Newham University Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

Following our last inspection in September 2018, we rated Newham hospital diagnostic imaging as requires improvement overall.

We had concerns that systems to assess, monitor, and mitigate risks to patients receiving care and treatment were not operating effectively. We also had concerns that governance systems and processes were not operating effectively.

We issued the trust with a Requirement Notice under Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment. The notice required the trust to make improvements and to send us details of how they were making improvements.

The trust responded with an explanation of action taken to respond to safety issues and an improvement plan to address the specific concerns included within the requirement notice.

We conducted this follow-up inspection on 2 and 3 October 2019. The inspection was unannounced. The inspection focused mainly on the issues identified in the requirement notice and where significant improvement was required in improving leadership, strengthening governance and oversight, engaging staff and addressing safety concerns. The key areas were:

Providing safe care and treatment:

- Ensuring equipment brought into the department was not left as a hazard within the corridors.
- Ensuring patients from CT and MRI were adequately segregated within the joint scanning workstation area to avoid issues regarding infection control, data protection, and patient and staff safety.
- Ensuring patients being cared for on medical wards were brought into the department with qualified escorts.
- Ensuring that the title and professional registration number of the reporter were being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards.
- Ensuring clinical audits were being undertaken within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test, for example by GPs or other clinicians, was made in accordance with IR(ME)R or (MHRA) safety recommendations.
- Ensuring staff were aware of learning from recent incidents.

Governance and systems to assess, monitor and improve the quality of services:

- Improving the visibility of the clinical support services and ensuring they were deemed approachable for all staff.

Summary of findings

- Ensuring the trust had addressed the cultural issue of fear of harassment and reprisal within the department.
- Improving the support for modality leads to ensure they have scheduled time to perform management duties.
- Ensuring there are quality assurance checks of equipment used by radiologists in their own homes.
- Ensuring plain film scans were reported on by a radiologist. Although there was a standard operating procedure in place to monitor unreported scans, we had concerns that the systems in place did not record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes.

The trust had achieved progress in addressing our concerns; however, there was still work to do to deliver and sustain progress. We judged that the requirements of the requirement notice had been met as far as possible within the short timescale.

We rated safe as requires improvement and requiring ongoing effort to achieve sustainable change. We rated well led as Good and recognised the improvements that had been made.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Requires improvement 	**This was a follow up inspection to assess whether the trust had made enough progress in response to the requirement notice issued in September 2019. We did not inspect all domains, but focused on Safe and Well led.** **The trust had drawn up an action plan and had put in place new systems to deal with the main concerns in safety and governance. Many senior staff were doing everything in their power to take the service forward. However, sustainable improvements were not seen in every area.** **We did not identify any breaches of regulation and rated safe as requires improvement to reflect that although improvement was seen we were not assured of long-term sustainability.** **We rated well led as Good to reflect the improvement seen since the last inspection.**

Summary of findings

Contents

Summary of this inspection

Background to Newham University Hospital

Bart's Health operates one of the largest imaging centres in the country, providing medical imaging and diagnostic services, ranging from routine x-rays to specialist imaging. Newham services are based at Newham University Hospital, Shrewsbury Road and Gateway Surgical Centre. The imaging department at Newham University Hospital performs approximately 11,500 examinations per month, and provides a service to GPs, mental health, outpatients, inpatients and a 24/7 service to the emergency department, theatres and wards.

The trust provides clinical services for:

- Ultrasound
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Plain Film X-ray
- Fluoroscopy
- Nuclear Medicine
- ERCP
- Mammography

Please refer to previous full inspection report from January 2019 for further background information if required.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Why we carried out this inspection

At the last inspection in September 2018, the diagnostic services were rated as requires improvement for the safe and responsive domains, good for the caring and inadequate for the well-led domain. We inspected all areas of the diagnostic service on this inspection.

In response to the specific concerns at the previous inspection, we focused on: Is the service safe? And Is the service well-led?

