that the RPA/LPA and the RPC have approved Local Rules, Employer’s Procedures and Systems of Work to fulfil the requirements of relevant legislation.

4.2.9 Appoint Radiation Protection Supervisors via the relevant Service Line Managers (SLMs) (see 4.5.4).

4.2.10 Ensure that sufficient resources are allocated to enable the implementation of the Radiation Protection Policy.

4.3 Trust Board

4.3.1 Ensure the Radiation Protection Policy is implemented throughout the trust notably within individual directors’ areas of remit, taking advice from the Executive Contact where necessary.

4.3.2 To facilitate the role of the Executive Contact through support at trust board level including allocation of appropriate resources.

4.4 Associate Directors

4.4.1 Ensure the Radiation Protection Policy is implemented within the Division.

4.4.2 Liaise with other Associate Directors to ensure such implementation across divisional boundaries.

4.5 Clinical Leads and Service Line Managers (SLMs)

4.5.1 Ensure the Radiation Protection Policy is implemented within the Department.

4.5.2 Liaise with other senior staff to ensure such implementation across departmental and divisional boundaries.

4.5.3 Where appropriate, Medical Physics Expert resource shall be provided as indicated by section 2.42 of the MDGN.

4.5.4 Where appropriate, appoint Radiation Protection Supervisors (RPS) and Laser Protection Supervisors (LPS) on behalf of the Trust, in writing, ensuring that they have been adequately trained to act as an RPS/LPS in the appropriate fields and that they have adequate resources at their disposal to fulfil their roles.

4.5.5 To establish an inventory of the relevant radiation sources (x-ray, radioactivity and laser) on behalf of the Trust.

4.5.6 To ensure that appropriate risk assessments are performed in relation to radiation hazards and in accordance with legislation and guidance (12.1).

4.5.7 Inform the appropriate enforcing authority following any major incident involving radiation, on behalf of the Executive Contact and in consultation with the RPA/LPA.

4.5.8 Ensure that any new radiation work, or significant modification to existing radiation work, is notified to the Executive Contact and the relevant RPA/LPA.

4.5.9 Ensure that the entire department’s radiation equipment is procured (in accordance with section 6.8), installed, critically examined, commissioned, maintained and assessed in terms of radiation dose and included in the equipment replacement program.
4.5.10 Ensure that the names of individual duty holders (ref. 4) are documented and explicitly identified with the justification and optimisation of all exposures to ionising radiation.

4.5.11 Ensure that a record of training of individual duty holders (ref. 4) is maintained.

4.5.12 SLM’s must inform the Estates Technical Manager of any new unusual or powerful light sources in their departments to enable compliance with reference 12.14. In terms of other non-ionising radiation and e/m fields (apart from lasers and optical sources), the responsibility for safety procedures lies with the relevant SLM in which the equipment resides; guidance can be sought from the RPC.

4.5.13 SLMs of departments that use services involving radiation or e/m fields are responsible for ensuring, as far as is practicable, that their staff follow the relevant safety procedures.

4.5.14 Ensure the implementation of relevant plans for external radiation incidents.

4.5.15 Ensure that non-trust staff who work in their department comply with this policy (see 4.15 below).

4.5.16 On behalf of the Radiation Protection Committee, and taking advice from RPA/MPE, ensure that this policy is appropriately reviewed.

4.6 **Head of the GHNFT Medical Physics Department** (in addition to the above).

4.6.1 Ensure the safe use of radioactive materials including secure and safe storage, appropriate methods of waste disposal and compliance with relevant regulations.

4.7 **Specialist Safety Adviser (SSA)**

4.7.1 The SSA is responsible for advising the Executive Contact, SLM’s and other staff on the radiation safety matters relevant to their area of expertise (as defined in table 1).

4.7.2 The SSA will provide appropriate advice following equipment safety and performance surveys.

4.7.3 The SSA will keep in good communication with the relevant local safety liaison.

4.7.4 The SSA will not be expected to advise staff and the general public on radiation protection matters directly but will provide relevant advice and support through duty holders identified within this document.

4.7.5 The SSA will take measures, through the attendance at conferences and seminars to ensure that his/her knowledge of radiation protection remains up-to-date. Funding will be provided for this activity.

