Barts Health NHS Trust

The Royal London Hospital

Inspection report

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Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at The Royal London Hospital

Good 

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the diagnostic imaging service.

The concerns related to aspects of the safe and well led domains which were the focus of this inspection. We did not inspect any other of the services at the Royal London Hospital because the concerns did not relate to any other parts of the hospital.

This service had not previously been inspected and rated as a standalone service. As we did not inspect all key lines of enquiry, we did not rate the service from this inspection.

See the diagnostic imaging section for what we found.

How we carried out the inspection

We visited all areas of the diagnostic imaging service. This included visiting all treatment rooms and waiting areas. We spoke with 35 members of staff which included departmental and divisional managers, speciality leads, radiologists, superintendent radiographers, radiographers, radiography assistants, and senior hospital and trust leadership. We reviewed documents that related to the running of the service including staffing rotas, policies, standard operating procedures, equipment, meeting minutes, incident investigations, as well as additional evidence provided by the trust post-inspection.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/whatwe-do/how-we-do-our-job/what-we-do-inspection.

Diagnostic imaging

Inspected but not rated

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services.

The information we received related to diagnostic imaging services. The concerns related to aspects of the safe and well led domains which were the focus of this inspection. We did not inspect any other of the services at the Royal London Hospital because the concerns did not relate to any other parts of the service.

We did not rate this service at this inspection.

See the diagnostic imaging section for what we found.

How we carried out the inspection

We visited all areas of the diagnostic imaging service. This included visiting all treatment rooms and waiting areas. We spoke with 35 members of staff which included departmental and divisional managers, speciality leads, radiologists, superintendent radiographers, radiographers, radiography assistants, and senior hospital and trust leadership. We reviewed documents that related to the running of the service including staffing rotas, policies, standard operating procedures, equipment, meeting minutes, incident investigations, as well as additional evidence provided by the trust post-inspection.

Is the service safe?

Inspected but not rated

Mandatory training

Imaging areas for the Royal London Hospital were not meeting the trust target of 85% for completion of mandatory training. This included lower than 75% completion in a number of areas, including in both risk management and information governance training.

The division did not have an overall training programme in place for specialist training and staff stated they were often made aware of training dates too late to be able to attend. Access to specialist training had been affected by other priorities taking precedence during the current pandemic. At the time of inspection the practice educator role for imaging was one day a week (protected time), and supported by another radiographer from the Education Academy. Previous leadership had not enabled equal access to specialist training opportunities which had affected staff morale.

Cleanliness, infection control and hygiene

The service controlled and monitored infection risk and hygiene well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment visibly clean, and equipment was regularly cleaned in line with infection prevention and control (IPC) guidance. Cleaning records demonstrated that equipment was cleaned regularly and after patient contact, and labelled equipment to show when it was last cleaned. We saw evidence of consistent use of cleaning and waste management audits and spot checks to monitor IPC compliance. Staff also followed infection control principles including the use of personal protective equipment (PPE) and effective hand hygiene.

Diagnostic imaging

However, some corridors in imaging areas were visibly untidy and at times cluttered with trolleys containing linen or bags of rubbish. We also observed cleaning trollies left unattended in communal corridors for long periods of time.

Environment and equipment

The maintenance and use of premises and equipment did not keep people safe and the divisional leadership did not have oversight of environmental and equipment risks. Access to rooms containing clinical equipment (which presented hazards including exposure to radiation or powerful magnets) were often not locked securely, which posed a significant risk to staff, visitors and patients. Access to office areas where patient and staff records were visible and easily accessed were also unlocked.

We observed a mobile X-ray set which had been left unsupervised while connected to the mains power and with the key required to operate it in place on the control panel. This unit was left unsupervised in a publicly accessible corridor outside the reception and staff office area in the Accident & Emergency X-ray department. This presented a risk of unauthorised use of equipment which could lead to exposure to ionising radiation.

