Public Health
England

# Screening Quality Assurance Visit Report

## NHS Breast Screening Programme
## West of London Breast Screening Service

**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.

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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.

www.gov.uk/topic/population-screening-programmes
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# 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 West of London breast screening service (WoLBSS), on 30 January 2018.

## 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:

1. Routine monitoring data collected by the NHS screening programmes.

2. Evidence submitted by the provider(s) and commissioner.

3. 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 meetings and a ‘right results’ walkthrough.

4. Information shared with SQAS (London), routinely and as part of the visit process.

## Description of local screening service

WoLBSS is provided by Imperial College Healthcare NHS Trust. The service operates from Charing Cross Hospital, London.

WoLBSS serves a total eligible population of 171,966 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 approximately 50,200 women. The service undertakes digital mammography and provides screening at 5 static sites: Charing Cross Hospital; St Mary’s Hospital, Paddington; Ealing Hospital; Heart of Hounslow Polyclinic; and Uxbridge Health Centre. Assessment clinics are held at Charing Cross Hospital.

Screen-detected cases are routinely referred for treatment to one of the following trusts: Charing Cross Hospital (CX); Royal Marsden Hospital (RMH, Chelsea site); West Middlesex University Hospital (WMUH); Hillingdon Hospital (HH) and London Northwest Healthcare (incorporating Northwick Park, Ealing and Central Middlesex hospitals).

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, WoLBSS personnel have experienced sizable changes and surmounted many challenges. This includes responding to a new commissioning model, changes to their 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 annual uptake rate of the service was 61.47%, 61.25% and 60.75% respectively (national standard is ≥ 70%).

The overall coverage rate in 2016-2017 was 67.06% (70.8% the previous year). There is significant variation in coverage between the clinical commissioning group (CCG) populations served by the service, ranging from 57.04% in Kensington & Chelsea to 73.34% in Hillingdon.

### Immediate concerns

The QA visit team identified no areas of immediate concern.

### High priority

There were 6 high priority findings:

1. 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.

2. Roles and responsibilities between WoLBSS and the Hub in relation to completing accurate KC62 and BASO returns are not clear.

3. The migration to the new PACS system is not completed.

4. The demands of the symptomatic service appear to be impacting on screening service resources.

5. Accreditation status was unclear for the pathology services at Hillingdon Hospital and Royal Marsden Hospital.

6. It was also unclear if 4 of the breast pathologists at the Hillingdon Hospital service participated in an external quality assurance scheme.

## Main Findings

1. There is not a direct reporting line from the Director of Screening (DoS) to the trust executive.

2. There were no established reporting lines between the breast nursing team, the DoS and programme manager.

3. During preparations for the pre-visit, there was evidence of a lack of clarity about resources, responsibilities and leadership across some disciplines/ areas of the screening pathway.

4. Lack of space is an issue in the service, both for staff and equipment. The service feels that it has outgrown the current accommodation.

5. Overbooking due to issues with the SMART booking process may result in poorer experience for clients and puts pressure on mammographers.

6. A review of the radiographic staffing establishment is yet to be undertaken following the publication of new guidance for breast screening mammographers.

7. High risk women are not always identifiable to the breast care nurses at assessment and as a result, the nurses are unable to tailor support in such instances.

8. The service is an outlier for B3 reporting (99.8% higher outlier, the highest in the country) and full specificity (99.8% lower outlier status). This may indicate B3 overcalling of benign cases.

9. There are substantial discrepancies between the interval cancers documented on NBSS and those identified by SHIM (Screening History Information Manager).

