Healthcare Improvement Scotland | Inspections and reviews
To drive improvement

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

Service: West Scotland Breast Screening Centre, Stock Exchange Court

Service Provider: NHS Greater Glasgow and Clyde

12-13 November 2025

NHS SCOTLAND

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Background

Healthcare Improvement Scotland 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 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 West of Scotland Breast Screening Centre (WSBSC) on Wednesday 12 and Thursday 13 November 2025. We spoke with several staff during the inspection including the clinical director, quality assurance (QA) lead, consultant breast radiologist, general manager, sector superintendent, site superintendent clinical specialist/QA radiographer, quality manager, medical physics experts (MPEs), and the centre manager. This was our first inspection to this service.

WSBSC provides six static screening rooms and one prone room as well as operating seven mobile screening units. WSBSC screens approximately 70,000 to 80,000 patients per year. 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 the NHS Greater Glasgow and Clyde, WSBSC 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 four recommendations. Requirements are linked to compliance with IR(ME)R.

Safety Culture and Leadership	
Requirements	
	No requirements.
Recommendations	
	No recommendations.

Implementation of IR(ME)R requirements	
Requirements	
1	The West Scotland Breast Screening Centre must clearly define in the employer's procedures or similar documents at what point justification is occurring when a referral is made on the SBSS system. Regulation 11 (1)(b) (see page 14).
Recommendations	
a	It is recommended that the West Scotland Breast Screening Centre should document in the employer's procedures or similar documents where the relevant medical history and imaging is stored on the SBSS system to assist the justification process. (see page 14).
b	It is recommended that the West of Scotland Breast Screening Centre documents the requirement to record who has authorised the technical repeats that are undertaken by assistant practitioners. (see page 15).
c	It is recommended that the West of Scotland Breast Screening Centre should document in their procedures the understanding of the term "Routine Recall" in relation to the production of a clinical evaluation. (See page 18).

d	It is recommended that West Scotland Breast Screening Centre undertake a risk assessment to evaluate the potential impact of insufficient resources on the timely completion of recommended PGMI audits. This assessment should identify specific resource gaps, analyse associated risks, and propose steps to mitigate risks identified. (See page 21).

Risk and Communication	
Requirements	
	No requirements.
Recommendations	
	No recommendations.

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

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 WSBSC 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 its 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

There was a strong ionising radiation safety culture in place with clear a governance structure and team awareness for the implementation of IR(ME)R.

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. There is a clear framework through the Employer's Procedures (EPs), protocols, and assurance programmes that support the safe delivery of ionising radiation. There are measures in place to ensure the appropriate entitlement and scope of practice, EPs, optimisation practices, QA systems, as well as the audit and governance arrangements in place.

The WSBSC is an extension of the radiology services. Representatives from breast screening attend the diagnostic radiation safety committee and submit a biannual report, which contains information on radiation safety compliance and incidents within the service. Areas of learning are also highlighted at the meeting. This links into the NHS GGC IR(M)ER working party, chaired by the IR(M)ER lead and which meets bi-annually. There are also separate routes through the clinical governance structures. These links provide the pathway for information to flow between the WSBSC and the NHS Board governance structures. There are also a variety of forums where IR(ME)R related issues can be discussed, such as the weekly senior management team meeting, monthly management meeting, a variety of QA meetings and a daily huddle in the WSBSC. There is also a bi-monthly consultants' meeting, where patient clinical care is discussed and reviewed.

Staff reported open lines of communication to raise concerns and discuss issues. The staff reported a safe environment to report incidents and described a learning environment within the service.

Requirement

- No requirements.

Recommendation

- No recommendations.

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 were 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 WSBSC is clearly aligned to the NHS GGC governance structure for the development of IR(ME)R procedures. There are three distinct levels of documentation which are all available to staff. We reviewed a selection of level one and level two EP documents and some further documentation on the day of inspection. Level one documentation applies to the whole NHS board, covering all modalities. WSBSC level 2 protocols are focused on breast imaging services, both screening and symptomatic. This includes protocols, practical procedures, competency assessment criteria, acquisition protocols, local rules, and information leaflets.

NHS GGC utilised an electronic document register system for all IR(ME)R related documentation. All EPs have a review date and are reviewed a minimum of every three years. The EPs have been recently updated and were all within the review period. These documents are developed with a multi-disciplinary approach from senior radiographers, MPEs and radiologists as required.

The WSBSC also print a copy of the standard operating procedures (SOP) to be used in the event online documents are not available. In addition, an online application is used for some additional procedural documents which are currently in the process of being included in the electronic document register.

