Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Breast Screening Programme South Birmingham

9 July 2019

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About PHE screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or 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 4 UK countries. PHE advises the government and the NHS so England has safe, high-quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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Executive summary

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

The findings in this report relate to the quality assurance visit to the South Birmingham screening service held on Tuesday 9 July 2019.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure 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
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-review visits to South Birmingham between 6 June and 8 July 2019
- information shared with the West Midlands regional SQAS as part of the visit process

Local screening service

University Hospitals Birmingham (UHB) delivers the South Birmingham breast screening service. The service screen within Birmingham Women's Hospital and use 2 mobile screening units covering 6 screening locations. Assessment clinics are held at Birmingham Women's Hospital twice a week. Pathology services and surgery are held at Queen Elizabeth Hospital Birmingham. Medical physics for the service is provided by the Regional Radiation Physics and Protection Service (RRPPS), University Hospitals Birmingham.

The South Birmingham breast screening service has an eligible population of 56,557 (women aged 50 to 71). The service is part of the national randomised age extension trial of women aged 47 to 49 and those aged 71 to 73. The eligible population including the age extension population is 72,779. The total population of the area served is 494,333. This is below the minimum population size of 500,000 as advised in the NHS public health functions agreement 2018 to 2019 service specification number 24.

UHB have recently merged with Heart of England Foundation Trust, which comprises Heartlands Hospital, Good Hope Hospital and Solihull Hospital (HGS). The Director of Breast Screening (DoBS) has confirmed that discussions have commenced between the service and HGS regarding cross site working in breast screening. The QA team were unclear how the service intends to work with HGS as it crosses geographic borders with 2 other screening services. This is an ongoing development and the service should remain involved in discussions and provide updates and developments to the programme board.

Findings

Immediate concerns

The QA visit team identified 1 immediate concern. A letter was sent to the chief executive on Wednesday 10 July 2019, asking that the following item was addressed within 7 days:

- succession planning for the Director of Breast Screening

A response was received within 7 days which assured the QA visit team that the identified risk had been mitigated and no longer poses an immediate concern.

High priority

The QA visit team identified 5 high priority findings as summarised below:

- there are a number of vacancies and gaps in clinical job descriptions which poses a risk – the service should complete a staffing review, update the risk register with vacancies and confirm the plan for recruitment
- the transfer of the Picture Archiving and Communication System (PACS) to Carestream commenced the week of the QA visit – the service should monitor progress and provide written feedback at intervals of 1 months and 3 months following implementation
- the use of the BS Select IT system is a risk to the service and several records had outstanding screening outcomes – this includes the high risk clients whose records should be recorded on both BS Select and NBSS as high risk
- the service should monitor and review their electronic round plan frequently to identify capacity needs for planning efficiently and effectively
- the image review completed by the QA team noted deterioration in image quality in room 3 when comparing images since the last QA visit in 2016 – it has been suggested that the service complete an audit into image quality within room 3

Shared learning

The QA visit team identified several areas of practice for sharing, including:

- an inequalities workshop run by the screening and immunisations team (SIT) where all screening programmes were invited, to share insight and actions for improving uptake
- use of a document to record film reader findings
- use of stereo vacuum biopsies first line in calcification cases
- a short reporting period for pathology specimens and reporting in time for the weekly MDT
- consultant radiographer fully trained and reports breast MRI

Recommendations

The following recommendations are for the provider to action unless otherwise stated.

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	The commissioner to provide assurance around contract management processes and escalation procedures	Service specification No. 24	3 months	Standard	Confirmed agenda of contract management meetings between the trust and commissioners
2	The commissioner to provide evidence that both the high risk and formal contract are signed off	Service specification No. 24	3 months	Standard	Written assurance from the commissioners, that these contracts have been agreed and signed, including date of completion
3	Risk assess sharing the Midlands Medical Partnership practice with City, Sandwell and Walsall Breast Screening Service	Service specification No. 24	6 months	Standard	Outcome of risk assessment. Confirm that all parties are aware of the increased risk to service delivery. Confirm the governance around responsibility
4	Director of breast screening (DoBS) to present QA report at executive board	Service specification No. 24	6 months	Standard	Trust executive board meeting minutes