- We reviewed information publicly available and data from our most recent comprehensive inspection.
- We conducted an unannounced inspection on 2 October 2019.
- We observed diagnostic imaging procedures, reviewed diagnostic imaging reports and training records.
- We reviewed clinical governance and risk management information including notes of governance meetings.
- We spoke with 15 members of staff across all grades and roles.
- After the inspection we asked the hospital to submit data to establish performance in standard areas within the focus of the site visit.

Requires improvement

Diagnostic imaging

Safe	Requires improvement
Well-led	Good

Are diagnostic imaging services safe?

Requires improvement

Our rating of safe stayed the same.We rated it as **requires improvement.**

At our last inspection we were concerned about the safety of patients for the following reasons:

- Equipment brought into the department weekly was left outside clinic rooms within the corridor. This was a hazard within the corridors.
- We saw patients from CT and MRI were in the scanning workstation area often together prior to examination. This led to issues regarding infection control, data protection, and patient and staff safety.
- Patients being cared for on medical wards were brought into the department without qualified escorts.
- We saw the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards. This was rectified and addressed during the time of inspection.
- We did not find evidence that clinical audits were being undertaken within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test, for example by GPs or other clinicians, was made in accordance with IR(ME)R or MHRA safety recommendations.
- Staff we spoke with could not describe with confidence learning from a recent incident.

During this follow up inspection we found:

- Despite the trust providing screens between the CT and MRI control area, these were not being used consistently.
- Staff were not aware of the most recent IR(ME)R incident and learning from this.
- Despite a focus of checking and restocking equipment, it was clear from our observation that further improvement was needed to ensure consistency.
- Staff had limited knowledge on medicines management within the department and there was no standard operating procedure for the use and storage of contrast.

However:

- On inspection we saw no equipment was left outside clinic rooms and there were no visible hazards within the corridors.
- All patients being cared for on medical wards were brought into the department with qualified escorts. All staff we spoke with were aware and showed us documentation relating to this.
- All clinical radiology reports seen on inspection had the title and professional registration number of the reported recorded.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- The service had revised elements of its mandatory training from 1 January 2019 to take account of newly identified needs.
- All staff we spoke with told us they were able to access mandatory training easily and were issued with reminders by the intranet software platform when training was due to expire.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring which showed that staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support. All met the trust target compliance of 85%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- There had been no change since the last inspection.

Requires improvement

Diagnostic imaging

- We spoke with staff about safeguarding. Staff were knowledgeable about the trust's safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff were aware of the dedicated safeguarding lead they could access for advice.

Cleanliness, infection control and hygiene

The service had measures to control infection risk. However, staff did not consistently use equipment and control measures to protect patients, themselves and others from infection.

- Hand sanitising gel dispensers were available in corridors. We saw posters in waiting areas and other communal areas advising patients and visitors to gel their hands. However, on inspection we found several to be empty. Staff were unable to tell us if replacement of the dispensers had been actioned. We raised this with management and we saw that the dispensers were refilled immediately.
- We saw clinical rooms had facilities for the disposal of clinical waste and sharps. Waste management was handled appropriately, with separate colour coded arrangements for general waste, clinical waste and recycling. Clinical bins had foot pedal operated lids and were not overfilled.
- Sharps bins observed were assembled correctly, signed and dated. However, on inspection we saw the sharps bin within the cannulation room was over filled with used sharps sticking out from the top. We raised this with senior management. Following inspection, the service told us the sharps bins were checked daily. We were told the staff member responsible was off on the day of our inspection.
- Information provided after inspection showed the responsibility for checking the sharps bins had been added to the checklist for the radiographer who starts at 8 AM. An updated checklist had been developed and we saw evidence of this.
- Staff were aware of infection-control processes such as the use of personal protective equipment and hand hygiene. Staff observed the hand hygiene and 'bare below the elbows' policy of the hospital.
- The previous inspection had found a lack of storage space for equipment in some areas with the mobile x-ray arm stored within the corridor. We previously saw equipment used for ERCP was brought from another ward once a week to the department and was left outside the clinical rooms within the corridor. On this inspection we saw no equipment stored within corridors. We saw no evidence of lack of storage for equipment.