Requirement

- No requirements.

Recommendation

- No recommendations.

Training

All radiographers working within breast screening are required to have a Post Graduate Certification (PG Cert) in Mammography. It is also required that all advanced practitioners (APs) complete a higher education certification in Mammography or equivalent. These certifications are provided by the Scottish Academy of Breast Imaging (SABI). The courses run by SABI are approved by the College of Radiographers (CoR). 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. Records of achievement of the PG certificate and higher education certificate were in place for all staff as appropriate. The training undertaken and records of achievement is aligned with staff entitlement.

APs that are signed off as entitled, work under indirect supervision from radiographers. 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 in folders and were available for inspection. We were shown examples of a number of radiographers' training records. Staff we spoke to were aware of the link between their training and their own individual scope of practice. Individual training records and competencies are reviewed regularly. Refresher training is also carried out with staff members across all breast screening centres in Scotland at various times.

For staff working in the assessment clinics, WSBSC have produced a "Assessment Clinic Introduction," an 8-day training programme for staff detailing the flow of the clinic, the equipment used and IT systems.

There is a specific training pathway for radiographers who as part of their role undertake breast reporting of both symptomatic and screening images. Readers undertake a post graduate module in image interpretation. This includes reviewing a minimum of 3,000 screening images under supervision, monitoring cancer detection rates, recall rates and missed cancer rates. This is in addition to the other competencies associated with the role. Advanced practice mammography radiographers 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 5,000 images a year to maintain their role and competencies.

Radiologists, consultant radiographers and AP radiographers in WSBSC 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 Royal College of Radiologists (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 to enhance image interpretation in the screening programme.

The WSBSC maintains a comprehensive suite of controlled documents that define the training, development and competency requirements for operators and practitioners. These documents include detailed training records that provide evidence staff have successfully attained the theoretical knowledge and practical skills necessary to meet the minimum standards for safe practice.

Training record documentation is available and specifies:

- the individual staff member assessed
- the specific area of practice or equipment for which competency was achieved, and
- the date on which competency was formally confirmed

Competency records are maintained for specialised procedures, including but not limited to:

- affirm tomosynthesis
- breast implant imaging, and
- affirm prone biopsy

This documentation demonstrates compliance with competency expectations by ensuring that all staff are trained, assessed, and deemed competent prior to undertaking independent clinical practice.

Under IR(ME)R regulation 6 (3)(b) every employer is to ensure that every practitioner or operator undertakes continual professional development (CPD). The radiologists confirmed there was dedicated CPD time allocated. Radiographers and APs confirmed that Learn Pro modules were available and there is training on new equipment and techniques. There are QA study days and there is an online based CPD breast screening group

Requirement

- No requirements.

Recommendation

- No recommendations.

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. As detailed in EP-1, Entitlement of Duty Holders for Medical Exposures. The entitlement and scope of practice is linked to the competencies of the staff member as demonstrated by their qualifications, role, training and experience. An individual's scope of practice can change over time, for example following additional training or moving to a new role.

Entitlement records were reviewed for several staff and examples of entitlement letters were available on inspection. The entitlement documents outlined the areas of entitlement such as referrer, operators or practitioner. Further details of an individual's scope of practice is contained within the further documentation such as BS-GGC-FORM-008 Competency Assessment Form for Radiologists/consultant Mammographers/Trainees. The staff we spoke to were aware of where to find their training records and their scope of practice. An annual review is undertaken of staff entitlement and scope of practice.

Requirement

- No requirements.

Recommendation

- No recommendations.

Referral

The letter of invitation to women to attend for screening is sent from the screening director (consultant breast radiologist), who is the entitled by NHS GGC as the referrer. The referral criteria are set out by the Scottish Government and UK national screening committee and is detailed in BS-GGC-JUST-001 Mammography Justification/Authorisation Guidelines which are aligned to EP 4 Referral Procedure and Referral Criteria. The referral criteria have been approved by the clinical director.

Two weeks prior to the attendance at the screening appointment a review is undertaken of the women's previous imaging history to ensure there were no mammogram in the previous six months, and the patient is not on the symptomatic patient pathway. In addition, there is a quarterly QA administration meeting to review the mechanisms of calling women to the screening service.

