Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

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

Service: North East Scotland Breast Screening Centre, Aberdeen Royal Infirmary

Service Provider: NHS Grampian

23 – 24 July 2025

NHS SCOTLAND

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Background

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

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 with 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 at NHS Grampian, North East Breast Screening Centre (NEBSC) on Wednesday 23 and Thursday 24 July 2025. We spoke with several staff, including clinical director, consultant radiologists, QA lead radiologist, medical physics experts (MPEs), superintendent radiographers, QA lead radiographer, breast services manager, radiographers, advance practice radiographer and assistant practitioners (APs). We spoke to staff in both mobile and static units. This was our first inspection of this service.

Based in Aberdeen at Aberdeen Royal Infirmary, the NEBSC provides breast screening imaging and assessment clinic services to those in Grampian, Shetland and Orkney Islands, who fit the national screening criteria. NHS Grampian have the use of two mobile units for screening. Approximately 33,000 women are screened per year in the region.

The inspection team was made up of three inspectors.

What action we expect NHS Grampian to take after our inspection

The actions that HIS expects the NHS Grampian North East Breast Screening Centre 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 HIS.
- **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 five recommendations. Requirements are linked to compliance with IR(ME)R.

Implementation of IR(ME)R Requirements	
Requirements	
1	The North East Breast Screening Centre must include in their Employers procedures or similar document the referral guidelines for when secondary imaging is required and the type of imaging recommended. (Regulation 6(5)(a)). (see page 12).
Recommendations	
a	The North East Breast Screening Centre should document where relevant clinical history is stored on the system to assist the justification process. (see page 12).
b	The North East Breast Screening Centre should provide a procedure for when the typical dose for an image is exceeded by a predetermined factor and requires further investigation. (see page 13).
c	The North East Breast Screening Centre should introduce a way of working to alert staff of any changes to the AEC to optimise images at future appointments. (see page 13).
d	The North East Breast Screening Centre should document in their procedures the understanding of the term “Routine Recall” is a form of clinical evaluation whereby no suspicious pathology was evident or words similar to that effect. (see page 15).
e	The North East Breast Screening Centre should document their clinical audit programme. (see page 18).

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

NHS Grampian, NEBSC, must address the requirement and make the necessary improvements as a matter of priority.

We would like to thank all staff at NHS Grampian NEBSC for their assistance during the inspection.

2 What we found during our inspection

Safety Culture and Leadership

This is where we report on how clear the service's safety culture and how supportive it's leadership and culture is.

Key questions we ask:
How clear is the service's vision and purpose?
How supportive is the culture and leadership of the service?

Our findings

A strong safety culture and environment was seen, with the necessary understanding and implementation of IR(ME)R demonstrated to the inspectors.

Safety culture

A strong safety culture can help to strengthen safety in the use of radiation technology, preventing injuries and reducing unnecessary or unintended radiation dose to patients. The safety culture is demonstrated through the measures in place to ensure the appropriate entitlement and scope of practice, Employers Procedures (EPs), optimisation practices, quality assurance systems, as well as the audit and governance arrangements in place.

Staff at the NEBSC reported an open environment to reporting incidents and raising queries. Governance for reporting incidents and outcomes are reported following department procedures and are escalated to the Scottish Breast Screening Programme (SBSP) in National Services Scotland (NSS) as required. Incidents are also reported locally through Datix. Staff we spoke to were aware of the reporting procedures and pathways.

Radiologists attend breast specific Radiology Events and Learning Meetings (REALM) to discuss complex cases once a quarter. This element of peer review at REALM meetings helps to maintain high quality standards in breast screening. As recommended by the Royal College of Radiologists (RCR), radiologists undertake a minimum number of procedures and reading of mammograms to retain their competencies, thus adding to the safety and quality of care.

Implementation of IR(ME)R requirements

This is where we report on how well the service implements the requirements of IR(ME)R and manages and improves performance.

Key questions we ask:

How well does the service manage and improve performance?

How does the organisation demonstrate the safe use of ionising radiation (patient exposure)?

Our findings

There was clear systems and processes in place for the development of EPs, entitlement of staff and staff training. Staff were clear on their scope of practice.

Employer's procedures

The NEBSC is clearly aligned to the NHS Grampian governance structure for the development of IR(ME)R procedures.