5	Review and update the programme manager and DoBS job descriptions to reflect national guidance and needs of the service	Breast screening: best practice guidance on leading a breast screening service	3 months	Standard	Updated job descriptions. DoBS to be signed by Chief Executive and programme manager to be signed by the DoBS
6	Review the internal governance structure and accountability between the service and trust	Service specification No. 24	3 months	Standard	Updated flowchart to show governance and lines of accountability
7	Review and update the trust incident policy	Service specification No. 24	6 months	Standard	Updated trust incident policy
8	Implement a formal process for managing incidents occurring throughout the whole screening pathway	Managing Safety Incidents in NHS Screening Programmes	3 months	Standard	Documented process or flow chart
9	Following the implementation of the new PACs review the Quality Management System (QMS) to ensure all policies and procedures are reviewed and updated as appropriate	Service specification No. 24	3 months	Standard	Audit schedule with timelines for review of updating policies and procedures
10	Review and document control all forms used within the QMS and link to relevant policies/protocols	NHSBSP47	3 months	Standard	Index of forms demonstrating document number and version number and/or effective date

11	Develop and agree an annual audit plan covering all parts of the programme	Service specification No. 24	6 months	Standard	Copy of the multidisciplinary team agreed audit plan
12	Develop a process for secure transfer of patient identifiable information	Service specification No. 24	3 months	Standard	Confirmation of the agreed process
13	Implement an individual check of letter to result prior to issuing results letters	The right results: guide to the correct processing and issuing of results 2003	1 month	Standard	Revised working protocol
14	Review data input process to ensure that positive cancer cases are fully audited to ensure data accuracy	Service specification No. 24	6 months	Standard	Outcome of review and resulting actions. Confirmation that all cancer cases are audited.

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Provide succession plan for DoBS vacancy	Breast screening: best practice guidance on leading a breast screening service	1 week	Immediate	Confirmation of plans to replace DoBS.
16	Undertake staffing review and recruitment	Service specification No. 24	3 Months	High	a.) Written confirmation of advertisement and recruitment to vacancies b.) Update risk register to include vacancies and share with programme board
17	Risk access the breast screening unit facilities and accommodation	Service specification No. 24	6 months	Standard	Written accommodation review, risk assessment and plan
18	Update the work instruction and the results spreadsheet for the daily reporting workstation tests to reflect practice	NHSBSP 1303	3 months	Standard	Revised Work Instructions
19	The unit should implement an internal audit programme of the Quality Control (QC) processes including the results spreadsheets	NHSBSP 1303	6 months	Standard	Updated work instructions. Outline of audit programme
20	Implement weekly quality control checks on the MRI used for high risk women	NHSBSP 68	6 months	Standard	Documented protocol and a sample of results

21	Provide feedback on progress of transfer of Picture Archiving and Communications System (PACS) to Carestream PACS	Breast screening: best practice guidance on leading a breast screening service	a.) 1 month b.) 3 months	High	Provide written feedback at 1 and 3-month intervals

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Address backlog of actions to ensure BS Select is up to date with all screening outcomes and all eligible high risk women are added	Service specification No. 24	1 month	High	Written confirmation that all outstanding screening outcomes have been resolved and that all younger high-risk clients have been added to BS Select and outstanding episodes have been added.
23	Complete all outstanding recommendations from the BS Select audit	Service specification No. 24	1 month	Standard	Written confirmation that all recommendations have been completed
24	Audit ceased cases and review ceased protocol to ensure ceasing of clients on BS Select and NBSS	Consent to cancer screening	3 months	Standard	Updated protocol and copy of audit
25	Review of high risk clients reported on BS Select and NBSS to ensure they are included in the NBSS high risk programme	NHSBSP 74	3 months	High	Confirmation that all clients on both NBSS and BS Select are included in the high risk programme

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Review of high risk clients once updated guidance has been received from national office to ensure that all clients have an appropriate genetics referral and high risk protocol	NHSBSP 74	6 months	Standard	Summary review of all high risk clients