Environment and equipment

Staff did not consistently follow actions put in place following the last inspection.

- During the last inspection, we saw jugs of pre-prepared contrast and jugs of water stored next to each other within a patient preparation room. Both jugs contained clear liquid, and both were unlabelled. There was a risk that a patient may be given the wrong fluid to drink. We escalated this to the department lead and the jugs of pre-prepared contrast were immediately removed. During this inspection, we saw that staff prepared contrast when and as it was needed.
- The MRI and CT Department worked in tandem and although there were separate examination rooms their scanner consoles and workstations were within the same room working opposite each other. There was one double door entrance to the private scanning area which gave entrance and exit to MRI and CT patients. This shared area contained consoles, workstations, staff, equipment and paperwork. Patients entered separate doors within this area into the examination areas.
- On our previous inspection, we saw patients from the different modalities were in the scanning workstation area often together prior to examination. This led to issues regarding infection control, privacy and dignity, data protection, and patient and staff safety. We previously witnessed patients in this area awaiting scans in beds, one patient at this time had a clear view of the console of CT which still had on screen the examination of a previous patient.
- Following the previous inspection, a screen was placed between the CT and MRI work stations. This prevented patients being able to view the opposite console areas. However, on this inspection we saw the screen was not drawn whilst a patient was being scanned within MRI. We were not assured staff were utilising the screens consistently and understood what purpose they served.
- On our previous inspection we noted the x-ray waiting area to be cramped with no clear area for patients in trolleys to wait. There had been no change in the

environment observed on this inspection. However, staff told us patients in trollies and paediatric patients were always prioritised to avoid waiting within the waiting room. We noted all waiting areas in the department were not child friendly. There were no toys or children's books within waiting areas. Following inspection, the trust told us they had plans in place to replace children's toys and books.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

- There were clear signs in the diagnostic imaging department informing patients, visitors and staff where radiation exposures were taking place. There were additional signs on the doors which indicated to cleaning staff when the machine was off and they were permitted to enter and clean.
- On inspection, we saw the cannulation room was occupied with a patient and staff member about to cannulate. The door was not closed fully or locked leaving the patient visible to the waiting area. There was a risk the staff member could be interrupted during cannulating a patient.
- The diagnostic imaging department had guidelines to ensure female patients and staff of childbearing age were asked if they were or might be pregnant. There were signs in waiting areas and x-ray rooms reminding patients to inform staff if they may be pregnant. Staff we spoke with were aware of the importance of checking the pregnancy status of female patients. However, on inspection we saw staff did not mention possible radiation risks if a patient were to be pregnant when having a CT scan.
- We saw evidence that radiation protection supervisors (RPS's) had completed recent IR(ME)R training in September 2019. However, RPS we spoke with had no knowledge of the responsibility to mention the radiation dangers associated with having an imaging procedure whilst possibly pregnant. Staff were unaware of recording the dose of a carer or parent if present with a patient during an imaging procedure.
- Diagnostic reference levels (DRLs) are typical doses for examinations commonly performed in diagnostic imaging departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses. However, they can be used as a signpost to indicate to staff when equipment is not operating correctly or when the technique is poor. Our previous inspection found DRLs were not displayed within CT.
- During this inspection, staff within CT were unable to demonstrate adequate knowledge or understanding about DRLs and were referencing levels from 2015. Diagnostic reference levels displayed in CT were from March 2012. We were concerned that staff were not referencing scans to the latest set of recommended national reference doses. Staff were unaware that new National DRLs were in place (as of August 2019).
- Following this inspection, a lunchtime talk on DRLs was given to the radiography staff at Newham by the clinical physics team and a link to national DRLs had been circulated to all staff in the department.The trust told us this would be followed up in the next monthly radiographer team meeting in November.
- Following inspection, the trust told us due to recent vacancies in the radiation protection team additional resource had been put in place. We were told a business case was in development to go forward to the trust business planning process.
- The previous inspection identified patients being cared for on wards were brought into the department by porters without qualified escorts. The trust had agreed this was unsafe practice. On this inspection staff were able to show us risk assessments for patients brought from the ward. Staff told us all patients from wards had qualified escorts. Staff said if a patient arrived without a qualified escort the patient would be taken back to the ward and a DATIX would be completed.
- On review of imaging reports during the last inspection, we saw that the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards. We viewed a selection of imaging reports at this inspection and all met the RCR standards.
- The previous inspection identified clinical audits were not being undertaken within the service to ensure that the requesting referral of an x-ray or other radiation diagnostic test, for example by GPs or other clinicians, was made in accordance with IR(ME)R or MHRA safety recommendations. We saw evidence that clinical audits of requesting referrals were completed following our last inspection.

