

Announced Inspection Report: Ionising Radiation (Medical Exposure) Regulations 2017

Service: Beatson West of Scotland Cancer Centre,
Glasgow

Service Provider: NHS Greater Glasgow and Clyde

21 – 22 January 2025

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1 A summary of our inspection

Background

Healthcare Improvement Scotland has a statutory responsibility to provide public assurance about the quality and safety of healthcare through its inspection activity.

The quality assurance system and the quality assurance framework allows us to provide external assurance of the quality of healthcare provided in Scotland. We have aligned the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 to the framework.

Our focus

The focus of our inspections is to ensure each service is implementing IR(ME)R 2017. Therefore, we only evaluate the service against quality indicators that align to the regulations. We want to find out how the service complies with its legal obligations under IR(ME)R 2017 and how the services are led, managed and delivered.

About our inspection

We carried out an announced inspection to NHS Greater Glasgow and Clyde Beatson radiotherapy services on Tuesday 21 and Wednesday 22 January 2025. We spoke with several staff, including the head of therapy radiography, general manager, department of clinical physics, scientific director Department of Clinical Physics and Bioengineering, head of radiotherapy physics, clinical director (consultant oncologist) clinical leads, quality manger, treatment lead radiographer and the chief of medicine.

The radiotherapy service has 13 external beam linear accelerators which is the second largest department in the UK. They treated 6500 patients in 2023/24 delivering 97,000 fractions. There are also two high dose rate, and one low dose rate brachytherapy services provided on the site.

The inspection team was made up of three inspectors.

What action we expect NHS Greater Glasgow and Clyde to take after our inspection

The actions that Healthcare Improvement Scotland expects NHS Greater Glasgow and Clyde to take are called requirements and recommendations.

- **Requirement:** A requirement is a statement which sets out what is required of a service to comply with the Regulations. Requirements are enforceable at the discretion of Healthcare Improvement Scotland.
- **Recommendation:** A recommendation is a statement that sets out actions the service should take to improve or develop the quality of the service but where failure to do so will not directly result in enforcement.

This inspection resulted in one requirement and two recommendations. Requirements are linked to compliance with IR(ME)R 2017.

Direction	
Requirements	
	No requirements.
Recommendations	
	No recommendations.

Implementation and delivery	
Requirements	
	No requirements.
Recommendations	
a	NHS Greater Glasgow and Clyde should continually monitor the medical physics expert workforce resources and consider the potential impact on the service provision and mitigate any risks to the service provision that are identified. (see page 16)

Results	
Requirements	
1	NHS Glasgow must undertake a study of risk in respect to all radiotherapeutic practices including accidental or unintended exposures, proportionate to the radiological risk. (Reg8(2)). (see page 19)
Recommendations	
b	NHS Greater Glasgow and Clyde should implement a procedure to undertake a pregnancy enquiry immediately before the initial treatment exposure. (see page 20)

An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website.

<https://www.healthcareimprovementscotland.scot/inspections-reviews-and-regulation/ionising-radiation-medical-exposure-regulations-irmer/>

NHS Greater Glasgow and Clyde must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at the Beatson West of Scotland Cancer Centre for their assistance during the inspection.

2 What we found during our inspection

Direction

This is where we report on how clear the service's vision and purpose are and how supportive its leadership and culture is.

Domain 1: Clear vision and purpose	Domain 2: Leadership and culture
Key questions we ask: <i>How clear is the service's vision and purpose?</i> <i>How supportive is the culture and leadership of the service?</i>	

Our findings

Staff demonstrated a strong understanding and implementation of IR(ME)R in the planning and delivery of external beam radiotherapy and brachytherapy. This included a positive culture and safety values.

Safety culture

A radiation safety culture can help to strengthen safety in the use of radiation technology, preventing injuries and reducing unnecessary or unintended radiation dose to patients. Radiotherapy staff told us about the supportive and positive culture for reporting and learning from incidents. They also told us of the collaborative learning environment. We were told that the culture within the department is one of openness and transparency, and that all staff are encouraged to speak up. Staff confirmed they can challenge information and there is a positive radiation safety culture. Oncologists undertake peer reviews as part of the care pathways which supports quality and safety.

The safety culture was also demonstrated through the measures in place to ensure the appropriate entitlement and scope of practice, employer's procedures, optimisation practices, quality assurance systems, as well as the audit and governance arrangements in place.

