Public Health England

NHS

Screening Quality Assurance Visit Report

NHS Breast Screening Programme
South East London Breast Screening Service

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk

Prepared by: SQAS London. For queries relating to this document, please contact: PHE.LondonQA@nhs.net

Published: November 2018
PHE publications
gateway number: 2018608

PHE supports the UN
Sustainable Development Goals

Contents

Scope of this report

	Covered by this report?	If 'no', where you can find information about this part of the pathway
Underpinning functions		
Uptake and coverage	Yes	
Workforce	Yes	
IT and equipment	Yes	
Commissioning	Yes	
Leadership and governance	Yes	
Pathway		
Cohort identification	Yes	Functions are shared with the pan-London administration Hub
Invitation and information	No	Functions are shared with the pan-London administration Hub
Testing	Yes	
Results and referral	Yes	
Diagnosis	Yes	
Intervention/treatment	Yes	

Executive summary

The NHS Breast Screening Programme aims to reduce mortality from breast cancer by finding signs of the disease at an early stage.

The findings in this report relate to the quality assurance (QA) visit of the south east London breast screening service (SELBSS), on 21 September 2017.

Purpose and approach to quality assurance (QA)

Quality assurance aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure that all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- evidence submitted by the provider(s) and commissioner
- information collected during pre-review visits to the service: administration and clerical, radiography including image review, radiology including image review, medical physics, breast care nursing, pathology slide review, surgical case note review, observation of the multidisciplinary team meeting and a ‘right results’ walkthrough
- information shared with SQAS (London), routinely and as part of the visit process

Description of local screening service

SELBSS is provided by King’s College Hospital NHS Foundation Trust. The service operates from bases at King’s College Hospital, London.

SELBSS serves a total eligible population of 198,073 women, aged 50 to 70. The service participates in the randomised age-extension trial and screens selected women aged 47 to 49 and 71 to 73, which represents an additional cohort of approximately 57,500 women. The service undertakes digital mammography and provides screening at two static sites: King’s College Hospital (104 Denmark Hill), and Queen Mary’s Hospital, Sidcup. The service has 5 mobile screening units. Assessment clinics are held at King’s College Hospital.

Screen-detected cases are referred for treatment to King's College Hospital NHS Foundation Trust (King's College Hospital and Princess Royal University Hospital), Queen Elizabeth Hospital, Queen Mary's Hospital and Guy's Hospital.

During 2015-16, NHS England (London) re-commissioned the provision of breast screening across London. Since 1 April 2016, the model has comprised a stand-alone pan-London call/recall administration hub (the Hub; provided by the Royal Free London NHS Foundation Trust) and 6 clinical services. Prior to this, each breast screening service in London provided an end-to-end pathway which included the functions now provided centrally by the Hub.

Over the past 2 years, SELBSS personnel have experienced significant change and they have risen to and met many challenges. This includes implementing a new commissioning model and new ways of working; and managing the impact of a new national cohort identification system.

Findings

In the 3 year period from April 2013 to March 2016, the uptake rate of the service was 61.2%, 65.8% and 68.3% (national standard is ≥ 70%).

The overall coverage rate in 2015-2016 was 70.8% (69.5% the previous year). There is significant variation in coverage between the clinical commissioning group (CCG) populations served by the service, ranging from 64.1% in Lambeth to 78.4% in Bexley.

Immediate concerns

The QA visit team identified no areas of immediate concern.

High priority

There were two high priority findings:

The specialised skill and knowledge in the administrative team may be at risk, pending a review.

The London breast screening administration hub and the provider have not signed a memorandum of understanding. A signed data sharing agreement is not in place. Agreement has not yet been reached about the administration of the age extension (trial) cohort.

Main findings

1. Inadequate workforce planning in some screening functions.
2. Equipment and estates provision is not fully aligned to the needs of the population and the service.
3. Impaired integration of teams, particularly where they are not co-located.
4. Some processes and protocols across the pathway require updating.