## Shared learning

Areas of good practice in the service included:

- an improved culture of reporting and investigating screening safety incidents over the last 2 years
- an ordered Quality Management System (QMS) in place which is well laid out and covers the full range of screening processes
- a process in place to check changes in registration and also to review the input of clinical symptoms for every woman, prior to film reading
- positive and supportive relationship with the trust's IT department
- high standards of the in-house equipment quality assurance programme and noteworthy radiation protection arrangements
- history of consistently maintaining screening round length above the minimum national standard
- nursing team participation in a wide range of health promotion activities in the local community and many examples of good practice

# Table of consolidated recommendations

## Governance and leadership

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 1 | Establish a screening committee led by the director of screening (DoS) to provide strategic and operational oversight of the screening pathway | Service specification No. 24 and local variations | 3 months | S | Terms of reference, membership and agenda |
| 2 | Review of the Service annual report at the executive board level (summary) | Service specification No. 24 and local variations | 12 months | S | Confirmation that annual report (summary) has been shared with the executive team |
| 3 | Make sure the DoS has access to the executive board and a deputy is formally assigned | Service specification No. 24 and local variations | 3 months | H | Updated structural chart and description of revised governance arrangements |
| 4 | Agree a way forward for the administration of age extension with the Hub (and commissioners) | Service specification No. 24 and local variations | 3 months | H | Confirmation of agreement |
| 5 | Establish a formal reporting line and working relationship between the DoS, Programme Manager (PM) and the breast care nursing team | Service specification No. 24 and local variations; Breast Care Nursing Guidelines | 1 month | S | Updated structural chart and description of revised governance arrangements |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 6 | a. Finalise and sign the MoU with the Hub.<br>b. Clarify and agree roles and responsibilities with the Hub in relation to reviewing data and completing accurate KC62 and BASO returns | Service specification No. 24 and local variations<br><br>Right Results | 3 months | H | Detailed protocols (in place with the Hub) as per signed MoU |

## Infrastructure

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 7 | Clarify responsibilities with the Hub to avoid duplication of reports/audit tasks and its monitoring within the administrative function | Service specification No. 24 and local variations | 6 months | S | Detailed protocols in place (with the Hub as part of MoU) |
| 8 | Involve key screening service personnel in the pending review of facilities and in the design of new premises | Service specification No. 24 and local variations | 12 months | S | Written evidence that all screening service needs have been assessed and prioritised in the estates and facilities plans |
| 9 | Commit to a timescale to promptly replace mammography X-ray equipment that has reached the end of working life (over 7 years) | NHSBSP Equipment Report 1303: Routine Quality Control Tests for Full Field Digital Mammography Systems (October 2013) | 1 month | S | Installation schedule and progress summary (for new equipment, already purchased) |
| 10 | Add to each respective protocol the total procedure dose (rather than the dose per projection), for digital breast tomosynthesis (DBT) and contrast-enhanced spectral mammography (CESM), in the diagnostic reference level section | The Ionising Radiation (Medical Exposure) Regulations (2017) | 6 months | S | Updated protocols for DBT and CESM |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 11 | Examine the monitors used by pathology and surgery for viewing images and ensure that they meet the current NHSBSP standard/ are fit for purpose | Guidance on image display equipment for use in breast screening: NHSBSP publication no 71 (December 2010) | 6 months | S | Summary of the outcome of the discussions (led by MPS) |
| 12 | Complete the migration to the new PACS | Service specification No. 24 and local variations | (a) 1 month<br>(b) 6 months | H | (a) mitigation in place<br>(b) Confirmation that migration has been completed |
| 13 | Increase the frequency of checks for orphan images | Service specification No. 24 and local variations | 3 months | S | Updated protocol (with weekly checks) |

## Identification of cohort

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 14 | Make sure the possibility of transcription and transfer errors between BS Select and NBSS (that may result from the current use of a single screen) is reduced | Service specification No. 24 and local variations | 3 months | S | Confirm any actions agreed |
| 15 | Sufficient resource to be in place for delivering the high risk pathway | Service specification No. 24 and local variations | 3 months | S | Confirmation of action taken |