Requires improvement

Diagnostic imaging

Allied Healthcare Professional staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment.

- Turnover rates within the allied healthcare professionals working in diagnostic imaging were still better than the trust average as identified in the previous inspection.
- In September 2018, staff told us there were issues with retention of trained staff. Newly qualified staff would be trained up to a certain level and they would leave for positions at other trusts. We were told there was a lack of career progression following recurring personal development plans. However, staff told us recruitment had improved greatly. A new on-call system had been introduced limited to a 12-hour shift. We were told an independent HR member of staff had undertaken a series of listening events in the department during March 2019 and issued a report with recommendations.
- During inspection, staff told us a change in skill mix of band five and six radiographers had been agreed and recruitment was in progress. Staff felt the recruitment and retention had improved and led to better staff training.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- During our last inspection, concerns were raised to us overlimited access to consultant radiologists by staff. We were told this was attributed to failedrecruitment rounds andanationalshortage. Consequently,reportturnaround times were reported as being affectedwith delays oftwo week wait outpatients CTs. Demand management measures were implementedwithin the last three to sixmonths prior to inspection. This meant CTs and MRIs were outsourced to an external teleradiology company.
- On inspection senior management told us several speciality doctor radiologists had been recruited to reduce the late reporting list. Staff told us the speciality doctors were authorised to report certain examinations independently without being checked by an appropriate consultant.
- Staff told us they were working outside their scope of practice and did not have enough experience, with some only having worked as a registrar for six months.
- We were told staff had reported to management they felt uncomfortable reporting some examinations given to them. Although there had been no incidents related to mis-reporting, staff we spoke with felt there was a potential risk.
- Management told us structuring of the radiologist working week was on-going with job planning.
- Turnover rates for medical staff were very low at 0 % within the diagnostic imaging service. This increased stability within the service and ensured retention of skills and experience.

Records

Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- Radiology reports were generated electronically and stored using the Computerised Radiology Information System (CRIS) and Picture Archiving and Communication Systems (PACS). These systems could only be accessed by passwords which ensured the images could not be viewed by unauthorised personnel. This meant that patient appointments were not cancelled as electronic records were always available.
- During the inspection in September 2018, we saw that the title and professional registration number of the reporter were not being routinely entered at the end of clinical radiology reports, as per Royal College of Radiology (RCR) standards. On this inspection all radiology viewed were completed in line with RCR standards.
- The last inspection highlighted that patients were transported to the radiology department from other wards with no official patient notes at hand in the case of potential emergency. Patients were transported into the department without any relevant clinical information, infection risks, resus information or escort and portering requirements. Staff we spoke with on this inspection stated that patients were not accepted from wards into the department without patient notes.