4.8 **Radiation Protection Adviser (RPA).**

4.8.1 The RPA will advise on any appropriate action that should be taken following an audit of staff radiation doses.

4.8.2 The RPA is to be consulted for advice on how to comply with the Ionising Radiation Regulations 1999 (and any future legislation).

4.8.3 The RPA will advise on external contamination incidents including those that evoke the MAJAX plan.

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5 - For example, the SLM of a department whose clinicians request MRI scans has a responsibility to ensure that such clinicians complete safety questionnaires in regard of magnetic field hazards.
4.9 **Medical Physics Expert (MPE)**

4.9.1 The MPE will be available for consultation on

- all aspects of the justification and optimisation of medical exposures.
- dosimetry for patients, including dosimetry of individual patient radiotherapy exposures

4.9.2 Provide dosimetry data for standard operating protocols.

4.9.3 Provide advice on radiation equipment, particularly specification, selection, commissioning and suspension.

4.9.4 Calculate appropriate dose constraints for medical exposures in research where there is no direct health benefit anticipated for the individual to be exposed.

4.9.5 Provide appropriate dose estimates and their significance in cases of overexposure or unintended exposure.

4.10 **Local Safety Liaison**

4.10.1 The full duties of the RPS/LPS/MRPS are to be detailed in the relevant Local Rules.

4.10.2 Responsibility for proactive supervision of all relevant work in accordance with the local rules rests with the relevant RPS/LPS/MRPS.

4.10.3 The RPS/LPS/MRPS has the responsibility of informing BOTH their own manager(s) and the relevant SSA of any significant matter relating to radiation protection in their area.

4.10.4 The RPS/LPS/MRPS will ensure that local rules and systems of work pertinent to their area are fully implemented. The RPS/LPS/MRPS is responsible for ensuring all staff read and understand these rules and are informed of any changes in procedures.

4.10.5 The RPS/LPS/MRPS will report formally to the annual RPC on all aspect of radiation protection within their area of remit.

4.11 **Radiation Protection Supervisor**

The RPS is responsible for ensuring the monitoring of radiation exposure of all staff especially those who have declared pregnancy (see 6.4).

The RPS will report any radiation incident which may cause a higher than intended radiation dose, and may need notification to an external body, to their SLM and the RPA immediately.

4.12 **Appointed Doctor**

4.12.1 Review the status of any classified workers employed by the Trust as defined in the MDGN (12.1).

4.12.2 Provide relevant clinical input to the RPC, and RPA/LPA/RPS staff.

4.13 **Estates Technical Manager**

Maintain a database of artificial optical radiation sources to enable compliance with reference 12.9.

4.14 **Radiation Protection Committee**

4.14.1 The SLM (Radiology) will be responsible for organising the Committee meetings.

4.14.2 Will have an annual meeting, chaired by the Executive Contact that will be scheduled to report to the Health and Safety Committee.
4.14.3 Will meet on at least one other occasion per annum, chaired by the SLM (Radiology).

4.14.4 Will review implementation of this policy and will commission, review and monitor other policies and procedures to this end.

4.14.5 Will monitor overlap of this policy into other areas of policy and practice and vice-versa and will refer any areas of unsolved variance to the Trust Board.

4.14.6 Will receive annual reports from the relevant Radiation Protection and MRI Supervisors and act appropriately upon them.

4.14.7 Will oversee a regular review of plans for dealing with external contamination incidents including those that involve the MAJAX plan. This will involve necessary liaison with the Major Incident Planning Committee.

4.14.8 The committee will advise on the safe use of all radiation falling within the remit of this policy (see 2.1 and 2.2).

4.14.9 Where the work of relevant agencies other than this trust involves, or potentially involves, radiation hazards on trust premises, procedures must account for compliance with this policy by the external agency, which may be a local NHS organisation, private healthcare providers or contractors. The RPC will ensure there is an appropriate framework in this regard. Where necessary, a member of the external organisation may be co-opted on to the RPC.

4.14.10 The Committee will comprise of the Chairman, Managers of Departments where radiation is used (to include A&E in respect of external contamination incidents), relevant radiation advisors and supervisors, representatives from relevant divisions, and representatives from areas using non-ionising radiation or hazardous e/m fields. The Chairman may also co-opt other persons to this committee where relevant.