The radiotherapy department is certified against BS EN ISO 9001 quality standard for radiotherapy services. The certification was undertaken by an external assessor from the British Standards Institution (BSI). This certification supports a quality management system which is a framework for an organisation to control its processes and to meet its statutory and regulatory requirements applicable to the radiotherapy service.

There are clear lines of accountability in place from the radiotherapy department to the NHS GGC Board structures. The IR(ME)R policy lead is the diagnostics chief of medicine and chairs the radiation safety committee. The policy lead escalates any concerns within the NHS Board.

Implementation and delivery

This is where we report on how well the service engages its stakeholders and also how it manages and improves performance.

Domain 3: Co-design, co-production	Domain 4: Quality improvement	Domain 5: Planning for quality
Key questions we ask: <i>How well does the service engage its stakeholders?</i> <i>How well does the service manage and improve performance?</i>		

Our findings

NHS GGC has a comprehensive set of employer's procedures and protocols in place with evidence of implementation. There are clear systems, process and quality assurance throughout the patient pathway.

Employer's procedures

NHS GGC objectives for external beam radiotherapy define the key purpose and outcomes of the care pathway for a patient which includes referral, booking patients, pre-treatment, treatment planning, prescriptions, treatment and post treatment.

We saw a defined structure for the development and updating of the employer's procedures. NHS GGC have a comprehensive set of employer's procedures (EPs) and supporting documentation that provides specific work instructions on radiotherapy techniques, including, local rules and clinical protocols. The radiotherapy department's ISO 9001 system provides the document control framework for the radiotherapy departments employer's procedures and quality-controlled documents. All the employer's procedures and supporting documents we reviewed were clear, up to date and cross-referenced as required. The employer's procedures are available to staff on the internal electronic document management system. A quality manager has responsibility for the quality management system and ensuring that the quality-controlled documents are up to date and reviewed as required. There is a multi-disciplinary approach for the development and review of quality controlled documents including employers procedures. Changes to the employer's procedures are communicated to staff at meetings and by email.

The IRMER working party has the primary responsibility for the operational aspects of IR(M)ER implementation which is linked into the Beatson West of

Scotland Cancer Centre quality management system which is managed by the quality manager. The radiotherapy management group provides oversight and links into the Beatson West of Scotland Cancer Centre clinical governance and radiation safety group. Collectively, ensuring the implementation of IR(ME)R related policies, procedures and the collation and review of audits and incidents. They provide departmental oversight and assurance for the implementation of IR(ME)R.

The radiotherapy department also undertakes an audit of employer's procedure compliance to demonstrate regulatory compliance and identify areas of improvement.

Training

There is a clear system for the delivery of training, development and assessment of competencies for staff working in external beam and brachytherapy services. Training and entitlement records define the competency description, described as tasks, and how it is assessed and evaluated. Training records are stored on the electronic quality management system. The staff training, qualifications and knowledge are linked to their entitlement and scope of practice.

Consultant oncologist staff training and competence is a part of staff's annual appraisal, in job plans and continual professional development. Oncology staff confirmed they have access to ongoing professional development to maintain their skills. In addition, all medical staff undertake medical revalidation every 5 years. There is a clear progression pathway for specialist registrars for their training and development. Specialist registrars training includes tumour site specific assessments, planning, dosimetry and brachytherapy.

There are clear processes for the training of therapeutic radiography and medical physics staff. The department has workbooks that define staff competencies that require to be achieved for different tasks. For example, medical physics staff have a training plan for each task and an assessment of competency. The tasks are linked to an individual's scope of practice. Competency assessors for medical physics and therapeutic radiography staff ensure that staff members achieve the necessary skills and knowledge for their role as detailed in the workbook. Once they are deemed competent, the assessor will sign the staff member off as competent. This is to inform the entitlement process. For example, dosimetry staff, records included planning sites and techniques.

Staff training is recorded in matrix documents that details the level of training for different tasks for all staff. The document demonstrates which staff are

trained, trained to supervise and trained to be an assessor. The staff training records that we viewed were up to date. Training records are available for various techniques and tumour sites for radiography staff. All staff are aware of where to find their training records and their scope based on their training level.