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Complete a review into use of mobile units to address capacity and round length	Service specification No. 24	3 months	Standard	Reviewed capacity and round length plan. Provide plan to increase capacity.
28	Review the provision of special appointments to ensure they are accessible in a timely manner	Service specification No. 24	3 months	Standard	Outcome of review and improvement of appointment availability
29	Review and update electronic round plan	Service specification No. 24	6 months	High	Updated round plan
30	Develop a health promotion strategy to increase uptake	Service specification No. 24	6 months	Standard	Provide a copy of the agreed health promotion strategy

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
31	Produce a formal agenda for staff meetings to cover standard items	Breast screening: best practice guidance on leading a breast screening service	3 Months	Standard	Copy of standard agenda
32	Audit 50 historic images against 50 current images in room 3 to ensure no deterioration in visual image quality	Guidance for breast screening mammographers	3 months	High	Written conclusion and outcome of audit
33	Review process and responsibility for updating NBSS after screening on the mobile units	Service specification No. 24	3 Months	Standard	Copy of agreed work instructions
34	Ensure DoBS and advanced practice staff have access to BSIS	Service specification No. 24	3 months	Standard	Written confirmation of accessibility to BSIS

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
35	Review availability of assessment clinics to improve timeliness to assessment (DoFoAa) and access for screening patients	Service specification No. 24	3 months	Standard	Written review of current clinic capacity compared to demand for the service and any plans to improve.

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
36	Review identified clinical nurse specialist hours in screening	Clinical nurse specialists in breast screening	6 months	Standard	Review current establishment in line with NHSBSP guidelines and provide confirmation of plan
37	Develop and implement an assessment protocol, ensuring that assessment: A) meets national guidance B) there is a local protocol for second responsible assessor review C) Standardised practice for the preparation of assessment clinics D) Local protocol when DBT (Digital breast tomography) is introduced	Clinical guidelines for breast cancer screening assessment: fourth edition	A. 3 months B. 3 months C. 3 months D. 12 months	Standard	Updated local written protocol

No.	Recommendation	Reference	Timescale	Priority	Evidence required
38	Run 2018/2019 KC62 to investigate potentially low standardised cancer detection rates (SDRs)	Service specification No. 24	1 month	Standard	KC62 report and results of investigation
39	Implement local duty of candour guidance for screening cases	Service specification No. 24 & Breast screening: interval cancers and duty of candour toolkit	3 months	Standard	Local protocol
40	Introduce imaging team audit/discrepancy meetings to identify and discuss cases	Service specification No. 24 and Clinical guidelines for breast cancer screening assessment: fourth edition	3 months	Standard	Minutes/dates of meetings
41	Implement a local policy for regular review of interval cancer cases	Reporting, classification and monitoring of internal cancers and cancers following previous assessment	3 months	Standard	Local protocol
42	Complete pathology staffing and equipment and create an action plan	Service specification No. 24	3 months	Standard	Action plan developed from business case to be submitted to QA team

43	Sign off the job plan for consultant breast pathologist	NHSBSP 02	3 months	Standard	Signed job plan
44	Review LIMS system requirements to facilitate audit and QA monitoring	NHSBSP 02	12 months	Standard	Written submission of review, findings and plan

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
45	Audit clinical nurse specialist (CNS) telephoning benign core biopsy results	Extended roles 2.5 QA guidelines CNS in screening	6 months	Standard	Audit report and patient satisfaction survey
46	Review access, resources and theatre capacity within breast surgery	ABS Best Practice Guidelines for surgeons in breast cancer screening	3 months	Standard	Provide a copy of the review and plans for action
47	Review framework for checking of surgical data for the ABS audit by each surgeon, taking into consideration the cross-breast screening service working	ABS Best Practice Guidelines for surgeons in breast cancer screening 2018	3 months	Standard	A copy of the agreed plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
48	Undertake job plan review for surgeons to include screening MDT activity	ABS Best Practice Guidelines for surgeons in breast cancer screening 2018	3 months	Standard	Copy of updated job plans
49	Review availability of wire localisations to support all operating lists	ABS Best Practice Guidelines for surgeons in breast cancer screening 2018	3 months	Standard	Confirmation of changes to wire localisation arrangements

Next steps

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

SQAS will work with commissioners to monitor activity and progress in response to the recommendations made for a period of 12 months after the report is published. After this point SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.