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

Requires improvement

Diagnostic imaging

- The last inspection identified unlabelled jugs of pre-prepared contrast and jugs of water stored next to each other within the cannulation room. There was a risk that a patient may be given the wrong fluid to drink. During this inspection we observed staff preparing oral contrast when and as it was needed.
- During inspection, we saw contrast within CT was being used out of license and guidance. Contrast which was labelled to be only used with auto injectors or pumps was being administered orally to patients and we had concerns about how this was stored and utilised within recommended guidance.
- On inspection we saw an open bottle of contrast left on the side within the cannulation room. Staff confirmed that it had been from the day before and stated it would be used again for the days list. Staff were unable to demonstrate safe storage and evidence adequate temperature recording.
- Following inspection, the trust provided additional evidence and information. We were told Newham Hospital was the only Barts Health site where this contrast had been administered orally for patients undergoing abdominal CT scans. We saw evidence from the manufacturer to support that this was safe to administer orally. However, the trust acknowledged practice was different across the Barts Health sites. Following a discussion between the Clinical Director and specialist radiologist it was agreed the contrast identified would no longer be administered as an oral contrast for abdominal CT scans. We were told this would ensure consistent standardised practice across Barts Health.
- In response to concerns raised, the trust ensured contrast was stored in the department in line with the trust medicines management policy. To mitigate further, the department produced a standard operating procedure (SOP) regarding storage of CT contrast media. We were told this would be taken to the monthly governance forum for approval.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents. However, lessons learned were not consistently shared with the whole team and the wider service.

- Staff described when the duty of candour applied and demonstrated an understanding of when it should be implemented. They informed patients when things went wrong and there was evidence of apology in incident investigations we reviewed. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The service ensured they notified the Care Quality Commission under IR(ME)R regulations or to the Health and Safety Executive (HSE) under the ionising radiations regulations (IRR99) requirements when radiation exposure was 'much greater than intended' was notified.

- Prior to our return inspection, details of a recent serious radiation incident had been shared with us. Staff we spoke with from different areas in the diagnostic imaging department could not reference or describe with confidence learning from this incident. We were not assured that learning from this incident had been adequately disseminated to all staff.
- In response to our concerns, we were told the site lead had an established method of disseminating information and sharing learning from incidents with Imaging staff. On receipt of an investigation report the radiography site lead would circulate to the whole imaging team via email. This would then be added to the agenda for discussion at the monthly governance forum (cogwheel) and the monthly radiographer's meeting. Senior management acknowledged that the serious incident report had not been circulated to the complete Newham site leadership team as per the usual process.
- Following this inspection, the trust acknowledged there had not been robust sharing of the learning from this incident with all diagnostic imaging staff. We were told the service was currently running a quality improvement project to explore with staff further opportunities to more effectively share the learning from incidents and complaints. Some of the immediate steps taken by the service to address our concerns has been to discuss incidents and learning at daily safety huddles and ensure these were on the agenda for discussion at cogwheel meetings.

Diagnostic imaging

- The trust were further implementing an auto cascade to divisional leadership teams of serious incident briefing and immediate learning once an SI had been approved by executive and prior to the formal investigation commencing.

Are diagnostic imaging services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

At our last inspection we were concerned about leadership and governance of the service for the following reasons:

- Staff stated that leadership of the clinical support services were not visible or approachable.
- Staff described themselves as highly stressed in a hardworking environment.
- Staff described a culture of fear if they were to raise any concerns. There was a common theme of mistrust within staff to make an official complaint for fear of harassment. Staff were unwilling to elaborate further for fear of reprisal.
- Modality leads did not have scheduled time to perform management duties and were part of the on-call rota so could be away from work for several days during the week leaving their modalities without management to support more junior members of staff.
- We found there were long-standing concerns on the risk register about equipment and environment which had not been addressed. The service told us remaining equipment requiring replacement was considered and prioritised based on risk.
- The service had no schedule in place for quality assurance testing of the home-based computers. There was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- Staff we spoke with discussed how because of being busy they had to perform tasks which were above their banding which made them feel uncomfortable. We were told that band five radiographers were “Left to run the department” and authorised CT scans which radiologists deemed inappropriate due to lack of training and experience.
- During our examination of electronic records, we noted that some plain film scans appeared not to have been reported on by a radiologist. Although there was a standard operating procedure in place to monitor unreported scans, we had concerns that the systems in place did not record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes.
- Radiologists described a stressful environment for reporting of on call studies and meeting demands of CT/MRI investigations, particularly outpatient two week wait patients.

