Barts Health NHS Trust

Whipps Cross University Hospital

Inspection report

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Ratings

Overall rating for this service	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  

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

The information we received related to 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 Whipps Cross University Hospital because the concerns raised did not relate to any other parts of the hospital.

Our rating of the diagnostic imaging service went down. We rated them as inadequate.

See the diagnostic imaging section for what we found.

How we carried out the inspection

We visited all parts of the diagnostic imaging service. This included visiting all treatment rooms and waiting areas. We spoke with 27 members of staff which included managers, superintendent radiographers, radiographers, radiography assistants and senior hospital and trust managers. 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/what-we-do/how-we-do-our-job/what-we-do-inspection.

Diagnostic imaging

Inadequate 

Is the service safe?

Inadequate 

Mandatory training

Imaging areas for Whipps Cross 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 a lack of practice development educators and other priorities taking precedence during the pandemic. Previous leadership had not enabled equal access to specialist training opportunities which had affected staff morale and did not meet the needs of patients. Managers had recently introduced a system that supported equal access to specialist training for their roles which needed more time to take effect.

Cleanliness, infection control and hygiene

The service controlled and monitored infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Cleaning records demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment 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.

Environment and equipment

The maintenance and use of premises and equipment did not always keep people safe and the divisional leadership did not have oversight of environmental and equipment risks. Access to rooms containing specialist equipment were not always secured which posed a risk to staff, visitors and patients.

Equipment fault logs and records were poorly maintained and filed inconsistently. Some did not have dates associated and some did not state what escalations and resolutions had been made. Some superintendent radiographers did not have the permissions or were not given administrative time to keep systems indicating faults and audit trails of repairs up to date. New systems were in development.

Ageing equipment did not always work which delayed patient care in some cases. An equipment replacement programme in place which staff told us did not cover all the issues. There were examples where new equipment had been purchased which could not be used because it was not yet integrated into the software systems, rendering them unusable. Manager's told us the equipment replacement programme covered all equipment however funding limitations meant any replacement was done in order of priority.

Diagnostic imaging

Staffing

Managers could not always calculate the number of staff needed for each shift in accordance with national guidance. Staff were still on 9 to 5 contracts and not compliant with the current pay and conditions structure for the NHS. Weekend and out of hours working was fulfilled through an agreement by which staff were rewarded with enhanced payments and time off in lieu. This made it difficult to adjust staffing levels according to the needs of patients.

Managers were unable to measure compliance with Working Time Directive legislation. Two different systems were in use which made it difficult to know if staff were working excessive hours as bank staff at other trust hospitals. Staff stated that switching of shifts also occurred informally outside of these systems, which further decreased management oversight of the overall staff rota This made it difficult to ensure that the staffing model kept patients safe.

Staff were not always able to identify who the medical physics experts (MPE) were. Previous audits had identified this and during our inspection ten members of staff we spoke with informed us that they were still not able to identify the MPEs, understand their roles, or know when would be appropriate to contact them.

Incidents

Staff raised concerns and reported incidents and near misses in line with trust policy. Some staff and management identified a good reporting culture within the department which included equipment breakdown. Other staff felt they did not want to report issues regarding equipment failure due to fear of unfavourable treatment. This reflected the fragmented culture within the department.

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?

Inadequate 

Leadership

Leadership of the service was not stable or embedded. Imaging areas for Whipps Cross Hospital were managed under the Group Clinical Services (GCS) division of the trust. The site leadership model consisted of a general manager, a radiographer site lead, and a clinical director. All were either interim, new in post or about to start in post. Trust wide leadership for the imaging directorate also reflected this position. Trust senior leaders were not fully aware of the challenges faced by the department.

Diagnostic imaging

Vision and strategy

Vision and strategy for what the service wanted to achieve was undeveloped. Trust managers were in the process of putting together individual strategies for each discipline within the department. This was a work in progress. At site level the service was working towards the five-year plan for the newly built hospital, community diagnostic hubs, workforce performance and a regional service within the north east London region. All were in development.

Culture

The service faced challenges relating to the culture of the department. There were factions and separate interests within the workforce. We were informed of allegations of bullying, harassment and sexism. Unresolved issues from previous management styles affected morale and staff did not always feel supported and valued. Staff across specialities and managerial roles recognised that the difficult working environment was having a negative impact on the delivery of the service. Instilling an open culture where staff could raise concerns without fear was a work in progress. 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 Whipps Cross Hospital was performing significantly below the trust average on 60 of the 78 measured questions.

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 the imaging service and a site-based governance model. The service was included in both structures which added time pressure for managers to attend and made it unclear where governance matters should be reported or followed up. Neither system was fully effective in managing the priorities and issues the service faced.

Minutes for 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.

Managing risks, issues and performance

Systems to manage performance and escalate relevant risks to reduce their impact were not always effective. The service faced a number of pressures and assurance processes lacked robustness to meet these challenges. There was an incomplete programme of quality assurance for equipment, where tests were either not routinely completed or were completed and not recorded. The systems in place for recording quality assurance processes were not effective, although some improvements were in development.

Areas for improvement

MUSTS

Location/core service

- 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)

Diagnostic imaging

- 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.