Following attendance at the initial screening appointment and after the initial images have been reviewed, if further investigation is required, the women are invited back to the clinic at this point and screening images and the initial findings from the screening are discussed at an assessment clinic. If necessary, the responsible assessor, which may be a consultant radiologist or consultant radiographer functions as the referrer and the practitioner for further imaging. The clinical director for WSBSC confirmed that they would refer for different images depending on the investigations undertaken, seeking a non-ionising radiation alternative where practicable. When further investigation is required, the referrer completes the referral on the SBSS system. The system details who the referrer was, and the examination requested. The referral criteria used at the assessment clinic is detailed in BS-GGC-PROC-004, Referral Procedure and Referral Criteria. A review of the referral criteria, led by the clinical director, is currently being undertaken.

Requirement

- No requirements.

Recommendation

- No recommendations.

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 by entitled operators prior to exposure.

When a woman attends for screening, the previous imaging history 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, if they have had any previous imaging. Staff have access to SBSS, screening and symptomatic Picture Archiving and Communication System (PACs) to check the imaging history if there is any ambiguity in the verbal response. If there is any further doubt, imaging will not be undertaken.

Technical repeats, further images are taken if the quality of the initial image is deemed inadequate by appropriately entitled operators at the time of screening.

What needs to improve

When an AP seeks authorisation from a mammographer it was confirmed that staff would record who they spoke with in the SBSS system. However, there was no corresponding guidance or procedure to confirm this practice.

The SBSS radiology system does not clearly use language to identify the person who has justified an exposure at an assessment clinic. The IT system SBSS does not include a separate “justified by” component. Instead, the “requested by” option on the assessment clinic module on SBSS was the only option and therefore it was assumed that this action is covered by the IR(ME)R role of justification.

Although a staff discussion is undertaken for each woman attending the assessment clinic, and the clinical information on SBSS is reviewed it is not documented in the EPs or protocols the type of information that was to be regarded as the medical history.

Requirement 1

- The West Scotland Breast Screening Centre must clearly define in the employer’s procedures or similar documents at what point justification is occurring when a referral is made on the SBSS system. Regulation 11 (1)(b).

Recommendation a

- It is recommended that the West Scotland Breast Screening Centre should document in the employer’s procedures or similar documents

where the relevant medical history and imaging is stored on the SBSS system to assist the justification process.

Recommendation b

- It is recommended that the West of Scotland Breast Screening Centre documents the requirement to record who has authorised the technical repeats that are undertaken by assistant practitioners.

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 WSBSC 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 with the national DRL that has one DRL range that covers 10% of women.

The service has implemented robust optimisation practices including clinical audits to assess dose and image quality, an established QA manual and structured equipment testing schedules, based on input from NSS MPEs. The programme involves a QA lead radiographer and QA lead radiologist which enhances the optimisation efforts and provides consistent oversight alongside the MPE staff.

DRLs will be reviewed by the MPEs annually as per document PROC 11. The age of equipment varies, with the oldest mammography machine being 16 years old. The mean glandular dose has been calculated for each mammography machine, and a positive finding was that the programme DRLs were shown to be lower than the national guidelines, adhering to ALARP principles.

DRL charts were displayed in mobile and static units and available to access online if required.

A review of the SBSP 2023 2D patient dose date showed that it is not common for the operators to exceed the DRLs when imaging. This is due to a combination of factors, for example the use of automatic exposure control, equipment design, QA, staff training and protocols and use of the SBSS flagging system to optimise individual exposures.

EP-Guidance-17 outlines the procedures for exceeding LDRLs of certain factors. This document aligns with EP 11 “Diagnostic Reference levels”, EP 12 “Assessment of Patient Dose” and EP 13 “Optimisation of Exposures”.

Following a previous inspection to NSS a national image optimisation group has been established, which will seek to improve optimisation across the Scottish centres. In addition, NHS GGC have an optimisation group and can discuss dose optimisation and image quality concern.

Operators also have a role in optimising exposures for women with implantable devices such as pacemakers, implants and 'popcorn' calcifications. A document based on the manufacturers' guidance is available at the imaging console to help support staff in choosing the imaging options. The AEC is an inbuilt function on the equipment to ensure that the mammogram has the correct or optimal exposure. A manual selection of the AEC chambers or manual exposure is chosen for these women to ensure the best quality image. The exposure settings from the side without an implantable device are used as the reference point for the settings on the side with the implantable device. Any person who has had a manual selection of an AEC chamber/manual exposure is "flagged" on the SBSS system for future appointments that a manual exposure or manual AEC has been chosen, but it does not record the chamber selected. It was the opinion of operators that recording of the chamber was not necessary as when the women attended in the future the chamber position may be different.

For all images the dose data is recorded on the digital imaging and communication in medicine (DICOM) header of each image taken. NHS GGC and NSS undertake retrospective audits of clinical dose against DRLs with further investigation undertaken by the NSS MPE if they deem it necessary.