4.14.11 The Executive Contact, after taking expert advice, will make the final decision in any areas of dispute or will decide to take a matter to the Chief Executive for a final decision.

4.15 All Staff

4.15.1 Employees working in areas using ionising or non-ionising Radiations will exercise reasonable care.

4.15.2 Employees will read, understand and comply with the appropriate Local Rules, Employer’s Procedures and Systems of Work.

4.15.3 Employees will take precautions to ensure that they protect themselves and others whenever they are using radiation or involved in any process that uses radiation.

4.15.4 Employees must wear their supplied radiation dosimeters as instructed.

4.15.5 Where work by an employee involving exposure to ionising radiation is undertaken out with the Trust’s activities, the nature of the work must be communicated to the appropriate RPS and the dosimeters issued by the Trust must be worn in carrying out this work.

4.15.6 Due regard will be given to advice given by RPS or LPS staff.

4.15.7 Employees will promptly undertake training deemed relevant.

4.15.8 The employee will report to their relevant RPS or manager as soon as possible a) suspected cases of higher than intended radiation exposure, b) - An example would be ensuring the compliance of external service engineers working on trust medical equipment.

7. An example is a radiologist performing procedures at a private hospital.
defects in protective equipment or dosimeters or c) any other matter that involves, or potentially involves (a 'near miss') increased radiation hazard.

4.15.9 Staff, including staff who do not work for the Trust, responsible for requesting procedures using radiation or e/m fields must ensure that the procedure is used in the management of the patient’s condition, that this use is appropriately documented and that the request complies with supplied referral guidelines. They should also diligently provide relevant clinical and safety data in regard of such a request.

5. Definitions

Ionising Radiation
X-rays, electrons, gamma rays, alpha and beta particles.

6. Main Body of the policy

6.1 Design of Departments
6.1.1 All departments envisaging the use of radiation for the first time or considering changes to the structure of the existing areas will communicate with the Radiation Protection Advisers prior to any work commencing.
6.1.2 The relevant Radiation Protection Adviser (RPA) will be involved in the design and development of all new facilities or in major modifications to existing areas to ensure compliance with current and proposed legislation.

6.2 Risk assessment
6.2.1 It is the responsibility of each SLM to ensure that risk assessments are carried out for all work with ionising radiation in their division/department.
6.2.2 These should cover both routine work and any potential accident scenarios. Advice should be obtained from the appropriate Radiation Protection Adviser (RPA) regarding the form and content of these risk assessments, and they should be reviewed at intervals of not less than two years, or whenever there is a significant change in equipment or workload.
6.2.3 The findings of the risk assessments must be incorporated into the local rules for each relevant area, and should be used to assess the requirements for monitoring of staff and the environment, along with any additional control measures that are required to restrict exposure to ionising radiation.

6.3 Local Rules and Systems of Work
6.3.1 Local Rules are a requirement for ionising radiation and lasers but may also be considered for other radiation hazards.
6.3.2 Local Rules will be maintained in all relevant areas (as defined by, or via, legislation e.g. MDGN).
6.3.3 These rules will be reviewed annually by the Radiation Protection Committee in conjunction with the RPA/LPA and departmental RPS/LPSs.
6.3.4 Local Rules will be modified if the introduction of new procedures involves significant changes to the use of radiation. It is the responsibility of the relevant departmental manager, radiation protection supervisors and laser protection supervisors to inform the RPA / LPA of any such changes so that advice can be obtained.
6.3.5 The RPS/LPS is responsible for ensuring that all staff read the Local Rules and are made aware of any changes to the Local Rules.

6.3.6 Incidents where any person (staff, the general public, patients, contractors or others) are involved in which greater than intended exposure occurs will be reported through the Trust internal incident reporting system to the Executive Contact. RPS/LPS and RPA/LPA will then take further action.

6.3.7 Any contravention of the Local Rules will be reported to the RPA/LPA who will investigate and advise on the occurrence. This may also be brought to the attention of the Radiation Protection Committee or senior managers and could result in disciplinary action.

6.3.8 Systems of Work must be appropriately maintained in areas using non-ionising radiation (other than lasers) or high e/m fields and are the responsibility of the relevant ADM; advice can be sought from the RPC.

