Mobile CT services

We have been trialling a programme of inspections on mobile CT services. The programme is in response to a risk identified during the pandemic where we became aware of a significant increase in the number of mobile CT units in the independent sector. Through notifications, we have seen unique risks to patients posed by the set-up of these services.

On our first inspection early in 2021, we visited the head office of a company to discuss with senior leaders the governance surrounding radiation protection. Six months after the original visit (delayed due to the further pandemic wave), we carried out 3 announced and 2 unannounced site visit inspections of the company.

The main findings from our inspections of this employer were unique to this type of service, and meant that we made a number of recommendations:

- Some parts of the patient pathway were shared with other employers, which meant the provider needed to rely on others to ensure duty holders were appropriately entitled and trained.
  Under Regulation 6(2) the employer must ensure that all duty holders, including those entitled by host sites, are able to comply with written procedures.

- The rotation of staff between different host sites sometimes meant radiographers needed to use different examination protocols because of the variation in some examinations, such as CT liver and urograms. This had led to radiation incidents involving several patients who needed to be re-scanned at the trust using the required protocol. But the mobile CT service had limited ability to standardise protocols because of contractual agreements.
  Under Regulation 6(4) the employer must ensure there are written protocols in place for every type of standard examination, and where possible, standardise these between host sites.

- Because of poor co-operation with host sites about reviewing and managing incidents, there were delays in concluding investigations and findings were not shared between employers. This also led to duplicated statutory notifications and delays in submitting reports of notifications to us.
  Under Regulation 8(4) the employer must ensure there is a process for investigating and managing accidental or unintended exposures and should co-operate with host sites when carrying out these investigations.

- The nature of the service meant there were only limited clinical audits, with another employer carrying out much of the clinical evaluation and justification.
  Under Regulation 7, the employer's procedures must include provision for carrying out clinical audit, which must be embedded within the governance programme.

We inspected another employer using this format in March 2022. Again, we visited the head office followed by 2 unannounced site visits. Some findings were similar to those of the other employer, although because this service was smaller in size there was less rotation of radiographers. This meant staff were more familiar with some site specifics such as protocols and employer's procedures.

However, we did find a number of breaches that resulted in 2 Improvement Notices.

We will continue this programme over the next 3 years because of the issues we have seen. Co-operation between employers is an area of focus as part of the community diagnostic centres and guidance on establishing an IR(ME)R framework. This will also support any memorandum of understanding or service level agreement for mobile services in a similar way. We also raised concerns with the clinical imaging board about the huge variation in some CT protocols.

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