Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Outer North East London Breast Screening Service

10 November 2016

Public Health England leads the NHS Screening Programmes

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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 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.

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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 (QA) visit of the outer north east London breast screening service (ONELBSS), held on 9 and 10 November 2016.

Purpose and approach to quality assurance

QA 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 of data collected by the NHS screening programmes
- evidence submitted by the provider(s) and commissioner
- information collected during the following pre-review visits to the service: programme management, administration and clerical, radiography including image review, radiology image review, medical physics, breast care nursing, pathology slide review (Queen's Hospital, Romford), surgical case note review (King George Hospital, Ilford), observation of the multidisciplinary team meeting (King George Hospital, Ilford) and a right results walkthrough
- information shared with the SQAS (London) as part of the visit process

Description of local screening service

The outer north east London breast screening (clinical) service (ONEL) is provided by InHealth Limited (IH), a private provider. The service operates from a local base at the Westland Medical Centre, Hornchurch.

During 2015/16, NHS England (London) re-commissioned the provision of breast screening across London. Since 1 April 2016, the model has been comprised of a stand-alone pan-London administration hub (the Hub), initially supporting the ONEL clinical service, and six clinical services by 31 March 2017. Previously, each breast screening service provided an end-to-end pathway, which included the functions now commissioned centrally from the Hub.

Over the past year, ONEL personnel have experienced significant change and they have risen to and met many challenges. IH and the personnel from the previous screening service (which was provided by the Barking, Havering and Redbridge university hospitals NHS trust, BHRUT) successfully completed the mobilisation of a new ONEL service, on 1 April 2016. This included: the transfer of personnel, the database and some equipment to a new organisation; a move to new premises; implementation of a new pathway model and new ways of working; and managing the impact of the introduction of the new national cohort identification system, BS-Select.

This report references recent data and activity as well as data prior to April 2016, for which the previous provider, BHRUT, was contractually responsible.

ONEL serves an eligible screening population of 85,000 women, aged 50-70. The service participates in the randomised age-extension trial and screens selected women aged 47-49 and 71-73, which represents an additional cohort of around12, 000 women. The service undertakes digital mammography and provides screening at two static sites: Westland Medical Centre and Harold Wood Polyclinic. The service has two mobile screening units, which are periodically sited at three further locations. Assessment clinics are provided at the Westland Medical Centre.

The local pathology service and the surgical services for treating screen-detected cases are provided by the BHRUT, from a pathology laboratory at Queen’s Hospital, Romford and a new breast care unit at King George Hospital, Ilford.

Findings

Immediate concerns

The QA visit team identified no areas of immediate concern.

High priority

The QA visit team identified no high priority concerns.

Key themes

The following were the key themes of the recommendations made:

- clarify leadership roles and strengthen leadership resilience
- undertake demand and capacity planning across the operational service, strengthening continuity and building resilience
- rationalise administrative processes to maximise efficiency and reduce duplication
- finalise the arrangements for comprehensive clinical supervision and support for the nursing team
- develop a screening user satisfaction strategy

Shared learning

Areas of good practice in the service included:

- personnel across the service have demonstrated significant flexibility, commitment and enthusiasm, during sustained periods of uncertainty and change
- a comprehensive quality management system is in place
- checking of registration changes and review of the input of clinical symptoms for every client, prior to film reading
- images are annotated whenever an abnormality is identified
- an experienced team is in place with evidence of effective practice across all screening functions

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Review the service leadership function to ensure that supervision, support, continuity and resilience arrangements meet the needs of the service	Service Specification 24	6 months	S	Evidence of risk assessment, completed action plan and fit-for-purpose supporting documentation, including role and responsibility profiling
2	Ensure that all service-critical contracts, agreements and SLAs are signed and reviewed at agreed intervals	Service Specification 24	3 months and ongoing	S	Confirmation that all agreements are up-to-date
3	Agree the process for compiling and presenting an annual report to the executive board	Service Specification 24	12 month	S	Annual report provided to the executive board
4	Review access arrangements for BS-Select to ensure that there are sufficient user rights and monitors in place to meet the needs of the service	Service Specification 24	3 months	S	Action plan agreed and completed
5	Undertake risk-assessment of resource across the screening pathway, especially the breast care nursing service, and agree a demand and capacity, continuity and resilience plan	Service Specification 24	6 months	S	Action plan agreed and completed
6	Review the local incident management process and supporting documentation to ensure that it is consistent with national guidance	Service Specification 24	1 month	S	SIAF submission process included in the local incident management process
7	Review the schedule of audits and all audit processes, and include these in the quality management system	Service Specification 24	6 months	S	Audit policies, procedures and work instructions in place

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
8	The passwords on the encrypted storage media should be changed in-line with the organisation's information governance and security policy	Right results walkthrough	Immediate	S	Confirmation that the service is compliant with the organisation's policies
9	Review the film-tracking process to ensure that it is efficient and fit-for-purpose	Right results walkthrough	3 months	S	Rationale for the agreed process documented
10	Discuss with the film reading team the benefit of pulling screening packets where previous digital images are available	Right results walkthrough	3 months	S	Rationale for the agreed process documented
11	Review the benefit of manually-recording information on technical recall and assessment where already captured on NBSS	Right results walkthrough	3 months	S	Rationale for the agreed process documented
12	Ensure that ONEL and the Hub understands their respective roles and responsibilities with regard to screening data	Right results walkthrough	3 months	S	Detailed and explicit data ownership and processing agreements in place with the Hub
13	Ensure that all true-positive cases are audited (pathology)	Service Specification 24	6 months	S	True-positive audit completed and repeated at the agreed frequency
14	Agree with the Hub the appropriate frequency of audit of clinic reconciliation	Service Specification 24	1 month	S	Agreed frequency documented in the agreement/policy
15	Agree a user satisfaction assessment strategy for screening activity	Service Specification 24	12 months	S	Report on user satisfaction shared with stakeholders