During this follow-up inspection we found:

- The service had a vision for what it wanted to achieve in improving key areas of safety and leadership with the involvement of staff, although it was evident it would take time to ensure all the changes became embedded as routine.
- Leaders were seeking through improved communication and training to promote a positive learning culture that supported and valued staff and move away from what staff perceived as a culture of blame in which they did not feel valued.
- The service was adopting a systematic approach to improve the quality of its governance, ensuring it was properly resourced. It was developing terms of reference for meetings to ensure objectives were clearly defined. Although there were improvements in managing serious incidents improvement in disseminating learning from incidents needed to be actioned as a priority.
- There was a new leadership team in the service and a new trust wide divisional structure bringing more clinical experience into the division. Staff morale had improved.

However,

- The service had set up a quality improvement group to improve quality within the service and ensure there were data sets for measuring diagnostic imaging performance. This work was at an early stage.
- The division was still at an early stage in engaging with service users to plan and manage appropriate services. More progress had been made in engaging with staff.
- Staff did not always follow protocols when storing and administering medicines.

Leadership

Requires improvement

Diagnostic imaging

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The diagnostic imaging department was part of the trust's clinical support services. The leadership structure consisted of site-based leadership (medical and radiographical managerial), modality site-based leadership and site-based imaging governance which reported to the imaging network governance.
- On the last inspection we saw the site lead working an extended day after an on-call session. We were told this was a regular occurrence as they were very passionate about their job and wished to have oversight of the department. On review, we saw the site lead held many roles within the department including RPS, safeguarding lead and infection control lead. Whilst very competent we were concerned about the amount of responsibility and lack of protected time the site lead had. During this inspection, the senior leadership team told us they had recognised the site lead was working on their own and had since introduced additional support.
- Since the last inspection there was a new leadership team within the division, bringing more clinical experience into the management structure to ensure the team had the right skills and abilities to run a service providing high-quality care.
- A deputy head of imaging at NUH site had been introduced and we saw evidence of the additional support this role had brought into the department. Staff we spoke with were very complimentary of the deputy head of imaging and stated they were approachable and pragmatic in their approach.
- There was a new management structure within the administration team. Administration staff told us the morale had greatly improved and they felt better supported with a clear job progression plan.
- On the last inspection staff told us the head of imaging was not visible within the department or available for advice. At the time, some staff were unable to name the imaging or governance leads of the trust. We noted this had significantly improved. All staff we spoke with commented how visible senior leadership team were. We were told the head of imaging regularly met with all staff and fostered an 'open door' policy for staff to speak with them.
- Staff told us the CSS managing director was very visible and approachable and one to one opportunity were given to speak with them.
- We saw meeting minutes of weekly senior team meetings which had a standard agenda of access, governance and patient feedback. Staff told us monthly team meetings and cogwheel meetings were well attended.
- During the last inspection some team leads described how they didn't get time to perform audits or ensure quality within their service. Staff now described an increase of support to further develop their roles. One team lead described how they were encouraged and supported to undertake management training to develop their role. We saw evidence of learning and clinical auditing.
- Senior managers still described a high demand on services, however, they felt the new leadership team within the division meant they could now forward plan effectively.

Vision and strategy

All staff we spoke with were aware of the trust wide vision which was "WeCare", and all staff spoken with knew what the trust values were.

- We spoke with the senior team about the vision and strategy for the department. We were told the draft strategy document had now been completed and would be formally finalised in quarter four.
- Senior management told us they were in the process of promoting band five radiographers to band six. Consultants had been recruited and there had been a focus on recruitment and retention with better staff training opportunities being made available. We were told the business planning for the three-year equipment replacement programme to include a second CT and MRI was still awaiting final approval.
- All staff we spoke with were aware of the development plans for the department and felt the senior management team had been responsive in addressing the concerns that were raised in our last inspection.

Culture

Requires improvement

Diagnostic imaging

Leaders were seeking through improved communication and training to promote a positive learning culture that supported and valued staff and move away from what staff perceived as a culture of blame in which they did not feel valued.