There are three distinct levels of documentation in NHS Grampian. We reviewed a selection of level one, level two and level three Employers Procedures (EPs) documents. Level one documentation applies to the whole NHS board, covering all modalities. Level two documents are modality specific, in this case covering all the radiology services. Level three documents, known locally as MAM documents are department protocols focused on breast imaging services, both screening and symptomatic.

The review of documents is conducted on a two-year basis. It was confirmed that all the breast screening EPs have been reviewed in the last 6 months. The level three EPs are updated in line with new technologies and advances. These documents are developed with a multi-disciplinary approach from senior radiographers, MPEs and radiologists as required.

Training

All radiographers working within breast screening must have a Post Graduate Certification (PG Cert) in Mammography. It is also required that all APs complete a higher education certification in Mammography. These certifications are provided by Scottish Academy of Breast Imaging (SABI). The courses run by SABI are approved by the College of Radiographers. SABI provides further training modules in advance practice to enable professional and clinical skills development for those who wish to extend their scope of practice within breast imaging for example in reading and reporting of images. They also carry out

refresher training with staff members across all breast screening centres in Scotland at various times.

When APs are in training, they practice under direct supervision, where the radiographers are physically in the room and overseeing practice. Radiographers in training follow the same process where they are under direct supervision until deemed competent by the relevant persons.

The training records for each staff member are stored electronically and were available for inspection. We were shown examples of a variety of AP's and radiographers training records. Staff we spoke to were aware of where to find their training records, were able to access them and were aware of their own individual scope of practice. Individual training records and competencies are reviewed regularly. Radiographers noted that emails are regularly sent out to inform the team of updates to the competencies of staff members.

To become a consultant radiologist who undertakes breast reporting and other screening roles, doctors must review a minimum of 3,000 screening images in addition to the other competencies associated with the role, such as ultrasound guided biopsy. The level of supervision changes as they progress through their training to become a specialist in mammography reporting. There are no registrars working in the breast screening service.

NHS Grampian also employ advanced practitioner radiographers who undertake breast screening reporting and assign clients to routine recall, technical recall or further assessment. As part of the training this staff group also must undertake a review of a minimum of 3,000 images under supervision to be able to carry out clinical evaluations. On completion of their training, they are required to review at least 5000 images a year to maintain their role and competencies.

Radiologists, consultant radiographers and advanced practitioner radiographers in NEBSC who are involved in the reading of images are enrolled into the PERFORMS scheme run by the University of Nottingham. This is a national programme, accredited by the RCR that enhances health professionals' interpretation and imaging diagnostic skills. Participants are required to review and report a set of test images including complex cases. The staff receive feedback from PERFORMS on their reporting efforts. This scheme is a positive element of self-assessment and peer review and is used enhance image interpretation in the screening programme.

What needs to improve

The training record document, MAM 01, detailed specific areas/equipment that staff were competent in and the date competency was reached. As a requirement to carry out mammography services, a Post Graduate Certification for radiographers or a Higher Education certificate for APs is necessary to be achieved. This is in line with staff entitlement as duty holders. No record of these certificates was included in the training record or held on the QMS; however it is held separately in an individual's personal records. However, this was rectified during the inspection and is now included in document MAM 01.

Entitlement

Entitlement processes are embedded and defined within the EPs, as per IR(ME)R 2017. A number of these documents were shared with the inspection team.

The entitlement procedures for medical staff changed approximately 15 years ago, since then newly appointed medical staff are entitled as per the scope laid out in the EPs. A letter is now given to the medical staff as they are appointed as part of their induction programme. Considering the recent inspection, NHS Grampian have taken the opportunity to remind all consultant radiologists of their entitlement as a referrer, practitioner and operator.

The clinical director is the responsible person for the referral of individuals based on the breast screening criteria and responsibility for the justification of an exposure. The departmental responsible person has responsibility for entitling other duty holders for their specific roles. During inspection the original entitlement documents for the clinical director could not be located. A revised document has now been issued and submitted to the inspection team. Entitlement documents for other staff were clearly signed by the appropriate persons and available for inspection. The entitlement documents outline the scope of practice for each role. All staff we spoke to were aware of their own entitlement and their roles and responsibilities. One AP has undergone additional training to be able to carry out technical repeats and has been deemed competent to do so. The entitlement for this AP was evidenced at inspection, which included the dates of competency for their further qualifications.