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Agree a plan and schedule for staff appraisals across the service	Service Specification 24	3 months	S	Plan in place
17	Provide all radiographers with routine access to the systems, to enable individual image and peer review	Service Specification 24	6 months	S	Review facilities are in place
18	Ensure that the privacy of clients is maintained in the clinic setting	Service Specification 24	1 month	S	Risk assessment and completed action plan
19	Assess the key functions and requirements of the planned new premises and ensure that each team has input to the design	Service Specification 24	1 month	S	Assessment and action plan completed
20	Undertake equipment-specific competency assessments for all operators and include the QA checks (and frequency) for each item of imaging equipment, signed -off by the trainer	Ionising Radiation (Medical Exposure) Regulations 2000, Guidance for the implementation of the Ionising Radiation (Medical Exposure) Regulations (2000, 2006) NHSBSP Publication no 75 (August 2014) NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	6 months	S	A copy of the equipment-specific training log for one mammography X-ray unit and stereotactic biopsy unit
21	Formalise the role of the quality assurance (QA) radiographer	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	3 months	S	Documentary confirmation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Record the stereotactic QA checks for needle accuracy as the distance, in millimeters, from the target	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	3 months	S	Confirmation of completion
23	Put in place machine-specific protocols for the mammography units, stating the automatic mode in which they should be routinely used for plain views, magnification, tomosynthesis, etc. and any exceptions to this; and how to use the units for implants, for example.	Ionising Radiation (Medical Exposure) Regulations 2000, Guidance for the implementation of the Ionising Radiation (Medical Exposure) Regulations (2000, 2006) NHSBSP Publication no 75 (August 2014)	6 months	S	Copy of the protocol/s
24	Undertake an audit of blurred images	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	12 months	S	Confirmation that technical recall due to blur is/has been minimised
25	Ensure that MRI equipment QA meets current national guidance	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	SLA to include the requirement to meet current QA guidance
26	Ensure that there are checks in place to confirm that workstations are performing within specification	NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013)	3 months	S	Confirmation of completion

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Make the following changes to procedures and protocols for medical exposures (IRMER file): a) Maintain a list of IRMER practitioners and referrers (including radiologists) and their roles b) Include the mechanism for women to self-refer for mammography (via the Hub or directly with the unit) c) Remove reference to the symptomatic service d) Section 8.3 – remove reference to the administration office e) Section 8.4.3 – ensure that the authorisation process for X-ray is specific to the service f) Section 8.10 - replace ‘medical staffing’ with ‘Office’	Ionising Radiation (Medical Exposure) Regulations 2000, Guidance for the implementation of the Ionising Radiation (Medical Exposure) Regulations (2000, 2006) NHSBSP Publication no 75 (August 2014)	12 months	S	Amended procedures and protocols

Identification of cohort

No.			Timescale	Priority *	Evidence required
28	Ensure that the high risk pathway reporting process meets national guidance	NHSBSP publication 73	3 months	S	Protocol/work instruction that reflects national guidance

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
29	Agree a clinical service health promotion strategy	Service Specification 24	12 months	S	Strategy document detailing health promotion activities

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
30	Ensure that the national leaflet on partial/incomplete mammography is used	Service Specification 24	1 month	S	Confirmation of implementation
31	Audit current practice when imaging clients with pacemakers and ensure compliance with national guidance	Service Specification 24	3 months	S	Confirmation of compliance
32	Ensure use of the national image evaluation form for all images	Service Specification 24	1 month	S	Confirmation of compliance
33	Ensure that all captured mammogram images are transferred to the database	Service Specification 24	Immediately	S	Revised work instruction

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
34	Ensure that radiation exposure charts are available in each room	Service Specification 24	Immediately	S	Confirmation of compliance
35	Ensure that film reader/assessment clinician job plans include time for reflection on performance and service improvement	GMC: Good Medical Practice	12 months	S	Captured in job plan/s

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
36	Agree a plan to address the bottleneck at assessment which is leading to long waits for patients	Service Specification 24	6 months	S	Completed action plan
37	Review the specimen transport function to minimise delays	Service Specification 24	3 months	S	Confirmation of completion
38	Ensure all pathologists/providers that report screening pathology samples participate in the external quality assurance scheme and meet the continuous professional development requirements	Service Specification 24	6 months	S	Confirmation of compliance
39	Monitor the high B2/low B5 biopsy rates and audit if there are any concerns	Service Specification 24	Once 2016 - 2017 data is available	S	Report on monitoring (and audit) outcomes
40	Continue the audit of grade 2 invasive cancers	Service Specification 24	6 months	S	Audit report

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
-	(No recommendations)	-	-	-	-

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
41	Ensure that there is appropriate clinical support and supervision in place for the BCN team	Service Specification 24	6 months	S	Nursing clinical governance structure
42	Review the display equipment in use at the multidisciplinary meeting to ensure that it is fit-for-purpose	Service Specification 24	3 months	S	Report on outcome of MDT equipment review
43	Ensure that the tip of the localisation wires (or the lesion, which is being localised) is surface-marked at the time of localisation.	Service Specification 24	3 months	S	Confirmation of implementation

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

Next steps

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

The Screening Quality Assurance Service (SQAS), London, will work with commissioners to monitor the activity/progress in response to the recommendations made, 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.