6.4 **Staff Doses**

6.4.1 The Trust will ensure that ionising radiation doses received by staff are kept as low as reasonably practicable. This will be audited via the use of personal radiation monitors and/or environmental monitoring.

6.4.2 An HSE approved Dosimetry service will be used to provide radiation monitoring.

6.4.3 **Classified Radiation Workers (CRWs).** CRWs are persons who exceed a significant, legally defined, fraction of an annual dose limit and thus are deemed at significant risk of exceeding such a dose limit.

6.4.4 The Trust will endeavour not to have any CRW but will classify workers if necessary. The trust will ensure that procedures are in place to minimise the number classified workers. Following classification of workers the trust will ensure that measures are put in place to ensure Radiation doses are kept to a minimum.

6.4.5 The advice of the RPA should be sought by the relevant RPS if the dose record of any member of staff suggests that CRW status is possible, and appropriate action should be taken based on this advice by the relevant SLM to ensure compliance with point 6.3.4.

6.4.6 All radiation doses to staff will be checked by the RPS immediately on receipt of the dose result returns. Any doses above the investigation level should be notified to the relevant SLM and the RPA who will advise on any further action to be taken. Doses considered by the RPA to be significantly above the investigation level should be entered on the Trust Incident Reporting System (in addition to any measures outlined by the RPA).

6.5 **Special Groups**

Certain groups of people are more sensitive to the harmful effects of radiation than the general population and consideration of these groups must be an integral part of systems of work. The following points refer specifically to ionising radiation but relevant consideration must be given to any group at significantly higher risk that the general population from any form of radiation used in the trust.
6.5.1 Foetal doses must be considered and efforts must be made to establish the pregnancy status of females of child-bearing capacity who may be exposed to ionising radiation (patients, staff or any other group).

6.5.2 Exposure to ionising radiation will be monitored and restricted if necessary for pregnant staff to ensure that the foetus does not receive a dose which exceeds the general public limit (1 mSv). The immediate manager must be informed as soon as pregnancy is confirmed so that the necessary constraints to dose limits may be applied.

6.5.3 Radionuclides can be passed to a baby via breast milk therefore systems of work need to be formulated in regard of nuclear medicine procedures on breast-feeding females.

6.5.4 Risks from ionising radiation are increased in inverse proportion to age so special consideration must be given to exposure in children.

6.6 Doses to Patients and Volunteers

This section refers to doses from ionising radiation only

6.6.1 All clinical examinations will be formally justified and only those which are essential to the health of the patient will be performed and then only if there are no alternative lower dose techniques suitable.

6.6.2 Examinations carried out solely as part of research programs that lead to a radiation dose to the patient or volunteer will be strictly controlled according to agreed standards (12.1) including consent, dose limitation and the involvement of ethics committees.

6.6.3 All doses will be kept as low as reasonably practicable whilst ensuring maximum diagnostic accuracy/therapeutic benefit.

6.6.4 By following a purchasing policy the Trust will ensure that all equipment installed will meet the low dose requirement.

6.6.5 Appropriate patient dosimetry will be performed at regular intervals.

6.6.6 Equipment involved in the use of ionising radiation will be subject to an ongoing programme of quality assurance.

6.6.8 For a range of common diagnostic exposures the employer shall determine a dose reference level, which shall, under normal exposure conditions, and for an average size patient not be exceeded. Where the dose reference level is exceeded on a regular basis the employer shall carry out an investigation to establish the reason for this adverse occurrence and remedial action taken.

6.7 Quality assurance

6.7.1 Quality assurance tests will be performed as laid down by relevant legislation (e.g. 12.3), authoritative good practice guides (e.g. 12.4) or following advice from the RPC.

6.7.2 Responsibilities for such tests must be clearly defined by SLMs.

6.7.3 A check on the radiation performance on all items of X-ray equipment at an appropriate frequency (as advised by the relevant MPE) will be carried out on behalf of the Trust Board and is the responsibility of the SLM of the department owning the equipment.
6.8 Radiation Equipment

6.8.1 Radiation equipment is defined as that which emits radiation falling within the remit of this policy, or any apparatus that may affect a) the function of such equipment, or b) the amount of radiation given to a patient, e.g. calibration or measurement equipment. Such equipment will be selected with radiation protection, and in particular the aims of this policy, as fundamental requirements.