Entitlement

NHS GGC have a robust process for the entitlement of staff to undertake the role of a referrer, practitioner and operator. There are clear lines of accountability of who can entitle staff to act as a referrer, practitioner or operator. The entitlement and scope of practice is linked to the competencies of the staff member as demonstrated by their qualifications and role, training and experience.

Consultant oncologists are entitled to refer for all radiotherapy procedures. Referrals can be for palliative treatments or radical treatment, with radical referrals being applicable to site specific tumour sites. The oncology registrars are entitled for palliative treatments and require sign off for radical treatments. Therapeutic radiographers are entitled, depending on their training, to act as operators and for the treatment of site-specific tumours. NHS GGC have three consultant therapeutic radiographers. A competency framework has been developed, and we were told it aligns to the Society of Radiographers' education and career framework. All staff are issued with their scope of entitlement and are clear on their personal scope of practice.

The quality manager updates the electronic records of staff entitlement and scope of practice. NHS GGC lists of all staff entitlements, which include specific techniques within their scope of practice, are held within the oncology management system. These are linked to the oncology management system. An individual scope of practice is used to determine access to different aspects of the oncology management system.

NHS GGC have the appropriate employers and practitioners' Administration of Radioactive Substances Advisory Committee (ARSAC) licenses. Procedures are in place to ensure practitioner licenses are up to date and aligned to the employer's site licence. In addition, all ARSAC licenses were available, and every brachytherapy procedure is linked to an ARSAC licence.

There is a review of entitlements as required. There are records that detail the entitlement and scope of practices of all staff groups.

Referral

The Beatson West of Scotland Cancer Centre covers patients from the west of Scotland and also other health board areas. Patients are seen by an NHS GGC oncologist consultant at a clinic at which time the consultant will complete a booking form to start the referral process. Consultant oncologists refer for radical and palliative patients and some brachytherapy treatments. The oncologists confirmed they have access to all the relevant clinical information when considering a patient for referral for treatment. The referral at this stage is a paper referral that is transposed into the oncology management system. The referral form includes a notes box for the inclusion of additional requirements such as specific imaging, inclusion of a bolus or wire. The electronic referral system has mandatory fields that require to be completed to ensure the correct key information is provided. Oncology specialist registrars and consultant therapeutic radiographers also refer within their scope of entitlement. NHS GGC have a defined referral criteria for different tumour sites. NHS GGC are currently in the process of replacing the initial paper form with an electronic form.

Justification

NHS GGC have comprehensive justification criteria and clinical protocols in place, which are regularly reviewed and updated. As part of the justification process, consideration is given to the risks and benefits for the patients. As part of the justification and authorisation process the consultant oncologist reviews the patients' clinical history, clinical information and any previous imaging. The justification confirms the prescription and the clinical protocol to be used.

The clinical protocols used at NHS GGC have been agreed by the consultant oncologist and ensure a consistent approach to patient treatment. Oncologists who are the leads for site-specific tumours develop protocols for their area of expertise. Clinical protocols will detail the dose tolerance of the organs at risk and the desired dose to the tumour. We were told how the protocols are evidence based and referenced, for example against guidance from the Royal College of Radiologists (oncology) and medical publications. Where the referral is out with protocol, a second consultant must also sign off the out of protocol to support referral and justification.

A justification includes verification imaging removing the need to justify every image as part of the patient's treatment pathway.

Should the patient's treatment need to be replanned at any point, this requires a new justification.

All brachytherapy justifications are undertaken by the ARSAC license holders and treatments are linked to the ARSAC guidance notes.

Optimisation

All patient treatments are individually planned in terms of the expected radiation dose. Treatment plans take into consideration the anatomical position of the site of exposure and nearby organs at risk, previous exposures and the treatment intent.

Optimisation seeks to reduce the dose to as low as reasonably practicable to the surrounding normal tissue and organs at risk while the target volume dose is optimised to be as close as possible to the prescribed dose. The consultant oncologist contours the gross target volume (GTV) for all tumour sites to identify the delivery site of the desired dose of radiotherapy. The GTV is expanded to form the clinical and planning target volumes by the oncologist for each individual patient.

Oncologists select from pre-agreed treatment pathways and clinical protocols. They will also review the patient notes and assess if any further dose restrictions are required based on previous treatment history. They can also use the text box for anything that is not included in the standard planning criteria.

