



Welcome to the Safer Radiotherapy E-bulletin, which provides key messages and learning from the national patient safety initiative to the entire radiotherapy community.

This is the first in a new look concise E-bulletin. Your feedback helps us improve these publications, please share your thoughts with the radiotherapy team [radiotherapy@ukhsa.gov.uk](mailto:radiotherapy@ukhsa.gov.uk)

Further information on the national patient safety initiative can be found [here](#), or accessed via the QR code located on this page.



## Patient Safety in Radiotherapy (PSRT) Group Update

The PSRT includes representatives from the UK Health Security Agency (UKHSA), the Royal College of Radiologists (RCR), the Society of Radiographers (SoR), Institute of Physics and Engineering in Medicine (IPEM), NHS England (NHSE) and a lay representative. The group collaborates to support the coordination of efforts to improve patient safety in radiotherapy across the UK. This work includes the collation, analysis, and dissemination of learning from radiotherapy events (RTE).









The group met face to face in Birmingham on May 14<sup>th</sup>, 2025. Key actions from the meeting included:

- Review and update Safer Radiotherapy publications in response to recent survey results
- Develop tools for providers to support the implementation of **Advancing Safer Radiotherapy (ASR)**
- Develop a series of presentations to support the application of recent radiotherapy patient safety guidance, including **ASR** and the **National Patient Safety RTE Taxonomy**
- Scope the feasibility of a national workshop to support providers in the adoption of the recently refined **National Patient Safety RTE Taxonomy**, updates will be shared in future publications.

Completed actions are summarised on page 3 'Latest Patient Safety News'.

## RTE Data Analysis – April to July 2025

### Findings:

 <p><b>4,691 RTE reports</b></p>	 <p><b>96.8% classified level 3 – 5 with little or no impact on patient outcome</b></p>
 <p><b>9.4% more reports than the previous period</b></p>	 <p><b>56 providers submitted data</b></p>
 <p><b>22.8% of all reports related to equipment failure</b></p>	 <p><b>Fantastic news! 603 reports received with new modality taxonomy</b></p>

The full **Triannual RTE analysis and learning report** is now available



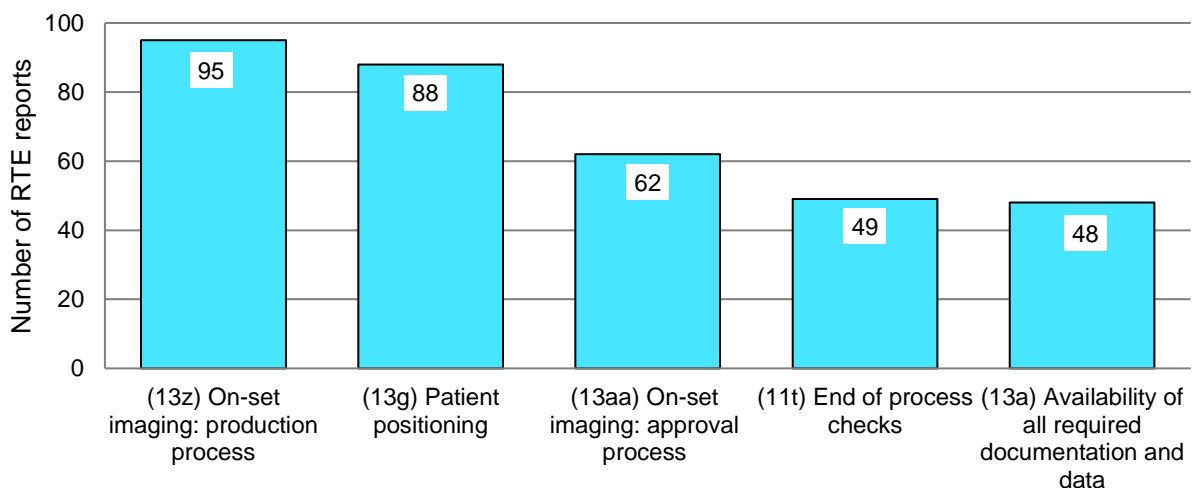
### Spotlight on:

#### Level 4, Good catch

**Involves the interception and prevention of a potential RI or MRI incident.**

- Terminology change from near miss to good catch, supports a positive focus on effective safety actions which detect and mitigate incidents
- The most frequently reported method of detection (MD) for good catch event is illustrated in the chart below. In accordance with **ASR**, it is important to learn from when things go right, for example the analysis of effective safety actions which detect and mitigate events, such as patient positioning processes, image guidance processes, and end of process checks.