6.8.2 The RPC, via the Executive Contact, shall be informed of the intention to purchase any radiation equipment by the relevant SLM. The RPC may veto the purchase of such equipment.

6.8.3 An equipment replacement programme will be updated annually by SLM and reviewed by the executive contact and shall be resourced to enable the aims of this policy.

6.8.4 The RPA/LPA and relevant MPEs will be consulted regarding the selection and purchase of all new radiation equipment.

6.8.5 Independent (of the manufacturer) acceptance tests on all new equipment will be performed prior to first use on a patient. The RPA may where requested and under contract by the manufacturer, carry out the critical examination on new equipment on the manufacturers behalf.

6.8.6 All instruments used in assessing radiation doses will be calibrated annually by an approved service.

7 Staff Training

7.1 All staff involved with the use of ionising and non-ionising radiations will be adequately trained before they can perform the intended role. This applies to staff requesting, performing, reporting or using the results of procedures.

7.2 Relevant staff will be appropriately trained where their role involves interaction with new equipment. This should include staff that come into contact with the equipment but do not use it; for example domestic staff.

7.3 Staff will be retrained periodically to ensure that they are fully up-to-date in regard of current practices. This will be performed locally or by attendance at external courses run by recognised organisations and/or the RPA/LPA/RPS/LPS.

7.4 Radiation Protection Supervisors will receive training from a recognised organisation and/or the RPA prior to assuming their roles. They will be retrained at intervals not exceeding five years to ensure that they are fully aware of current legislation and practice.

8 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

For example pregnant staff and patients will be provided with protection through implementation of the policy.

This policy has had an equality analysis undertaken.
9 Monitoring compliance with the policy

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Compliance with this policy will be monitored by the Radiation Protection Committee and annual reports made to the Trust Health and Safety Committee and hence to the Governance Committee and Trust Board.

Periodic external inspections by Health and Safety Executive, Environmental Agency, Department of Transport and Care Quality Commission will also monitor compliance.

When an area of non-compliances is identified, an action plan will be agreed between the relevant managers and clinical leads with advice from an appropriate Radiation Protection Adviser. The Radiation Protection Committee will subsequently review the actions taken to manage the risk as set out in the plan.

10 Consultation and review

The policy has been reviewed with comments being sought from members of the Radiation Protection Committee.

11 Implementation of the policy (including raising awareness)

This policy will be implemented in accordance with policy OP27 “Policy for the development, management and authorisation of policies and procedures”

12 References

1) A good practice guide on all aspects of ionising radiation in the clinical environment. IPEM 2002 (Medical and Dental Guidance Notes, MDGN).
7) Principles for the Protection of Patients and Volunteers During Clinical Magnetic Resonance Diagnostic Procedures. NRPB 1991
9) The Control of Artificial Optical Radiation at Work Regulations 2010.

Previously there have been no specific legal provisions covering non-ionising radiation and control of exposure was governed by the general provisions of the Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999. This has now changed and non-ionising radiation is now under the Control of electromagnetic fields at work regulations 2016

13 Associated documentation (policies)

RM02 Health and Safety Policy
RM08 COSHH Policy
RM11 Security Policy
RM13 Provision and Use of Work Equipment Policy
RM17 Personal Protective Equipment at Work
RM18 Electrical Equipment Protocol
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<td>via duty holders</td>
<td>via duty holders</td>
</tr>
<tr>
<td>On-going training</td>
<td>via CPD funding provided</td>
<td>via CPD funding provided</td>
<td>via CPD funding provided</td>
<td>via CPD funding provided</td>
</tr>
<tr>
<td>Specific areas of advice</td>
<td>Risk assessment, control measures, PPE, monitoring, audit, design of new or altered facilities, External contamination incidents (MAJAX)</td>
<td>Risk assessment, control measures, PPE, audit, procurement and testing of new or altered equipment or facilities</td>
<td>Risk assessment, control measures, PPE, audit, procurement and testing of new or altered equipment or facilities</td>
<td>Introduction of new clinical techniques, justification, optimisation, patient dosimetry (incl. dose constraints for research work), procurement and testing of new or altered equipment</td>
</tr>
</tbody>
</table>

Table 1 Summary of responsibilities, duties, legislation and guidance regarding specialist safety advisers