Shared learning

Areas of good practice in the service included:

- the Director of Breast screening has an inclusive approach, is an effective leader and acts as a champion of the service
- decision-making is consensual and there is regular review of performance to make improvements
- the service has a focus on patient outcomes
- staff within the service work very hard to make the screening pathway work for women by putting in place fail-safes and audit to check pathway integrity
- both administrative and clinical staff demonstrate expertise and in-depth knowledge across the screening pathway
- staff demonstrate an ethos of team working, professional growth and development across most areas, promoting upskilling and skill-mix
- staff demonstrate partnership and collaborative working with internal specialities such as the pathology service and external providers such as the surgical teams

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Make sure there is an up-to-date MoU and DSA is in place with the Hub including agreement on the administration of age extension	Service specification No. 24 and local variations	3 months	H	Signed copy of latest MoU and DSA
2	Formalise the arrangements for the deputy director of screening role	Organising a breast screening programme	12 months	S	Arrangements formally documented
3	Improve communication and information sharing between the management and administration teams (based in screening and radiology)	Service specification No. 24 and local variations	3 months	S	Evidence of agreed actions to improve communication and information sharing
4	Demonstrate compliance with national guidance on notifying screening safety incidents	Managing safety incidents in NHS screening programmes	1 month	S	Confirmation that all screening safety incidents are routinely reported to NHSE and SQAS
5	Undertake annual audit of the QMS	Service specification No. 24 and local variations	12 months	S	Confirmation annual audit has been completed
6	Agree a protocol for changing the passwords used on portable media (used to transfer confidential data)	Trust information governance policy	1 month	S	Protocol in place
7	Revise the process of manually recording information on technical	Right Results	3 months	S	Review undertaken and actions completed

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	recall and assessment where already captured on NBSS				
8	Make sure that respective roles and responsibilities are clear (with the Hub) in relation to completing KC62 and BASO returns	Right Results	12 months	S	Successful completion of next KC62 and BASO data returns

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9	Make sure that administration team meetings include both teams (104 Denmark Hill and main radiology)	Service specification No. 24 and local variations	3 months	S	A schedule of meetings that allow both teams to be present
10	Make sure that the highly specialised administrative skill and knowledge is protected, in the context of the pending review	Service specification No. 24 and local variations	Ongoing	H	Evidence that this was considered in any case for change, impact assessment and action plan
11	Make sure that there is sufficient resource (including establishment of posts) in the administration, high risk co-ordination and breast care nursing functions	Service specification No. 24 and local variations	12 months	S	Review of workforce plan and action plan completed
12	Make sure that key service personnel are involved in planning the estates strategy and in designing new premises	Service specification No. 24 and local variations	12 months	S	Written evidence that screening service needs have featured and are appropriately prioritised in the trust's master

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
					estates plan
13	Review lack of IT equipment at QMH site	Service specification No. 24 and local variations	3 months	S	Direct NBSS access or laptop with Daybook software
14	Make sure that there is a plan for replacing mammography X-ray equipment that is over or approaching the end of its intended working life	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	6 months	S	Timetable for equipment replacement
15	Make sure that there is adequate medical physics support for the MRI service	NHSBSP 68 “Technical Guidelines for Magnetic Resonance Imaging for the Surveillance of Women at Higher Risk of Developing Breast Cancer” December 2012	6 months	S	Agreement confirming support is in place

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Make the following changes to the 'Escalation of radiation incidents' procedure (WI 3.7.72): • add clinical lead to the list of responsible persons • add criteria for identifying what constitutes a radiation incident (eg an exposure where the woman is known or suspected to have received a radiation dose greater than intended) • state that medical physics should be contacted with full details of the incident (not just the recorded doses), or reference information on Datix • state who is responsible for notifying external authorities of an incident and state that these incidents may also be reportable to the Health and Safety Executive • state requirements of duty of candour	The Ionising Radiations Regulations 1999. The Ionising Radiation (Medical Exposure) Regulations 2000.	6 months	S	Updated 'escalation of radiation incidents' procedure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
17	Make sure that there are sufficient TORMAM test objects so that image quality tests can be performed at all locations, at the prescribed frequency	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	6 months	S	Evidence that there are sufficient test objects available
18	Remove dose investigation levels from the local rules (as personal dose monitors are not used). Add: 'inform the radiation protection supervisor/ adviser if suspect unintended exposure' and 'comforters and carers should wear a protective lead apron' (or equivalent)	The Ionising Radiations Regulations 1999	6 months	S	Updated local rules
19	Review with the clinical team the practice of requesting prior images for all women (regardless of attendance)	Service specification No. 24 and local variations	3 months	S	Review and actions completed

Identification of cohort

No.			Timescale	Priority *	Evidence required
	(See recommendation 11)				