Referral

Referral for the breast screening programme is carried out by invitation based on a referral criteria set out by the Scottish Government and UK national screening committee. The SBSP is aligned and evidenced by the breast screening programme in NHS England. All criteria and recommendations are agreed nationally.

Women who meet the nationally agreed criteria are invited to attend for breast screening on a rolling three-year cycle. The invitation letters are sent from the NEBSC and are identified by women registered at a GP practice. The invitation letters from NHS Grampian are signed by the clinical director for the NEBSC. An example of a signed invitation letter was seen at the time of inspection.

Following the review of the screening images, clients may be assigned as Routine Recall, Technical Recall or Assessment Review. A technical recall is required if the diagnostic quality of the initial image did not allow for a clinical evaluation to be made. An invite for technical recall is by means of a separate invite letter which is signed by the clinical director. Technical recall clients are booked into routine screening sessions to have the image which did not meet diagnostic quality repeated.

For assessment review, an invite assessment clinic is by means of a separate invitation letter, also signed by the clinical director.
An example of an invitation letter to assessment clinic was seen at inspection and signed appropriately. As outlined in the document MAM 08, "*the referral for a recall to assessment clinic (This is not an IR(ME)R referral for imaging, but a clinical referral to the Assessment Clinic)*". At assessment, clinic images will be discussed at the clinical assessment meeting. The assessment clinic lead on the day, who could be a radiologist or consultant radiographer, will then decide if the client should go for secondary investigations which can include tomo-synthesis, magnification view or other further imagining. Referral for further imaging in the assessment clinic is the responsibility of the assessment clinic lead on the day in question.

A referrer must be a registered healthcare professional, therefore APs as a staff cohort are not entitled to act as a referrer.

The SBSS radiology information system is used to map the patient pathway and record the referral information, secondary imaging and results.

Justification

Radiation exposure through the breast screening programme throughout Scotland is based on agreed national population and criteria. The justification for exposure is applied at the invitation stage of the screening process by means of an invitation letter. Clinical justification is carried out in the boards by appropriately entitled operators prior to exposure also.

When a woman attends for screening, the previous imaging is reviewed to ensure that no images have been taken in the previous six months. Staff reported they ask the women verbally as part of the pre-exposure tasks, this

includes imaging taken outside of Scotland or in a private healthcare setting. The staff also have access to SBSS, Picture Archiving and Communication System (PACs) and national PACS to check the imaging history if there is any ambiguity in verbal response. If there is any further doubt, imaging will not be undertaken.

Technical repeats, which can be undertaken at the time of screening, are further images taken if the image quality is deemed inadequate by appropriately entitled operators. In addition, there is a single AP who can authorise under guidelines for a technical repeat.

As the screening images are read on monitors with a much greater pixelation, areas of blurring not visible on the modality monitors may become apparent requiring technical recall. Other reasons requiring a technical recall may also become apparent at this stage. The entitled reader can determine if a technical recall is required and which view requires repeats. A reason and which view is required for technical recall is recorded on SBSS and is visible to the operator when the client attends screening for their technical recall. When a client is referred to assessment clinic, further imaging can be justified based on assessment by clinic leads. Further imaging can include adapted views, tomo-synthesis, magnification views, cone views and stereo biopsy. Clinic leads will be a consultant radiologist or consultant radiographer.

In assessment clinic, the cases are discussed by the leads and the mammographers each morning and the women requiring further imaging are identified. The document MAM 08 outlines the pathway for each step of the screening pathway. It establishes that the consultant radiologist or consultant radiographer functions as the referrer and the practitioner for further imaging taken in the assessment clinic.

What needs to improve

The SBSS radiology system does not clearly use language to identify the person who has justified exposure at assessment clinic. The system records the referrer and there is an understanding that this is also the justifier. The document MAM 08 refers to the fact that the referral and justification of exposure is recorded “by adding their name in the ‘Requested by’ box”.

Although a staff discussion is undertaken for each woman attending the assessment clinic, it was unclear where the relevant clinical history for justification of secondary imaging is documented for each person, or where the criteria for further imaging is referenced. Staff were able to clearly define when secondary imaging would be applicable and the type of imaging that was appropriate for use in the assessment clinic, however no reference to written procedures were available.