The treatment planning staff develop a delivery plan based on the information supplied by the oncologist and information in the clinical protocol. We were told that 90% of plans are volumetric modulated arc radiotherapy with the remaining 10% being image modulated radiotherapy. Each plan is individually developed based on the location of the disease, clinical protocols and agreed tolerance limits (ionising radiation) for the organs at risk (OAR). Dosimetry staff will develop a plan that delivers the desired outcome and will try to reduce the dose to the OAR as far as reasonably practicable. Where the dose limit for an OAR cannot be achieved, the results are discussed with the consultant oncologist and for any alterations to be agreed and approved. The oncologist is the responsible person for the patient treatment plan. They review and confirm patients' treatment plans as prepared by the dosimetry staff to ensure this meets the treatment intent.

Further measures in place to ensure that medical exposures are kept as low as reasonably practicable include:

- operator training which includes applications training
- routine equipment maintenance
- daily quality assurance, and

- dosimetry reviews.

Operator

Therapeutic radiographers carry out the practical aspects relating to external beam radiotherapy to the patients. Every patient has a checklist on the oncology management system that the radiographers review before they speak with the patient. The checklist includes information on fraction numbers, patient positioning, patient immobilisation devices and the shift details. They also check the selection of the correct treatment plan and clinical protocols. Staff described how they undertake kilovoltage x-ray imaging as part of the patient set and cone beam CT to ensure the machine isocentre has been matched to the tumour and it's anatomical position. We were told that sometimes the matching process must be repeated, for example after emptying the bladder.

Online and offline matching is undertaken as part of the quality control process to ensure the patient is correctly positioned. A record of who undertook the checks is recorded in the oncology management system. Online matching is undertaken by two therapeutic radiographers.

Clinical evaluation

All treatment plans are evaluated by a consultant oncologist.

It is routine practice for the oncologists to write a letter to the patient's general practitioner at the conclusion of treatment.

Records

NHS GGC have an electronic care pathway for each patient. It details the requirements at every stage of a patient's journey. It includes a checklist to be completed before the system moves onto the next stage of the patient's journey. The checklist confirms the clinical protocol being used, the relevant log sheets have been uploaded and approved within encounters, as well as confirmation of immobilisation.

We reviewed the information recorded on the referral system and oncology management system and noted staff have documented the following:

- details of the referrer, practitioner and operator
- correct patient information and pregnancy capacity
- justification and authorisation
- check lists throughout the care pathway
- peer review
- clinical protocol

- treatment plan and delivery
- identification checks
- scanned documents, such as pregnancy check questionnaires
- patient immobilisation, and
- dose monitoring.

Staff described how they undertake kilovoltage x-ray planar imaging or cone-beam CT as part of the patient set up to ensure the treatment isocentre is in the appropriate position.

Patient identification

All staff that we spoke with clearly described how they carry out identity checks and were familiar with the relevant employer's procedures. They told us they ask the patient their name, date of birth and one further identification check before any exposures. Interpreter services are available when required.

Patients' details are available to staff in the treatment room. All inpatients must also have a wristband in place. An exposure does not proceed if there are any concerns about the patient's identification.

What needs to improve

For the majority of patients undergoing treatment photographs are taken and uploaded at the first visit, this is usually the planning CT visit, however this is often taken during the first fraction visit and is currently only displayed at the workstation within the radiotherapy department. It was discussed during the inspection that based on the learning from a recent notification it would be beneficial if the picture could also be displayed on the monitor in the treatment room with the patient details.

Expert advice

NHS GGC's medical physics team support external beam radiotherapy and brachytherapy. The medical physics expert role provides support with:

- commissioning of new equipment
- acceptance testing of new equipment
- establishing baselines for quality assurance
- calibration of equipment
- quality assurance records
- optimisation
- dose reference levels (CT planning images)
- analysis of incidents, and
- dosimetry.

Documentation is in place to demonstrate that the above activities are undertaken by the medical physics team. The medical physics expert provide advice on whether any incidents are required to be reported to Healthcare Improvement Scotland.