- At the last inspection senior managers had limited awareness of staff morale. At this inspection senior staff recognised that there were some long-standing barriers to change. We found managers had provided opportunities for staff to express their views about the service and areas for improvement and identify how to provide a better service to patients.
- An external peer review was conducted about staff morale and fed back to senior management. All staff we spoke with on this inspection said there had been positive improvement since the change of management, and visible and proactive local leadership.
- The CSS managing director and interim head of imaging was encouraging open and honest discussions to encourage staff to voice both what worked well and what concerned them. Senior management told us they aimed to develop individual accountability amongst staff and pride in their work, although recognised this would take time to establish.
- There was also more emphasis now on sustaining staff well-being and developing supportive ways of working. An example was that now x-ray night shifts were restricted to 12 hours.

Governance

The service was adopting a systematic approach to improve the quality of its governance, ensuring it was properly resourced, and was developing terms of reference for all governance meetings to ensure objectives were clearly defined.

- At our last inspection we identified a lack of process to ensure that all patient scans were being reported or in a timely manner. The systems in place did not fully record or highlight these patients effectively and there was a risk of patient harm due to the lack of processes. On this inspection staff told us scans were outsourced to an external company without filter or consideration as to the type of examination, speciality or time constraint. We were told the external company had sent scans back after four weeks stating no staff could complete the report due to the speciality involved. We raised this with the trust following inspection. We were told during July 2019, a number of exams were sent to the external company for reporting from two trust sites. We were told this was more than the capacity available which resulted in some delays to images being reported. Several mitigations were put in place which included:
  - An agreed plan to report all outstanding images waiting longer than 21 days. As part of this a small number were returned to the trust for in-house radiologists to report. This backlog was cleared during August and at the time of inspection there were five outstanding images to be reported.
  - The external company now provided the trust with a capacity plan so they are aware how many scans can be outsourced.
  - An SOP was in place to monitor what had been outsourced to ensure early notification was received if the external company were unable to report any scans. We were told this had been in place since August 2019, however, it was still awaiting sign off through the cogwheel meeting and the imaging network board.
  - Contract monitoring meetings were set up between the division and external company with agreement of key performance indicators around reporting turnaround times and reporting of incidents.
- We were told there had been no incidents or serious incidents reported via Datix at Newham relating to delayed or incomplete reports from external company.
- Staff previously told us that due to the lack of CPD time, team leads held information sharing meetings and staff we spoke with previously said they did not have enough time for this meeting to be effective and they were regularly held during lunch breaks. During this inspection staff told us they were given protected time for CPD and sessions were held at all trust sites. We saw evidence of CPD in staff records and was assured.
- Learning from incidents and complaints were not previously shared during this forum and was shared through the monthly radiological site meeting (Cogwheel). On inspection, senior staff told us they were currently running a quality improvement project in diagnostic imaging and through this would explore with staff further opportunities to more effectively share the learning from incidents and complaints. Immediate actions taken to address this included discussing

incidents and learning at daily safety huddles and ensuring these were on the agenda for discussion at the site based monthly governance forum (Cogwheel). We were told the leadership team would be implementing an auto cascade to divisional leadership teams of serious incident briefing and immediate learning once the serious incident had been approved by executive and prior to the formal investigation commencing.