Requirement 1

- The North East Breast Screening Centre must include in their Employers procedures or similar document the referral guidelines for when secondary imaging is required and the type of imaging recommended. (Reg 6(5)(a))

Recommendation a

- The North East Breast Screening Centre should document where relevant clinical history is stored on the system to assist the justification process.

Optimisation

The role of optimisation is to ensure that doses to individuals are kept as low as reasonably practicable (ALARP), consistent with the desired clinical results. The NEBSC have adopted the Scottish diagnostic reference levels (DRLs) as set by NSS. NSS have developed a range of four DRLs that cover 80% of women, in comparison the national DRL only has one DRL range that covers 10% of women. We were told that due to the comprehensive DRLs it is not common for the operators to exceed the DRLs when imaging. DRL charts were visible at the operator console at the static and mobile sites.

On inspection, exposure charts for the recommended values were visible on the walls in the static centre and mobile unit. The provided document, MAM 24 outlines the recommended exposure levels for screening and symptomatic manual exposures, while document MAM 04 gave guidance for overriding the AEC. NEBSC have a process in place for overriding the AEC for ladies who have implants or implantable devices. These documents were all accessible online if required. The dose for each image is recorded on the individual image on PACs. Operators can also see the given dose on exposure to the women.

Following on from a previous inspection to NSS, an image optimisation group has been established in the SBSP, which will add to optimisation across the Scottish centres.

For all images the dose data is recorded on the digital imaging and communication in medicine (DICOM) header of each image taken. Regular audits are in place that includes a review of the dose information.

What needs to improve

The automatic exposure control (AEC) devices on every x-ray unit are set up to maintain the radiation dose to the patient based on the highest density part of the breast, while delivering the necessary level of clinical image quality for the clinical task. It was reported that any manual AEC exposure changes are not recorded.

As these changes are technically not standard procedure, recording of manual changes should be implemented if done out of protocol to reduce the potential for taking images that are not clinically optimal. SBSS hosts a flagging system to alert users of changes or previous comments made by staff to aid in the delivery of care for example, whether a person requires to sit for during their imaging. Manual changes to the AEC, selection of a different chamber, are not recorded using the flagging system and there is currently no other mechanism to convey this optimisation information to be used at the next routine examination.

Operators, when imaging, can see the data visualised on an exposure dial on the equipment which shows red, amber and green levels. A typical good quality image will read zero and be in the green level indicating the dose was as low as was reasonably practical. When exposures are too low and can affect the image quality the low dose exposures are indicated as red and amber readings. Overexposure is difficult to detect visually in digital imaging. If there is a high dose delivered, where the dial is at the extreme end of the green scale, no procedures are in place for reporting. This may be due to the image quality in this scenario will still be of diagnostic purpose compared to a low dose quality image. It is understood that there are scenarios where a higher dose is expected or can be explained, for example presence of an implantable device.

Currently when operators undertake an exposure that exceeds the DRL, operators do not have any criteria on when they should record any mitigating information in the comments box. Additional comments on image dose may support the justification of the increased image dose.

Recommendation b

- The North East Breast Screening Centre should provide a procedure for when the typical dose for an image is exceeded by a predetermined factor and requires further investigation.

Recommendation c

- The North East Breast Screening Centre should introduce a way of working to alert staff of any changes to the AEC to optimise images at further appointments.

Operator

There are a set of operator procedures in place which staff were familiar with and could locate them if required. Staff were familiar with the four national DRLs. Staff described the process for imaging women including the need to review previous imaging, ID checks, accurately position the women and breast, number of views, adequate compression and imaging women with breast implants or implantable devices.
Staff reported they will always work in a team of two operators or an additional member if someone is in training and requires direct supervision. A trail of working where the team was made up of two APs was tested in NEBSC. However, this practice of working has not continued, and an entitled radiographer will always work alongside an AP. APs have a certain scope of practice and are not entitled to carry out all aspects of the screening process. One AP, who has the higher certificate and has undergone further qualifications through SABI, is entitled to authorise technical repeats and can image women with implantable devices.

Staff reported having regular access to continuous professional development (CPD), and had sufficient time allocated on the rota to dedicate to CPD.

Records

The NEBSC uses the NHSG Intranet System for upkeep and management of EPs of all levels. They also house their document library on SharePoint to allow access to required documents when on the mobile units. Documents were accessible online on the mobile unit at the time of inspection. Paper copies of some documents were available in the event of failure to access the internet in remote areas, for example QA manual.