Requirement

- No requirements.

Recommendation

- No recommendations.

Operator

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 therefore requires direct supervision. APs have a certain scope of practice and are therefore not entitled to carry out all aspects of the screening process. AP staff were aware of their responsibilities

and role when seeking help and authorisation from radiographers for example when requesting a technical repeat.

Requirement

- No requirements.

Recommendation

- No recommendations.

Records

The WSBSC uses an electronic document management system for the upkeep and management of EPs and protocols of all levels. Documents were accessible online in 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 the QA manual. Screening records are held on the national SBSS system and follow the individual's screening pathway and history.

Requirement

- No requirements.

Recommendation

- No recommendations.

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 system to the imaging equipment. Operators record on SBSS that they have carried out the identification process and check that the details match. For women who require an interpreter, these services are available. Imaging exposures will not be carried out if there are any concerns over patient identification.

Requirement

- No requirements.

Recommendation

- No recommendations.

Clinical evaluation

Clinical evaluation is the clinical interpretation of an image and the recorded outcome (documentary evidence) of that reading. All the images in WSBSC are

read by two readers. The readers are a mix of specialty doctors, consultant radiologists, consultant radiographers, and advanced practitioners who completed extra training and qualifications. For each image acquired, both readers are required to record their clinical opinion and arrive at a consensus on the findings. Where there is a difference of opinion, an experienced screen reader will act as an arbitrator and will review the images to provide a third-party independent reading. Arbitration will finalise the consensus and confirm the clinical evaluation outcome.

What needs to improve

There are three options available when initially reading an image to clinically evaluate the findings. These options are “Routine Recall,” “Technical Recall” and “Assessment Clinic.” As there is no option to record the findings and clinical evaluation in the routine recall option on SBSS, it is assumed by generation of a letter to the women that they will be invited for a routine recall in the future when there are no suspicious findings on the images. The letter is seen as an outcome from the clinical evaluation whereby no suspicious pathology was evident. Staff involved in the process understand their role in relation to IR(ME)R and the implications of the function options to report images within the SBSS system.

The processes for clinical evaluation, arbitration, and the recording of the outcome of the assessment should be clearly described in the EP, providing guidance on the role and responsibilities of staff in relation to IR(M)ER and how this is demonstrated on the SBSS system.

Requirement

- No requirements.

Recommendation c

- It is recommended that the West of Scotland Breast Screening Centre should document in their procedures the understanding of the term “Routine Recall” in relation to the production of a clinical evaluation.

Expert advice

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. NSS MPEs are responsible for the procurement and commissioning of all screening equipment for the WSBSC.AT the completion of the technical commissioning a report will be sent by the NSS MPE to the local NHS GGC MPE, the superintendent and clinical director. The commissioning process then

includes a review stage of the first 100 images by an experienced screen reader to sign off the image quality. The NSS MPEs are not based in the WSBSC however, they are readily available to support both the static centre and mobile units via phone or online.

MPEs from NSS provide the expert physics advice for the screening programme. NSS MPEs carry out investigations on reportable incidents and NHS GGC MPEs are informed of the outcomes.

A strong working relationship was evident at the inspection between NHS GGC, WSBSC and NSS MPEs.

Requirement

- No requirements.

Recommendation

- No recommendations.

Contracted services

WSBSC will use locum services to support the breast screening service when required. When locums are used, they are subject to the same level of training and evaluation as any other member of staff. Any locum will be assessed as part of the process to define their scope of practice

Requirement

- No requirements.

Recommendation

- No recommendations

General duties in relation to equipment

The QA manual, compiled and provided by NSS MPE provision, had been adopted and implemented at WSBSC. All staff are trained to undertake the daily, weekly and monthly QA tests on the mammography equipment. The mammography equipment has the daily, weekly and monthly QA tests scheduled internally thus highlighting to staff that the tests must be carried out on a certain day. Results from each test is recorded onto a live spreadsheet. This is accessible by NSS MPEs for review and to aid in any test failures. Should there be any faults or failure of QA tests, staff were aware of the procedures to follow, the routes of escalation and who to contact. In the scenario where equipment is taken out of clinical use due to test failure, the appropriate out of

clinical use signs were available. A laminated sheet is also used to record the QA as a reminder to staff. There are additional QA tests to be carried out when equipment is returned to use and after any engineer has been on site to carry out work, along with a handover form and QA checks post movement of the mobile unit. The WSBSC centre had developed a user guide "Common Equipment Issues and Further Steps" and a "Guidance Note on Performing Clinical Settings Test", to support staff undertake QA. This also included a guidance on QA for artifacts and common issues. It was recommended that the guidance document be shared with other centres.