Management of risk, issues and performance

- The trust was reviewing its risk register and the process for agreeing risks for inclusion. This was work in progress and would take time to embed.
- Senior management told us that following the inspection in September 2018 every individual item on the risk register had been reviewed and a majority had been addressed.
- A previous site risk identified was sole breast radiologist for the whole service, we were told there was now two breast radiologists within the service. The capital cost of equipment replacement remained as one of the highest risks.
- Staff within CT were unable to demonstrate adequate knowledge or understanding about diagnostic reference levels and were referencing levels from 2015. Diagnostic reference levels displayed in CT were from March 2012. We were concerned that staff were not referencing scans to the latest set of recommended national reference doses. Staff were unaware that new national DRL'S were in place (August 2019).
- Following inspection, evidence submitted stated the current trust local CT DRLs based on a 2015 audit covered a much wider range of examinations than the national DRLs. We were told dose audit data for the period April 2018 to March 2019 was collected from trust CT scanners using a dose management system during April 2019 to June 2019. The data had been sent to Public Health England (PHE). It would also be used to review the Trust DRLs. We were told the data was still being analysed and reviewed. Senior management told us the intention was to issue new Trust CT DRLs this year.
- Following our recent inspection, we were told a lunchtime talk on DRLs was given to the radiography staff at Newham by the clinical physics team and a link to national DRLs had been circulated to all staff in the department. Management told us this would be followed up in the nextmonthly radiographer team meeting in November.
- Following inspection, we were informed there had been some recent vacancies in the staffing of the radiation protection team. This had been risk assessed with a score of 16. Additional resource had been put in place and a business case was in development to be presented to the trust business planning forum.

Information management

The service collected reliable data and analysed it.

- In September 2018 following inspection, we issued the trust with a requirement notice under The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15. This was due to some speciality doctors using personal laptops and desktop computers without official trust antivirus software installed when they reported from home. There was no schedule in place for quality assurance testing of the home computers. Furthermore, there was no assurance of Digital Imaging and Communications (DICOM) grey scale display function compliance.
- Following the last inspection, the consultant radiologists were provided with the appropriate facilities at home to report examinations this included testing of the screens with regard to the correct luminescence. We saw evidence of yearly quality assurance testing.
- Staff we spoke with told us the software installed on home facilities was too slow to cope with the number of images which needed to be viewed in an appropriate way (scrolled, re-visited etc). In addition, we were told there was no appropriate voice recognition facility provided as was present within Newham Radiology Department. This meant consultants still had to attend the department to report examinations which could be completed at home, wasting considerable time travelling and discouraging them from working extra hours at home due to the laborious nature of the task. We were told this had been raised with the Trust who were working with the information and communications technology (ICT) team to scope the feasibility of this.

Engagement

Requires improvement

Diagnostic imaging

The trust was at an early stage in engaging with service users to plan and manage appropriate services. More progress had been made in engaging with staff.

- At the time of our last inspection, staff told us they did not feel their views were reflected in the planning and delivery of the service. They were unable to attend team meetings due to work pressures. We also we found staff considered communication to be top down rather than two-way and there was limited opportunity for open discussion.
- On this inspection we noted an improvement in engagement with staff. We saw that staff were actively engaged and their views were reflected in the planning and delivery of the service. This had been achieved by implementing role development and welcoming and acting on comments from an anonymous pulse check survey of all staff within the department.
- We saw meeting minutes from monthly cogwheel meetings and monthly radiographer meetings. Both had set agendas and we saw they were both regularly well attended.
- Staff told us there was a meeting every two weeks with the managing director of CSS. Staff felt they were visible and welcomed discussion and openness.
- All staff felt the new leadership structure and improved visibility had positively influenced the department. Staff stated it was a happier place to work in. They commented they feel they have something to contribute.

Learning, continuous improvement and innovation

The hospital was making efforts to improve services by learning from when things went well and when they went wrong and to establish a learning culture. There was greater dissemination of information to staff than at the previous inspection, and over time this should improve the service.

- The service was seeking to identify and share learning from incidents, including serious incidents, and from complaints using a range of different approaches.
- The head of imaging advised the service was still committed to improving services by promoting training, research and innovation. Training was to be supported to develop radiographers, sonographers and nurses to undertake tasks to relieve the pressures of the vacancies in radiology.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The service should continue to monitor all areas of the improvement plan, even when apparently complete to ensure new processes are fully embedded.
- The service should ensure all staff are aware of the SOP regarding storage of the contrast media and are made aware of the discontinuation of use of oral contrast for Abdominal CT scans.
- The service should continue to check sharps bins within the department as part of the radiographer daily checklist.
- The service should ensure there is robust sharing of learning from incidents with all diagnostic imaging staff.
- The service should ensure that all staff are aware and understand the new national DRLs.