What needs to improve

Employers are required to appoint medical physics staff to undertake the required level of service provision. The level of involvement is commensurate with the hazard and risk associated with each type of practice. A medical physics expert must be closely involved in every radiotherapeutic practice other than standardised therapeutic nuclear medicine practices. During the inspection it was identified that current provision of medical physics staff can be below the agreed staffing levels. When this occurs, it was acknowledged that it can have a detrimental effect on the ability of the medical physics staff to support commissioning, quality assurance and responding to incidents. During commissioning of a piece of external beam radiotherapy equipment a temporary additional medical physics expert had to be recruited to support the current team. (recommendation a)

Recommendation a

- NHS Greater Glasgow and Clyde should continually monitor the medical physics expert workforce resources and consider the potential impact on the service provision and mitigate any risks to the service provision that are identified.

General duties in relation to equipment

A planned system of quality assurance is in place to maintain equipment and there are parameters and mechanisms that respond to faults. Employer's procedures outline the management of equipment quality assurance, dosimetry and fault rectification. Daily, weekly and monthly checks are in place. Planned preventative maintenance is arranged a year in advance. As these tests require the equipment to be out of use for an extended time, the testing is also recorded on the oncology management system, this is to prevent any disruptions to patient treatment.

As part of the commissioning process of any piece of equipment, the medical physics staff develop the quality assurance requirements. Quality assurance is benchmarked against published guidance such as IPEM reports and manufacturer's guidance to ensure it meets acceptable performance criteria.

The radiotherapy department maintains an equipment register. The quality assurance requirements cover all equipment on the register that can deliver ionising radiation to a person or directly control or influence the extent of the exposure.

Quality assurance is undertaken of the external beam radiotherapy equipment by medical physics staff at the beginning of each day and before any patient treatments. The medical physics team have the necessary test equipment to undertake the quality assurance checks, and this equipment had been calibrated. The medical physics team communicated that the quality control had been undertaken successfully using a signage system. The medical physics team must indicate that the equipment is safe before staff use it. All staff confirmed that this system of communication is clearly understood and works well. It was highlighted that medical physics staff also undertake dosimetric quality control checks on a sample of VMAT and IMRT plans as an additional assurance on the operation of the external beam radiotherapy equipment. In brachytherapy the clinical technicians undertake the daily quality assurance.

All staff who conduct quality assurance have been trained and records in place reflect this. A quality control log is used to support the implementation of quality assurance for each piece of equipment. This details the list of equipment and frequency of quality assurance. We observed quality assurance procedures being undertaken and the recording of the results. When results are outside the expected parameters, remedial action is taken. If a piece of equipment did not pass the quality assurance checks, it is taken out of use until faults are rectified.

The scientific lead for equipment and dosimetry is responsible for ensuring that testing is undertaken in accordance with this sampling frequency.

What needs to improve

Some quality assurance results are currently recorded on paper. The results are then copied into a MS Excel spreadsheet. The medical physics team are considering how to update this process and move to electronic recording. This will lead to better support the evaluation of trend analysis e.g. for faults for preventative measures.

Clinical audit

Clinical audit is a quality improvement process that is central to patient care and involves the review of the delivery of healthcare to ensure that best practice is being carried out. It was confirmed that clinical audits are conducted, and examples of audits were discussed during the visit.

Peer review

The Royal College of Radiologists encourages regular peer review meetings to review planned target volumes and supports peer reviews that are undertaken on an on-demand basis of patient treatment. NHS GGC oncologists carry out peer reviews on a high percentage of complex plans. There is a dedicated stage in all radical care pathways to undertake the review prior to planning patient treatment. The peer reviews are completed by at least three consultants. Any changes agreed at the peer review are recorded. The head and neck treatment plans seen during the inspection had clear detailed information on who was involved and the resultant outcome of the meeting.

What needs to improve

It was acknowledged that the level of detail recorded in the peer reviews is not consistent.

Accidental or unintended exposure

Every radiation incident is investigated and an assessment of the radiation dose made. The radiotherapy department employer's procedure details the process for the management of radiotherapy errors. Staff are clear on the roles and responsibilities of those involved in an investigation, how to carry out an investigation and the reporting mechanisms. When an incident is identified, local protocols for recording and reporting any near misses or incidents are implemented. The MPE team completes a report on any incident which has the potential to meet SAUE criteria for reportability. Staff we spoke with fully understood the criteria for reporting significant accidental or unintended exposures to Healthcare Improvement Scotland. We saw evidence that NHS GGC records near misses and incidents. Clinicians lead on any discussions with the patient if required.