Patient identification

All staff we spoke to were aware of the patient identification procedures in place. A three-point ID check is used for all patients. The worklist for patients each day is linked from the SBSS IT system to the imaging equipment.

For women who require an interpreter, these services are available.

As per the level 2 document RA3, operators take responsibility for patient identification by “ticking the ‘Verified’ or ‘Verified with changes’ box on the Pre-Screening Questions tab of the SSBS and recording the operator’s name in the Mammography Details tab”. At assessment clinic, this is recorded “by completing the IRMER verification tab on the Assessment Clinic section of SBSS”.

Imaging exposures will not be carried out if there are any concerns over patient identification.

Clinical evaluation

Clinical evaluation is the clinical interpretation of an image and the recorded outcome (documentary evidence) of that reading. All the images in NEBSC are read by two readers. The readers are a mix of consultant radiologists, consultant radiographers and entitled advanced practitioner radiographers who completed extra training and qualifications.

For each image acquired, both readers are required to record their clinical opinion and come to a consensus on the findings. Where there is a difference of opinion an arbitrator will review the images to provide a third reading, finalise the consensus and confirm the outcome for the woman.

What needs to improve

There are three options available when reading an image to clinically evaluate the findings at the initial reading. These options include “Routine Recall,” “Technical Recall” and “Assessment Clinic.” As there is no option to write the findings in the routine recall option on SBSS, it is assumed by generation of a letter to the women and placement back on the routine call list, that there was no suspicious finding on the images. The letter is seen as an outcome from the clinical evaluation. As per the NHS breast screening IR(ME)R guidance, the processes for clinical evaluation, arbitration, and the recording of the outcome of the assessment should be clearly described in the employer’s procedure.

Recommendation d

- The North East Breast Screening Centre should document in their procedures the understanding of the term ‘‘Routine Recall’’ is a form of clinical evaluation whereby no suspicious pathology was evident or words similar to that effect.

Expert advice

Medical physics experts (MPEs) from NSS provide the expert physics advice for the screening programme. NHS Grampian MPEs are informed of local Datixes however NSS MPE provision carry out investigations on reportable incidents. Local MPEs contribute to the development of the local EPs and provide advice on compliance to IR(ME)R.

In relation to the equipment NSS provide MPE input and are responsible for the following:

- commissioning and procurement of new equipment
- 6 monthly and annual quality assurance of equipment

- dose monitoring and
- analysis of incidents.

MPEs are involved in carrying out a range of audits and reports for example dose monitoring, image quality. Results from these reports and audits are disseminated back to NEBSC for learning.
While NSS MPEs are responsible for the procurement and commissioning of all equipment for the NEBSC, there are representatives from NHS Grampian that are included in this process.

Whilst the NSS MPEs are not based in the NEBSC, they are readily available for support from both static centre and mobile units via phone or online. A strong working relationship was evident at the inspection between NHS Grampian, NEBSC and NSS MPEs.

Contracted services

While there are no locum or agency services used in NEBSC, cross border reporting may be utilised between other NHS Scotland breast screening departments when required.
No third-party external imaging reporting services are used for image reading.

General duties in relation to equipment

There is a quality assurance (QA) program in place that details the frequency of testing, equipment to be tested, type of test and the tolerance limits. A comprehensive QA manual, provided and compiled by NSS MPEs, is available to staff undertaking QA tasks. The QA manual was available for review at inspection on the mobile unit, and it was confirmed it was the most recent version.

All staff had been trained to undertake the daily, weekly and monthly tests. The imaging equipment has the required QA tests programmed for the relevant days. There were clear escalation procedures in place for equipment that was found to be out of tolerance. Staff confirmed that, if required, they could contact the manufacturer or the NSS MPE to resolve issues. Online live spreadsheets are used to input data from the daily, weekly and monthly QA tests, which highlights if a result is out of tolerance. There was evidence of remedial action being taken for faults and issues. QA testing also includes image quality to ensure that the images are clinically optimised. The six monthly and annual tests are carried out by NSS MPEs. These tests are more comprehensive, and dedicated time is provided for these tests to be undertaken.

