Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Hull and East Yorkshire Hospitals NHS Trust

Public Health England leads the NHS Screening Programmes

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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: Screening QA Service (North).
for queries relating to this document, please contact: PHE.NorthQA@nhs.net

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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 to the Humberside Breast Screening Programme (BSP) held on 10 November 2016.

Purpose and approach to quality assurance

The aim of quality assurance is to maintain minimum 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 is derived from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations as appropriate
- evidence submitted by the provider(s), commissioner and external organisations as appropriate
- information collected during pre-review visits: a selection of evidence completed by the service covering a number of specialist areas within breast screening
- information shared with the SQAS (North) as part of the visit process

Description of local screening service

The Humberside Breast Screening Service has an eligible population of 166,238. This population consists of women aged 47 to 73, including women in the age extension trial (women aged 47 to 49 and 71 to 73) within the geographic area of the Hull, East Riding of Yorkshire, North Lincolnshire and North East Lincolnshire Clinical Commissioning Groups (CCGs). For more information please refer to the Description of Local Breast Screening service section of this report, pages 21.

The service is provided by The Hull and East Yorkshire Hospitals NHS Foundation Trust. It is commissioned by NHS England (Yorkshire and the Humber).

Findings

The immediate and high priority findings, and areas for shared learning, are summarised overleaf. For a complete list of recommendations, refer to the related section within this report or to the list of all recommendations on page 9.

Shared learning

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

- the use of tomosynthesis in assessment of screen detected abnormalities
- the use of Biomedical Scientists in cut up at Hull Royal Infirmary
- introduction of “paperlite”
- succession planning and career opportunities: Advance Practitioners progression to Consultant Radiographer roles
- the nurse led survivorship clinics, a quality initiative which offers a comprehensive patient centred approach to cancer follow up

Immediate concerns for improvement

The review team identified no immediate concerns.

High priority findings

The review team identified 3 high priority issues, as grouped below. Please see page 9 for related recommendations.

Leadership – there is no job description for the Clinical Director role. This is required to define management responsibility across hospital sites, MDTs and individual specialisms. It will also increase clarity of the difference in roles and responsibilities of the Programme Manager and Clinical Director.

Processes – the quality management system (QMS) and standard operating procedures (SOPs) need to be revised to ensure they are accurate and up to date.

Business Continuity – pressures on delivery of the symptomatic service must not compromise delivery of the screening service (eg budget, staffing or equipment). There was no evidence of monitoring by the service to ensure that this is not occurring.

Recommendations

A number of recommendations were made related to the high level issues identified above. These are summarised in the table below:

Level	Theme	Description of recommendation	Full recommendation found on page
High	Leadership	Review clinical director and MDT management arrangements to ensure effective clinical governance	Governance and Leadership Recommendation 1, Intervention and outcome Recommendation 20
High	Processes	QMS and SOPs to be reviewed and updated	Governance and Leadership Recommendation 4
High	Business Continuity	Ensure staffing levels, training and equipment resources are appropriate and effective to cover all national screening programme requirements	Governance and leadership Recommendation 2

For more information on expected timeframe for completion of recommendations, see page 9.

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Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	A detailed job description with allocated time to undertake the substantive roles of Director of Breast Screening and Programme Manager	[1]	28 February 2017	S	Detailed JD for the role and time allocation. Confirmation that the Programme Manager is a substantive appointment.
2	Review staffing levels, training, equipment and resources to ensure they are appropriate and effective in delivering all aspects of the NHSBSP. Succession planning should also be considered	[1], [2]	31 May 2017	S	Details of the review, outcome and succession plans. Confirmation that the role of the assistant director of screening undertaken by one of the consultant radiographers has been formalised. Confirmation: of the name of the replacement lead radiography educator of management training courses attended by the Programme Manager. That there are sufficient PACS workstations to permit all reporting radiographers to work effectively that symptomatic service delivery does not compromise screening service resources that laboratory staffing complies with the current

