Barts Health NHS Trust

Whipps Cross University Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Whipps Cross University Hospital

Requires Improvement 

In September 2021 we carried out an unannounced follow-up inspection of diagnostic imaging at Whipps Cross Hospital. The inspection was to investigate if the trust had addressed warning notices we had issued following an inspection of diagnostic imaging in May 2021.

The warning notices issued in May 2021 related to Key Lines of Enquiry (KLOEs) in the safe and well led domains. At this inspection we found:

The provider has complied with the warning notices issued in June 2021. The provider had made improvements to ensure that diagnostic imaging services had more oversight of staffing rotas and risk assessments.

This service has previously been inspected and rated as inadequate. As this inspection was a follow up inspection and we did not inspect all key lines of enquiry, we did not rate the service from this inspection.

See the diagnostic imaging section for more detail on 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 25 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

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

During this inspection we looked only at specific aspects of the safe and well led domains relating to open warning notices.

Staffing

At the last inspection, managers for diagnostic imaging at Whipps Cross Hospital could not evidence sufficient oversight of the radiographers staff rota. At this inspection, we found that managers could demonstrate improved oversight of the rota and staff arrangements to provide out of hours cover.

At the last inspection in May 2021, we viewed the staffing rota, of which eight weeks were available, which did not adequately evidence consistent out of hours cover of radiographers at Whipps Cross Hospital. The trust had one staff rota system for recording 9am to 5pm (regularly contracted) hours, and another rota system for recording shifts outside of these hours. Multiple staff stated that switching of shifts occurred informally outside of either of these rotas. These concerns were corroborated by both frontline and managerial staff on both sites and on the staff rota we saw. We also viewed an example of a serious incident at Whipps Cross Hospital where lack of clarity regarding out of hours cover had led to inadequate patient care.

Following the inspection in May 2021, the imaging leadership took steps to improve managerial oversight of staffing and mitigate the risk of informal shift swapping. Managers developed an improvement plan to manage the change required to address these concerns.

The department removed the use of the separate system for recording out of hours shifts for staff in June 2021 and transferred all existing shifts to a single source for recording staff shifts. This allowed more effective monitoring of shifts both in and out of hours, and allowed managers more oversight of skill mixes between shifts. Managers could also quickly review the total hours worked for individual staff (for compliance with the European Working Time Directive). Following this inspection, we reviewed four weeks of staff rotas and found they reflected improved oversight of rostering staff for shifts, including out for hours cover, across imaging specialities.

The rollout of a single staff rostering tool was supported initially by a weekly rostering steering group, which provided an effective transition from two rostering systems into one single system. We also saw evidence of involvement from the trust rostering software team to provide training and support to rostering leads. Following inspection we viewed site level imaging improvement actions plans which reflected a measured approach to rolling out changes to rotas and informing staff about those changes.

Managers also introduced a standard operating procedure (SOP) to standardise the process by which staff could swap shifts and how swaps could be authorised. The SOP was developed with input from diagnostic imaging staff and formalised the role of managers in authorising the swapping of shifts as a necessary part of the process. We viewed evidence which showed that the need for compliance with this SOP was reinforced in staff huddles and in improvement plans for imaging. This improved the reliability of staff rotas accurately identifying which staff members were on site, at any given time.

Diagnostic imaging

Imaging leadership continued to monitor staffing issues and its impact on other key performance indicators through the imaging dashboard, such as fill rates, vacancies, sickness leave, turnaround times, and appointment cancellations.

Both divisional leadership and frontline staff we spoke with on this inspection stated that the changes in rostering and communication provided better oversight of staff rotas and reduced informal shift swapping.

Is the service well-led?

Requires Improvement 

During this inspection we looked at specific aspects of the well-led domain. Please see the overall summary for more information.

Governance

At the last inspection, the service could not demonstrate sufficient governance processes for the completion, monitoring, and dissemination of risk assessments. At this inspection, we found that managers could demonstrate improved governance processes for diagnostic imaging services, and staff were more aware of the processes for managing risk.

At the last inspection in May 2021, we found that the service was not adequately completing or monitoring risk assessments for imaging equipment or the environment, therefore we were not assured as to the overall safety of patients undergoing diagnostic imaging and screening procedures at the hospital. The service could not demonstrate there were sufficient governance processes in place for the completion, monitoring, and dissemination of risk assessments in the service. Service and radiation safety leads in imaging areas were also unable to consistently provide or identify where risk assessments were managed, disseminated or reviewed. Additionally, clinical staff we spoke to that worked with imaging equipment were often unaware of specifics risks presented by the equipment, where to access information on risks, and what contingency actions should be taken in the event of an incident or need for an emergency stop.

Following the inspection in May 2021, the leadership took steps to improve the completion of risk assessments and staff-wide awareness of risk management within the imaging department. The trust acknowledged that the initial departmental review identified necessary improvements were required in governance processes for risk assessments, and that many risks assessments were not in the current trust radiation risk assessment template (or were readily available to staff).

On this inspection, we found that the risk assessments we reviewed had now been updated, transferred into the up to date format, and a process for validation and review had been introduced. This included oversight of risk assessments by radiation safety leads, with local risk management plans developed in conjunction with site imaging staff to ensure risk mitigation measures reflected each modality and location. Imaging leadership were also now informing site level leadership of quality and safety issues, which had not formally been in place before. This meant the Whipps Cross executive and governance leads had improved oversight of the issues within diagnostic imaging, and could provide involvement if needed.

Diagnostic imaging

Risk registers were updated to reflect the local issues that had been identified on the last inspection. We reviewed the risk register as part of this inspection and found it reflected the concerns identified and had action plans for each risk.

As well as improved site-level oversight of governance and risk related to imaging equipment, imaging departments in each hospital continued cross-site collaboration with other trust imaging departments. This would allow imaging specialities across the trust to maintain benchmarking, information sharing, and learning while also being part of the site-level governance and leadership structures. Senior managers for the department we spoke with suggested "imaging board" would be similar to other cross-site specialities such as maternity or cancer care. Following inspection we reviewed the minutes of the first imaging board meeting, which reflected participation from imaging departments across the trust.

Attendance and the structure of governance meetings had also changed following the last inspection. Local imaging governance meetings had updated the processes for consistently signing off risk assessments. On inspection we attended the monthly Radiation Protection Committee for the site, which was now led by hospital medical director, and found this meeting was providing effective oversight of the risks related to imaging.

We observed that imaging departments displayed more visible and up to date information on how to access specialist advice and support, such as who the local radiation protection advisers (RPA), radiation protection supervisors (RPS), and Medical Physics Experts (MPE) were, and how to contact them. Divisional leads for the imaging department for this site had also developed an intranet resources for imaging staff, which included quick access to risk assessments and risk management plans, staffing rotas, polices, and other learning resources. Staff we spoke with on inspection stated they were now more informed on how to access support and information when they needed it.

At the time of this inspection, the imaging departments had recently transitioned from being a subdivision of Clinical Support Services (a cross-site division within the trust) to being managed more directly by the site hospital leads. The long term arrangements for the governance and leadership structures under this new division were not solidified, however staff we spoke we were positive about improved site-level leadership. The imaging department continued to carry out both the monthly governance meetings, Radiation Incident Review Meeting (RAIN) and Diagnostic Imaging Governance Group (DIGG), alongside the local and trust-wide imaging improvement plan meetings.

Our inspection team

The team that inspected the service comprised a CQC lead 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.