#### Most frequently reported Level 4 method of detection (April to July 25)



## Latest Patient Safety News

### Advancing Safer Radiotherapy self-assessment tool

A new self-assessment tool for radiotherapy providers has been developed to support the adoption of the **ASR** recommendations. The tool is available [here](#).

### Learning resources

A new series of presentations have been developed to support the application of radiotherapy patient safety guidance, including **ASR** and the **National patient safety RTE taxonomy**. The presentations may be accessed [here](#).

These include:

- National patient safety RTE terminology and taxonomies
- Application of the national patient safety RTE taxonomies
- ASR: guidance for radiotherapy providers on improving patient safety

### National Safer Radiotherapy publication survey

A national survey to better understand readership needs and use of safer radiotherapy publications was conducted. This was an opportunity for the radiotherapy community to help shape the future safer radiotherapy publication series. The findings from the survey can be found [here](#).

All feedback on Safer Radiotherapy publications would be gratefully received at [radiotherapy@ukhsa.gov.uk](mailto:radiotherapy@ukhsa.gov.uk).

### NHS England being fair tool

A new NHS England being fair tool is now available [here](#). This tool replaces the 'just culture guide'.

### New resources to support implementation of the Framework for Involving Patients in Patient Safety (IPIPS)

A refreshed resource to support implementation of the **Framework for Involving Patients in Patient Safety** is available on the **Future NHS workspace**, including learning, tips, and materials from NHS organisations.

### SEIPS in action – Health Services Safety Investigation Body (HSSIB)

HSSIB are hosting a new course 'SEIPS in action' which is designed to equip healthcare professionals with practical skills in applying the Systems Engineering Initiative for Patient Safety (SEIPS) framework. Further information can be found [here](#).

### Dates for the diary

<b>BIR, palliative radiotherapy</b>	14 November 2025, Online
<b>IPEM, AI in imaging and treatment planning</b>	17 November 2025, Online
<b>BIR, Annual radiotherapy and oncology meeting</b>	12–13 February 2026, London

## Collaboration through notifications

**Sarah Delappe,**

**IR(ME)R Inspector**

**Healthcare Improvement Scotland (HIS)**



HIS is the regulator in Scotland responsible for enforcing the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) on behalf of the Scottish Government. IR(ME)R protects patient safety by promoting safe practices, identifying areas of improvement and responding to incidents.

Within Scotland all clinically significant or significant accidental or unintended exposures (SAUE) to ionising radiation must be notified to HIS. Through the building of transparent and collaborative relationships between HIS and radiotherapy providers, an open culture has been fostered with a desire for shared learning. Reports received by HIS reflect a strong culture of collaboration and demonstrate staff commitment to continued learning and improvement.

HIS received a SAUE notification involving multiple patients who received additional verification images as a result of a software fault during CBCT image acquisition. The software fault prevented the image acquiring fully, whilst allowing the movement of the machine to continue without capturing any further image data.

(NPSRTE code: [Level 1/ 13z/ MD13z/ CF3a/ D04](#))

Following discussions within the community further notifications were raised, which highlighted that this was not an isolated incident. Feedback from the manufacturer resulted in a temporary work around, until a subsequent software upgrade could resolve the issue.

To alert departments and reduce the risk of further unnecessary radiation exposure, HIS issued an email to providers informing them of the software involved, the clinical implications and the need to implement safety actions. HIS requested providers respond if they were affected and provide details of the mitigation procedures implemented to reduce the risk of reoccurrence.

Providers were advised to report the software issue to the manufacturer, and the Incident Reporting and Investigation Centre (IRIC), as the incidents involved a medical device in Scotland.

This SAUE notification has prompted multidisciplinary discussions, collaboration and dissemination of shared experience across providers and appropriate forums across Scotland and the UK. By encouraging providers to share experiences from SAUE notifications, and through HIS identifying themes from the submitted notifications, insight and support can be provided to support safer clinical environments and drive meaningful, system wide learning.