Equipment repair incidents and records were poorly maintained and filed inconsistently and, where reported, progress on repairs was not appropriately followed up. We saw examples where reports of faults and equipment in need of repair had not been addressed, and equipment incidents that did not state what actions had been taken. Staff stated that it could often require a problem to be reported more than once before the issue would be addressed.

The division did not have a process in place to assure the reliability of aging imaging equipment and the quality of imaging. Tests were not completed or were not consistently recorded. This had been identified as an issue in divisional audits in 2019 and 2020.

Resuscitation trollies kept people safe. Records showed they were checked regularly in line with guidance from The Resuscitation Council (UK).

Staffing

Managers could not always calculate the number of staff needed for each shift in accordance with national guidance and were not able to accurately monitor staff hours. Radiography staff were contracted for their regular hours (9am to 5pm, Monday and Friday), while their weekend and out of hours working was filled on a voluntary basis. This meant that the department operated different rota systems, one for regular hours and one for out of hours, which were not monitored and reviewed together. Staff stated that switching of shifts occurred informally outside of these two systems, which further decreased management oversight of the overall staff rota. We reviewed incidents where the lack of clarity regarding staff availability had resulted in poor patient experience.

Managers were unable to measure staff compliance with Working Time Directive legislation. The contracted hours and out of hours systems were not considered as one system, which meant senior staff could not be assured of the hours individual staff members were working.

Staff we spoke with were unable to consistently identify who their Radiation Protection Advisor (RPA), Radiation Protection Supervisors (RPS), and medical physics expert (MPE) were. Some RPSs we spoke with on inspection were not clear on the regulatory purpose of their role (to supervise the arrangements set down in local rules by the employer). RPSs did not have allocated time to perform their supervisory duties, which staff stated meant the role was a lower priority. Members of staff gave examples of where they had escalated issues to radiation safety leads which were not addressed in a timely way.

Diagnostic imaging

Incidents

Staff did not consistently recognise and report incidents. The division had a system to raise concerns and report incidents in line with trust policy, however staff stated that this system was not being consistently utilised by staff. Staff stated that they felt they did not want to report issues or raise incidents for fear of being treated unfavourably, which reflected the wider cultural issues within the division at the time of inspection.

Managers investigated incidents; however, it was not clear how successfully learning from incidents was shared. Divisional leadership had monthly clinical governance meetings where incidents were reviewed as part of the agenda, however minutes we reviewed from these meetings did not always reflect qualitative review of incidents or dissemination of learning to staff. We did not see evidence of learning being shared outside of these meetings, and staff were not aware of other ways in which learning from incidents would be shared.

When things went wrong, staff apologised and gave patients honest information and suitable support. We reviewed recent examples of investigations into serious incidents within the division, and found the investigations included evidence of Duty of Candour being considered.

Is the service well-led?

Inspected but not rated

Leadership

Leadership of the service was not stable or embedded. Imaging areas for the Royal London Hospital were managed under the Group Clinical Services (GCS) division of the trust. The site leadership model for Group Clinical Services consisted of a general manager, a radiographer site lead, and a clinical director. Many of the site leadership were either interim or relatively new to their posts in the last 6 months to 12 months.

Staff stated that senior leadership for the service were not visible. Some staff were not aware of who the service leads were or had not met them. This partially reflected that some managers had been unavailable on site due to the current pandemic, however staff suggested that the lack of visibility meant the leadership were seen as inaccessible. Some staff stated that when they had approached local leadership, they were supportive to their needs.

Local and divisional leadership did not have consistent support from hospital or trust level leadership when trying to address persistent issues within the division. Trust senior leaders were not fully aware of the extent of the challenges faced by the department. The imaging leadership at the Royal London stated they were isolated in escalating issues due to a lack of clear reporting pathways. Staff we spoke stated that local leaders were regularly occupied with long standing issues such as staffing conflicts, which they felt impacted on their ability to focus on operational duties.

Vision and strategy

The vision and strategy for imaging was undeveloped and did not reflect some of the operational challenges we identified on inspection. Divisional and trust managers were in the process of putting together individual strategies for each imaging service within the department, which had not been finalised at the time of report.