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20	Agree how to reduce transcription and transfer errors between BS Select and NBSS (that may result from the current use of a single screen)	Service specification No. 24 and local variations	3 months	S	Confirm any actions agreed
21	Review the (SMART) clinic booking template to maximise the smooth throughput of clients (include the number and spread of implant and transport slots)	MoU and operational policy (with the Hub)	3 months	S	Review and agreed actions completed
22	Agree a consolidated health promotion plan and track its progress	Service specification No. 24 and local variations	12 months	S	Health promotion plan in place

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
23	Make sure radiographers' competencies are maintained; provide training to undertake biopsies (advanced practice); and build experience of prone table biopsies	NHSBSP "Quality Assurance Guidelines for Mammography, April 2006, publication no 63 section 6	12 months	S	Completed action plan (including for example, radiographers rotated through screening and assessment clinics)
24	Assess the impact of the symptomatic service on screening	Service specification No. 24 and local variations	6 months	S	Review and agreed actions completed

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
	service resource				
25	Minimise repetitive strain injuries in the mammography workforce	NHSBSP “Quality Assurance Guidelines for Mammography, April 2006, publication no 63	12 months	S	Risk assessment and action plan completed
26	Review mammography case review feedback and agree training needs	NHSBSP “Quality Assurance Guidelines for Mammography, April 2006, publication no 63	6 months	S	Action plan in place

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
27	Clarify managerial, clinical and professional reporting lines for the lead BCN	Service specification No. 24 and local variations	6 months	S	Updated service structure
28	Make sure that all women are seen by a breast care nurse at the beginning of the assessment appointment	Breast Care Nursing guidance	6 months	S	Confirmation that this is taking place
29	Make sure that the process for entering assessment outcome data onto NBSS is accurate and meets Trust policy (and best practice) for maintaining clinical records	Service specification No. 24 and local variations	1 month	S	Protocol
30	Make sure that PRUH breast pathologists report at least 50 primary breast cancer resection specimens per year (and consider sub-specialisation)	Section 4.7.7 of the Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	S	Confirmation of compliance

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
31	Make sure that breast pathologists attain a minimum of 8 breast pathology CPD points/year (GST, PRUH and QEH) and all attend breast pathology courses (at least every 2 years)	Section 4.7.2 of the Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	S	Confirmation of compliance
32	Review the timeframes for requesting pathology reports (including surgical excisions)	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	6 months	S	Summary of review
33	Submit remaining pathology service information to SQAS	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	3 months	S	Submit (1) Reports of UK NEQA breast steroid hormone receptor and HER2 assessments for KCH and GST, and (2) Outcome of KCH CPA /UKAS inspection, July 2017
34	Implement synoptic reports for breast cancer resections at KCH (pathology)	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	S	Synoptic reports in use

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
	(no specific recommendations in this section)				

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
35	Provide women with information on the likely duration of assessment appointments	Service specification No. 24 and local variations	1 month	S	Appointment letter amended
36	Make sure that breast care nurses are supervised, particularly the training post	Service specification No. 24 and local variations, and Breast Care Nursing guidance	12 months	S	Access to supervision in place
37	Take action to minimise interruptions during nurse consultations	Service specification No. 24 and local variations, and Breast Care Nursing guidance	1 month	S	Review and agreed actions completed
38	Make sure oncology is represented at all MDMs	NHSBSP Clinical guidance for screening assessment, 49, 2016	12 months	S	Summary of review and completed actions
39	Make sure QEH surgical is post is filled promptly (and with sufficient breast PAs)	NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009	6 months	S	Confirmation of completion
40	Provide assurance that there is sustainable capacity at Guy's Hospital surgical unit	NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20,	12 months	S	Agreed actions completed

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
		2009			
41	Make sure individual surgeon surgical caseload remains adequate at KCH/PRU	NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009	6 months	S	Summary of review and completed actions
42	Agree stereotactic localisation pathway at PRUH	NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009	6 months	S	Pathway in place

I = Immediate priority recommendation
H = High priority recommendation
S = Standard priority recommendation

Next steps

The screening service provider is responsible for developing a plan, in collaboration with the commissioners, to action the recommendations contained in this report.

The London screening quality assurance service (SQAS) will work with commissioners to monitor the progress made in response to the recommendations, for a period of 12 months following issue of the final report. After this, SQAS (London) will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.