					RCPath/CPA guidelines for staffing. That there are identified structures in place for the surgical service with responsibilities for clinical and service management.at the Diana Princess of Wales Hospital Grimsby.
3	Internal breast screening management meetings to have a formal record capturing relevant issues raised	[1]	28 February 2017	S	Copies of meeting notes.
4	Review and update 'right results' protocol, ceasing protocol and QMS system to reflect changes in practice. Include a document control process.	[1]	28 February 2017	S	Programme Manager to confirm completion of the process. An updated copy of the Right Results and ceasing protocols Confirmation that all work instructions, standard operating procedures and associated paperwork have headers and footers as part of the document control process. Updated confirmation of ceasing of clients under the mental capacity act including the appropriate make up and documentation from a best interest review panel. In addition, such documents should only be signed by a representative in receipt of an

					appropriate power of attorney for health and wellbeing and not by a general practitioner

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Ensure compliance with Trust IR(ME)R employers procedure	[2]	31 May 2017	S	Confirmation of adherence
6	Create a formal numbered error log to provide a documented audit trail of corrected images and clinical responsibility	[2]	31 August 2017	S	Confirmation of adherence

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority*	Evidence required
7	Review the following failsafe processes Run failsafe batches monthly and do not automatically exclude GP practices scheduled to be screened within 6 months. Use failsafe report on BS Select to prevent longer waiting times for clients moving into the area. Ensure there is a robust failsafe in place for MR women	[1]and [2]	31 August 2017	S	Confirmation of outcome of the review
8	Ensure women who do not attend (DNA) an MRI appointment are offered a further appointment by improving communication between the MR department at Hull Royal Infirmary and the screening service	[2]	31 August 2017	S	Confirmation of outcome of the review

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9	Identify reasons for uptake rate falling below the minimum standard of 70% and develop an action plan	[3]	31 August 2017	S	Copy of action plan
10	All radiographers to attend the MDT for discussion of screening cases in line with national guidelines	[2]	28 February 2017	S	Confirmation of adherence
11	Radiographic staff to ensure lateral views are performed in line with protocol	[2]	31 August 2017	S	Confirmation of compliance
12	Review images categorised as TR/TP to inform learning	[4]	31 August 2017	S	Confirmation of review
13	Review the crystal report “more than 4 images” to authenticate the data on TR/TP.	[4]	31 August 2017	S	Confirmation of review
14	Image review trends to be identified monthly using the proforma methodology (missing nipple in profile or pectoral muscle not shown to nipple level) in line with national guidelines. Act on outcome of image review and use the proforma methodology to support CPD.	[2]	31 August 2017	S	Confirmation of compliance Copy of monthly image review rota

The screening test: accuracy and quality

No.	Recommendation	Reference	Timescale	Priority*	Evidence required
15	Audit TR/TP cases recalled for blurring to see if a cancer was detected on the repeat image(s) when it was not visible on the initial set of images.	[4]	31 May 2017	S	Confirmation of outcome of audit

Referral

No.	Recommendation	Reference	Timescale	Priority*	Evidence required
16	Referrals of high risk women to be received into the service from the genetics or oncology services only	[1]	31 May 2016	S	Confirmation of adherence

Diagnosis

No.	Recommendation	Reference	Timescale	Priorit	Evidence required
17	Ensure there is appropriate turnaround time for breast pathology reports including a review of specimen transportation	[5]	31 August 2017	S	Confirmation of compliance, outcome of review and action plan
18	All breast pathologists to participate in the EQA slide circulation scheme	[5]	30 November 2017	S	Confirmation of adherence
19	An internal audit of B3 biopsies and benign surgical excisions to be undertaken	[5]	31 August 2017	S	Confirmation of audit outcome

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority*	Evidence required
20	Review current MDT process to ensure effective clinical governance; surgeons from both trusts must participate cross site in MDTs to maintain consistent decision processes in both MDTs. MDT decisions must be signed off by the MDT lead	Requirement to meet [6]	31 May 2017	S	Attendance sheet with confirmation that surgeons from both trusts attend MDTs on either site. Confirmation that MDT decisions are signed off by the MDT lead.

21	Identify reason why the service was an outlier on the “Less than equal to 62 days from date of last read to first surgery minimum standard 90%” key performance indicators (KPIs) in the national ABS audit.	[5]	31 August 2017	S	Details of the review and outcome

Key:

I = immediate
H = high
S = standard

Next steps

The Hull and East Yorkshire Hospitals NHS Trust is responsible for developing an action plan to ensure completion of recommendations contained within this report.

SQAS (North) 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, to allow time for at least one response to all recommendations to be made.