Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Kettering

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.

PHE Screening, Floor 2, Zone B, Skipton House, 80 London Road, London SE1 6LH
www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
Prepared by: East Midlands SQAS. For queries relating to this document, please contact: kirsty.dare@phe.gov.uk

Published: September 2018
PHE publications
gateway number: 2018436

PHE supports the UN
Sustainable Development Goals

Executive summary

The NHS Breast Screening Programme (NHSBSP) 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 to the Kettering breast screening service held on 6 July 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 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 programme
- data and reports from external organisations
- evidence submitted by the provider, commissioner and external organisations
- information collected during pre-visit reviews to Kettering breast screening service between June and July 2017
- information shared with the East Midlands SQAS as part of the visit process

Description of local screening service

The total population is 331,145 with an eligible population of 46,406 (women aged 50 to 70). This total population is less than the minimum recommended size of 500,000 as advised in the NHS public health functions agreement 2016 to 2017 service specification number 24. The service has extended the screening age range as part of the national randomised age extension trial to include women aged 47 to 49 and those aged 71 to 73. Small numbers present a challenge to QA processes as performance could be masked or exacerbated.

The provider is Kettering General Hospital NHS Foundation Trust. NHS England Central Midlands commission the service.

The breast screening service operates 1 mobile unit which rotates between 4 locations. All assessment clinics take place within the Kettering General Hospital. The pathology, surgery and nursing teams are also based within Kettering General Hospital.

Findings

Immediate concerns

The QA visit team identified 2 immediate concerns. A letter was sent to the Interim Chief Executive on 7 July, asking that the following items be addressed within 7 days:

- review the MRI service for high risk women within the NHSBSP. There was no approved protocol in place at the time of the visit, although it was already under development by the consultant radiographer
- clarify the criteria for referral for adjuvant therapy. There were no clear criteria at the time of the visit causing inequity of treatment for screening women

The service sent a response within 7 days which assured the QA team the provider had addressed the issues.

An audit of a specific cohort of cases has raised questions that require a more detailed review. This finding will be pursued outside of the QA visit and reported separately.

High priority

The QA visit team identified 8 high priority findings as summarised below:

- ensure that high risk MRI protocols meet the technical standards of NHSBSP and that radiological reporting is in line with good practice (NHSBSP 68)
- ensure images with laterality corrections are easily identifiable and notified to other trusts when cases are sent off site
- ensure the specimen cabinet in theatres is correctly linked to the picture archiving and communication system (PACS) to ensure that a worklist is available
- review film reader documentation to increase clarity of area of concern and assessment plan if recalled
- audit all assessment cases recalled for further assessment following second review
- review assessment documentation to ensure it is efficient for multidisciplinary discussion
- complete the pathology grading audit
- ensure that a single multidisciplinary team (MDT) record is validated in real time and available to the team in clinical areas to support patient care

Shared learning

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

- text reminder service for screening appointments
- early screening clinics now held 3 times per week to improve access in response to user feedback
- communications with screening staff members including a weekly memorandum sent out to update staff and radiography rota sent to personal email addresses
- comprehensive user quality control (QC) system in place (medical physics), contrast enhanced spectral mammography (CESM) and digital breast tomography (DBT) user QC undertaken
- the training matrices developed since Care Quality Commission (CQC) visit including user quality control for all equipment

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Update organogram to show direct reporting line to chief executive or medical director	NHSBSP 52	3 months	S	Organisational chart and escalation pathway
2	Director of breast screening to present the QA visit report at a trust executive board meeting	NHSBSP 40	3 months	S	Trust executive board meeting minutes
3	Implement a job description for the director of breast screening	Service specification no. 24	3 months	S	Job description signed by the chief executive or medical director
4	Appoint or designate a programme manager with clearly defined roles and responsibilities	Service specification no. 24	3 months	S	Details of job plan and a copy of the job description
5	Update the trust incident policy to correctly refer to the requirements of the screening safety incident guidance	PHE guidance Managing Safety Incident in NHS Screening Programmes	12 months	S	Copy of the updated trust incident policy
6	Review and document control all forms utilised within the quality management system (QMS) and link to relevant policies/protocols	NHSBSP 47	3 months	S	Index of forms demonstrating document number and version number and/or effective date