It was confirmed that there is dedicated time in the day to undertake QA tests as required daily and post engineer checks.

Requirement

- No requirements.

Recommendation

- No recommendations.

Clinical audit

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

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) to monitor clinical image quality. Operators should undertake a self-assessment of 20 images per month. The QA lead radiographer will also audit a further 5 images per staff member, totalling approximately 205 images per month.

The QA lead radiographer regularly audits recall and retake rates. This data is monitored, and all staff are provided with feedback on the outcomes of the audits and rates. There is a target rate of <3% for recall & technical recall rates over a 3-month period. If a rate goes above 3% over this period staff will be advised and supported to reduce their recall rates.

As part of the annual review of 5,000 image reports, the lead QA radiologist assesses the recall rate for further investigations. The recall rate was confirmed to be optimal for the service. In addition, cancer detection rates from both first and second reads, missed cancer rates and biopsy rates are systematically

evaluated. Individual readers receive feedback on their performance metrics, and where necessary, further audits and targeted support are implemented to enhance practice. Overall, the WSBSC has demonstrated that it is successfully achieving the desired outcomes.
All readers participate in the review of images for interval cancers. Meetings for discussion of these rates are held twice a year. A report from these figures is produced to go towards the national data on interval cancers.

What needs to improve

It was confirmed that due to staff shortages it was not always possible for staff to undertake the recommend 20 PGMI assessments per month and that service delivery had been prioritised over the requirement to undertake the full number of assessments. Regular monitoring and audit of mammographic technique is an important part of maintaining clinical image quality. Mammography staff should carry out the agreed target of image assessment every month against the criteria laid down for the MLO and CC images.

Requirement

- No requirements.

Recommendation d

- It is recommended that West Scotland Breast Screening Centre undertake a risk assessment to evaluate the potential impact of insufficient resources on the timely completion of recommended PGMI audits. This assessment should identify specific resource gaps, analyse associated risks, and propose steps to mitigate risks identified.

Accidental or unintended exposure

The WSBSC centre follows the NHS GGC procedure for the reporting of incidents as outlined in the EPs which also include reference to the statutory notification criteria.

Staff involved in an incident phone to report the incident and they are reported locally through Datix. Staff we spoke to were aware of the reporting procedures and pathways. Those involved in an incident input into an investigation. If an incident meets the criteria to become a statutory notification NHS GGC will provide details of their investigation and learning to HIS. Inspectors can request any person they reasonably believe is able to give relevant information to answer questions and provide information. Inspectors can require the production of, inspect or take copies of any entry in any books or documents which by law the business is required to keep and any other books or documents which it is necessary for the inspector to see. The provision of a

complete report as part of a notification reduces the requirement for inspectors to seek further information or discuss incidents with staff directly at a later date.

The radiation safety lead collates incident data for analysis to identify trends and learning. Governance for reporting incidents and outcomes are reported following the departmental procedures and are escalated to the SBSP in NSS as required. During the inspection examples of learning from incidents were shared, involving the imaging of the wrong side which led to the introduction of a SOP and as a result we were advised that incidents had reduced.

Requirement

- No requirements.

Recommendation

- No recommendations.

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

As the screening programme is delivered nationally, information leaflets from NHS Scotland and Public Health Scotland are provided to the centres to be given to the women along with their invitation letter. The leaflets include the risks and benefits of screening. The invitation letter contains a phone number for women to call the department should they have further questions. The opportunity is available to speak to a staff member in person, should they have further questions prior to imaging. The service has audited client awareness of risks and benefits of screening and has introduced further steps to ensure risks are communicated.

Requirement

- No requirements.

Recommendation

- No recommendations.

Making enquiries of individuals who could be pregnant

Exposure of individuals of child-bearing potential or pregnancy is not a contraindication for mammography examinations. Therefore, pregnancy and breast-feeding status is not routinely asked. Information posters are displayed in the screening centre to advise women to inform staff if they are pregnant or breast feeding to let staff know. BS-GGC-PROC-009 states that mammography should not be undertaken on women who are breast feeding due to changes in the breast tissue which can affect the ability to diagnose lesions. Women are to be advised to reappoint two months after they have stopped breast feeding.

Requirement

- No requirements.

Recommendation

- No recommendations.

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 GGC. It was reported that if the women are not able or suitable for imaging without the need for a carer or comforter being exposed, then they will not be imaged.

Requirement

- No requirements.

Recommendation

- No recommendations.

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.

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

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