Incidents are discussed at the multidisciplinary meeting monthly meetings. At the meetings there is a review of the outcomes from investigations and incidents and if required recommendations for improvements can be made at the meeting, such as a change of a form, process or shared learning.

All staff we spoke with described the positive culture around the reporting of near misses and incidents. We were told that learning from near misses and incidents is shared to help prevent incidents in the future through emails and team meetings.

Staff awareness sessions have been introduced to share learning from incidents and take place every three months.

Results

This is where we report on what difference the service has made and what it has learned.

Domain 6: Relationships	Domain 7: Quality Control
Key questions we ask: <i>What difference has the service made?</i> <i>What has the service learned?</i>	

Our findings

Clear procedures for the management of risks and communication of risk and benefits with patients are in place.

Study of Risk of Accidental or Unintended Exposures

NHS GGC have implemented employers' procedures and standard operating procedures which control the radiation risk to patients. The study should detail the risks, control measures, likelihood and the potential impact on the patient. Study of risk documents were presented during the inspection, however the study of risk has not been fully implemented.

What needs to improve

NHS GGC has not completed the study of risk for all areas of radiotherapy services. (requirement 1)

Requirement 1

- NHS Glasgow must undertake a study of risk in respect to all radiotherapeutic practices including accidental or unintended exposures, proportionate to the radiological risk. (Reg8(2)).

Risk benefit conversations

The oncologist discusses the patient's treatment plan with each patient. We found that the benefits and risks of having an exposure to ionising radiation are discussed as part of the consent process. NHS GGC use the Royal College of Radiologists consent forms that are developed to support these conversations. The cancer site-specific forms include details of the radiotherapy, short- and long-term side effects and confirm if patient information leaflets have been provided. Patients sign the form to confirm the conversation and that they understood the risks. Examples of the patient consent forms were found to be in place.

Making enquiries of individuals who could be pregnant

NHS GGC procedures detail the responsibilities of the referrer, practitioner and operators in establishing and communicating pregnancy status. All staff we spoke with were familiar with the procedure and how it is implemented in their department.

NHS GGC use the Royal College of Radiologists consent form which includes a question confirming that there was no risk that the patient was pregnant and confirmation that the patient was aware they should not become pregnant during treatment. Patients are again asked to confirm their pregnancy status before the initial planning exposure. The patient signs the form to confirm the conversation prior to the planning images being taken. A copy of the form is scanned into the oncology management system and the patient retains the original copy.

What needs to improve

The pregnancy status questions should be asked prior to the initial treatment exposure. (recommendation b)

Recommendation b

- NHS Greater Glasgow and Clyde should implement a procedure to undertake a pregnancy enquiry immediately before the initial treatment exposure.

Carers and comforters procedures

NHS GGC have a strict policy on carers and comforters. Only the patient can remain in the room during imaging or treatment exposure.

Appendix 1 – About our inspections

Our approach

Healthcare Improvement Scotland has a statutory responsibility to provide public assurance about the quality and safety of healthcare through its inspection activity.

The quality assurance system and the quality assurance framework together allows us to provide external assurance of the quality of healthcare provided in Scotland.

- **The quality assurance system** brings a consistency to our quality assurance activity by basing all of our inspections and reviews on a set of fundamental principles and a common quality assurance framework.
- **Our quality assurance framework** has been aligned to the Scottish Government's *Health and Social Care Standards: My support, my life* (June 2017). These standards apply to the NHS, as well as independent services registered with Healthcare Improvement Scotland. They set out what anyone should expect when using health, social care or social work services.

We have aligned the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 to the quality assurance framework.

Further information about the framework can also be found on our website at: <https://www.healthcareimprovementscotland.scot/>

How we inspect services that use ionising radiation for medical exposure

The focus of our inspections is to ensure each service is implementing IR(ME)R 2017. Therefore, we only evaluate the service against quality indicators that align to the regulations.

What we look at

We want to find out:

- how the service complies with its legal obligations under IR(ME)R 2017 and addresses the radiation protection of persons undergoing medical exposures, and
- how well services are led, managed and delivered.

After our inspections, we publish a report on how well a service is complying with IR(ME)R and its performance against the Healthcare Improvement Scotland quality assurance framework.

Complaints

If you would like to raise a concern or complaint about an IR(ME)R service, you can directly contact us at any time. However, we do suggest you contact the service directly in the first instance.

Our contact details are: his.irmer@nhs.scot

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