Culture

The service faced significant challenges relating to the culture of the division. There were factions and separate interests within the workforce and nearly all staff suggested that this conflict created a difficult and hostile working environment.

Diagnostic imaging

We were informed of numerous allegations of bullying, harassment, racism, and sexism that had been escalated to requiring intervention from human resources. Staff stated that human resources was not providing adequate resolution to these issues for either frontline staff or the divisional management, and disruption related to individual staff issues remained a source of conflict.

Unresolved and persistent staffing conflicts were having an impact on staff morale and staff did not always feel supported or able to raise these concerns. Staff across specialities and managerial roles recognised that the difficult working environment was having a negative impact on the delivery of the service. Staff did not know how to access support if they wished to raise concerns, stating that they were unaware of the Guardian service or did not believe it would provide confidential support. Results from the staff survey from September 2020 (published in April 2021) showed that imaging areas at the Royal London was performing significantly below the trust average on 36 of the 78 measured questions, with 15 significantly above the trust average.

Staff told us that there was a lack of support and consideration in relation to staff wellbeing in the last twelve months. Staff stated that working in the division while there was conflict (as well as during the current pandemic) could be difficult, and that they were not aware of the resources available to promote staff wellbeing. We saw evidence on inspection of planned psychological support sessions and some signposting of staff to wellbeing resources.

Governance

Structures, processes and systems of accountability were not effective in supporting the delivery of sustainable services. There was a trust wide governance structure for imaging and a separate site-based governance structure for each hospital. Imaging was included in both structures which meant it was not clear where governance matters should be reported or followed up. Neither system was fully effective in managing the issues the service faced.

Minutes for local and divisional governance meetings did not reflect the full discussion during meetings in relation to governance and risk management. We observed meetings where minutes were not taken, despite actions for follow up being agreed. This meant that staff who could not attend meetings would be unable to gain much information from meeting minutes, and that actions agreed in the meeting may be missed for follow up. Senior managers for imaging stated that arranging for minute taking had been a consistent issue for local and divisional GCS meetings.

Managing risks, issues and performance

Systems to manage performance and escalate relevant risks to reduce their impact were not effective. Service leads and clinical staff in imaging areas, including radiation safety leads, were unable to provide risk assessments for imaging equipment, or identify where risk assessments were kept, when asked. Some risks assessments were identified to either have not been completed or completed and not recorded. Some imaging areas displayed protocols that had been due for review in 2015. There was no formalised process for completing and reviewing risk assessments, for removing out of date guidance, or a process for routinely sharing risk assessments with staff. This meant management did not have oversight of the risks related to the imaging equipment and the risk the equipment presented to staff and patients.

The lack of up to date risk assessments meant that clinical staff working with imaging equipment were unaware of what risks were presented by the equipment or where to access information on risks. This was reflected in conversations on inspection with imaging staff. When asked staff were not able to describe the necessary actions to take in the event of an emergency in line with protocols.

Where risk assessments had been completed, contingency protocols were not reviewed or rehearsed. Radiation safety leads for the division were not able to evidence regular reviews of contingency plans or provide evidence of rehearsals of emergency situations in line with the policy.

Diagnostic imaging

Areas for improvement

MUSTS

Location/core service [amend as appropriate]

- The trust must ensure that the gaps between the staff rota for contracted hours and the staff rota for out of hour shifts are addressed to ensure managerial oversight (Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment)
- The trust must ensure that the governance and risk management structures for completing and monitoring risk assessments are improved (Regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Governance)

SHOULDS

Location/core service [amend as appropriate]

- The trust should improve the governance structure of the division to ensure actions decided in meetings are followed up, useful records of meetings are available, and learning from incidents is disseminated.
- The trust should consider the divisional structure to improve hospital level oversight of imaging services at each location, and executive level oversight of imaging across the trust.
- The trust should consider improving pathways for GCS staff to access on-site estates and facilities support if needed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a second CQC inspector and two CQC Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspectors specialising in radiography. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.