When QA is undertaken and an artifact is identified as minor, the operator will contact the consultant radiologist to ask whether the location of the artifact will

impact on the ability of the reader to carry out a clinical evaluation, until such time as it is rectified. Imaging can continue to be carried out if the consultant is content with the image quality otherwise the equipment is taken out of use until repair is undertaken.

The NEBSC covers a large geographical area and the mobile units travel to cover the wider population. The units regularly travel around Aberdeenshire and are transported to the Orkney and Shetland Islands. As equipment may be affected by the movement, a specific QA checklist is completed before screening any patients after any move.

When an engineer requires to visit and undertake a repair, staff confirmed that they would always undertake the daily QA again before putting the equipment back in use. It was confirmed that there is dedicated time in the day to undertake QA. The use of signage is used to visibly see when a unit is not for clinical use e.g. if an engineer is on site.

As part of the SBSP there are dedicated QA roles appointed in each screening centre. The QA lead radiographer and QA lead radiologist in NEBSC link with the other national QA leads to aid in the standardisation of practice across the SBSP.

The monitors used to undertake clinical evaluations also have a QA programme in place.

Clinical audit

Clinical audit is a tool used in improving healthcare outcomes across the breast screening pathway. NEBSP undertake a comprehensive range of audits as part of the screening program and locally.

All staff undertake a self-assessment audit on previous images they have taken using the Perfect, Good, Moderate Inadequate (PGMI) image evaluation system established by the National Health Service Breast Screening Programme (NHSBSP). Operators self-assess 20 images per month. The QA lead radiographer will also audit a further 10 images per staff member.

The QA lead radiographer regularly audits recall and retake rates. This data is monitored for all staff and all staff are provided with feedback on the outcomes of the audits and rates. If a high level of recall or retake was seen, further investigations are carried out into the circumstances.

Audits on interval cancer rates are used to drive learning and improvement. Interval cancer meetings are carried out every three months. A report from these figures is generated to go towards the national data on interval cancers.

NSS QA lead radiologists have a continuous audit programme, which includes all six breast screening centers in Scotland. These audits include visiting the centers in person and having virtual meetings. NSS QA lead radiographers have a similar national audit programme. Information from the annual reports is shared with NSS, National Services Division, Screening Oversight and Assurance Scotland, NHS Grampian, NHS Orkney and NHS Shetland.

What needs to improve

There is a wide degree of clinical audits being undertaken, there is no document that describes the overarching programme of clinical audits in place.

Recommendation e

- The North East Breast Screening Centre should document their clinical audit programme.

Accidental or unintended exposure

The NEBSC centre follows the IR(M)ER procedure for the notification of incidents as outlined in their EPs.

In the provided EPS, level two document RA10 states that “Investigations into incidents in breast screening will be led by an MPE from NSS, including performing dose and risk calculations. A report will be provided to NHS Grampian MPE and Radiology for further consideration.”

Incidents or locally raised Datixes are included in a monthly newsletter to staff provided by the practice educator to raise awareness and communicate learning from incidents.

There have been no reported incidents from NEBSC in the last three years to HIS.

Risk and Communication

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

Key questions we ask:

How well does the organisation communicate with service users?

Our findings

It is required under IR(ME)R that adequate information is provided to individuals prior to exposure relating the risks and benefits of radiation exposure from imaging. Systems are in place to communicate this information to eligible individuals.

Risk benefit conversations

Risk benefit conversations are navigated through patient information provided by the SBSP and public forums for example NHS Inform. An information leaflet containing risks and benefits of screening including the risks from radiation, is sent alongside the invitation letter to all those eligible for screening. The letter contains a phone number for women to call the department should they have further questions. The opportunity is available for women to speak to a staff member in person, in the department should they have further questions prior to imaging.

Making enquiries of individuals who could be pregnant

Enquiries to individuals who may be pregnant are not routinely carried out in the SBSP. As stated in the breast screening IR(ME)R implementation guidance, there is no requirement from a radiation dose perspective to routinely enquire about pregnancy prior to the exposure for routine breast screening imaging.

The guidance also notes that mammography is not routinely performed when a woman is breastfeeding, due to the density changes in the breast tissue.

Carers and comforters' procedures

Whilst there are EPs in place covering the wider radiology service, including breast screening, for comforters and carers, these procedures are not required in the breast screening programme in NHS Grampian. It was reported that if the women are not able or suitable for imaging then they will not be imaged.

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.

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.

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.

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