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
7	Agree an audit plan covering all parts of the programme	Service specification no. 24	6 months	S	Confirmation that the methodologies, objectives and reporting mechanisms have been agreed at a multidisciplinary team meeting. A copy of the schedule for a 12 month period
8	Film readers to ensure appropriate separation for each classification of results	NHSBSP 55	3 months	S	Revised right results process

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9	Ensure that high risk MRI protocols meet the technical standards of NHSBSP 68	NHSBSP 68	6 months	H	A copy of the revised standard operating procedure/protocol
10	Review the MRI reporting systems and policies for high risk women within the NHSBSP	NHSBSP 68	Immediate	I	Action plan to implement the requirements of NHSBSP publication 68
11	Ensure images with laterality corrections are easily identifiable and notified to other trusts when cases are sent off site	WHO Surgical Safety Checklist, NPSA 2009	3 months	H	A copy of the revised standard operating procedure
12	Ensure that women who do not attend for screening have no images on PACS	NHSBSP 55	6 months	S	A copy of the agreed standard operating procedure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
13	Link the specimen cabinet in theatres to PACS so that a worklist is available	NHSBSP 71	3 months	H	Confirmation that the specimen cabinet in theatres is linked to PACS

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
14	Review the current administrative staffing structure to provide resilient succession planning	Service specification no. 24	6 months	S	Copy of the review outcome and agreed action plan

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	Develop and implement a health promotion strategy	Service specification no. 24	6 months	S	Health promotion strategy document

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Ensure all staff have access to workstations to undertake image review	NHSBSP 63	6 months	S	Confirmation that improved access to workstations is available for staff to undertake image review
17	Review radiographic staffing levels	NHSBSP 63	6 months	S	Copy of the review outcome and agreed action plan

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
18	Appoint an additional consultant radiologist	Service specification no. 24	3 months	S	Confirmation of the start date
19	Review the quality of the specimen x-rays from the specimen cabinet in theatre	NHSBSP 71	6 months	S	Evidence of the review of the specimen cabinet and future plan

Referral

No recommendations

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20	Review the clerical support given to the breast care nursing team	NHSBSP 29	3 months	S	Confirmation of the dedicated clerical support available to CNSs
21	Provide breast care nursing support at assessment clinics as per guidelines	NHSBSP 29	3 months	S	Confirmation of the agreed plan
22	Ensure all women leave the assessment clinic with a results appointment	NHSBSP 29	3 months	S	Confirmation that all women leave with an appointment and a copy of the amended protocol
23	Ensure every woman is seen at assessment by their responsible assessor	NHSBSP 49	3 months	S	A copy of the amended assessment protocol
24	Ensure stereo guided procedures for women attending assessment clinic are available on the same day	NHSBSP 49	3 months	S	A copy of the amended assessment protocol

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
25	Audit all assessment cases recalled for further assessment following second review	NHSBSP 49	6 months	H	Result of the audit and the outcome of any recall to assessment cases
26	Ensure there is an individual radiological report for each specimen x-ray	NHSBSP 49	6 months	S	Confirmation of the agreed plan
27	Review assessment documentation to ensure it is efficient for multidisciplinary discussion	NHSBSP 49	1 month	H	A copy of the agreed assessment form
28	Ensure locum pathologists meet the requirements of the NHSBSP	NHSBSP 02	1 month	S	Confirmation that all locum consultants are meeting the requirements of the NHSBSP
29	Complete the pathology grading audit	NHSBSP 58	3 months	H	Outcome of the audit
30	Discontinue the use of the local references B3a/B3b for presence or absence of epithelial atypia	NHSBSP 02 / NHSBSP 49	3 months	S	Confirmation that B3a/ B3b are no longer used

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
31	Ensure breast care nurses have access to clinical supervision	NHSBSP 29	6 months	S	Confirmation of the clinical supervision available
32	Ensure breast care nurses have access to level 2 psychological support	NHSBSP 29	6 months	S	Confirmation of the level 2 psychological support available

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
33	Ensure there is a single, validated MDT record	The Characteristics of an Effective Multidisciplinary Team (MDT) NCAT 2010	1 month	H	Confirmation that the MDT record is validated in real time and the record immediately available to the team in clinical areas.
34	Agree a uniform way of assessing benefit for chemotherapy so that there is equitable access to adjuvant treatment	NHSBSP 20	3 months	S	A copy of the agreed protocol
35	Clarify criteria for adjuvant therapy referral	NHSBSP 20	Immediate	H	Confirmation of the criteria agreed by the MDT

I = Immediate
H= High
S = Standard

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/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. 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.