## Invitation, access and uptake

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 16 | Review SMART clinic booking with the Hub to maximise the smooth throughput of clients | MoU and operational policy (with the Hub) | 3 months | S | Review and agreed actions completed |
| 17 | Formulate a consolidated health promotion strategic plan for the screening service and track its progress through the new Screening committee (See recommendation 1) | 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 |
|---|---|---|---|---|---|
| 18 | Assess the impact of the symptomatic service on screening service resources along the pathway | Service specification No. 24 and local variations | 3 months | H | Review and agreed actions completed |
| 19 | Review the radiographic resource necessary to meet the requirements of the service | Guidance for breast screening mammographers' (December 2017) | 12 months | S | Workforce plan |
| 20 | Clarify/formalise training and development plans with the radiographic workforce | Service specification No. 24 and local variations | 12 months | S | Summary of agreed actions |
| 21 | Use the national consent form when using the Eklund technique | Service specification No. 24 and local variations | 1 month | S | Updated protocol |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 22 | Review the practice of recording radiation dose for every client | Service specification No. 24 and local variations | 1 month | S | Outcome of review |
| 23 | Increase opportunities for team discussion of subtle cases (from reading) to improve individual cancer detection rates | Service specification No. 24 and local variations | 1 month | S | Summary of agreed actions |

## Diagnosis

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 24 | Enable access to a second radiologist for discussion of discharged cases | Clinical guidance for breast cancer screening assessment | 1 month | S | Evidence of agreed actions |
| 25 | Document the reason for recall to assessment (and ideally the level of suspicion) in advance of the assessment clinic so that it is clearly understood by the breast Clinical Nurse Specialist (CNS), prior to seeing/interacting with the woman | Service specification No. 24 and local variations | 3 months | S | Evidence of agreed process for documentation |
| 26 | Provide accreditation status for the pathology services at (a) Hillingdon Hospital and (b) Royal Marsden Hospital | Service specification No. 24 and local variations | 1 month | H | Confirmation of compliance for all pathology services |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 27 | Confirm that all (4) breast pathologists at the Hillingdon Hospital service participate in the external quality assurance scheme | Service specification No. 24 and local variations | 1 month | H | Confirmation of compliance for all breast pathologists |
| 28 | Provide individual primary cancer resection specimen numbers for review (following merger of WMUH, HH and CX pathology services) | Service specification No. 24 and local variations | 12 months | S | Complete data |
| 29 | All involved pathologists should complete at least 8 breast pathology-related continuous professional development points per year | Service specification No. 24 and local variations | 12 months | S | Confirmation of compliance for all (linked) pathology services |
| 30 | All involved pathologists should have completed a relevant breast pathology course within the last 12 months | Service specification No. 24 and local variations | 12 months | S | Confirmation of compliance for all (linked) pathology services |
| 31 | Audit B3 outlier status and agree actions | Service specification No. 24 and local variations | 12 months | S | Summary of B3 audit |

## Referral

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 32 | Audit of the calls received following invitation to assessment to ensure that access to nursing support is maximised | Service specification No. 24 and local variations | 12 months | S | Summary of audit and resulting action plan |

## Intervention and outcome

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 33 | Review of locally produced information/ leaflets at an appropriate frequency | Service specification No. 24 and local variations | 12 months | S | Confirmation that all local leaflets/information have been reviewed |
| 34 | Review the wording of the results letter around how/where to access treatment | Service specification No. 24 and local variations | 1 month | S | Outcome and completed actions |
| 35 | (Continue to) reduce prevalent round benign biopsy rates, to meet (at least) the acceptable standard, working with the pathology team | Consolidated programme standards | 12 months | S | Completed action plan |
| 36 | Use the current cancer registry matching exercise to ensure that all potential interval cancers have been logged, reviewed and classified and entered on NBSS:<br><br>(a) Confirm to SQAS the number of cancer registry potential interval cancers up to 2015<br><br>(b) Submit to SQAS a schedule for review of potential intervals.<br><br>(c) Submit to SQAS quarterly updates on progress against schedule | NHS Breast Screening Programme Reporting, classification and monitoring of interval cancers and cancers following previous assessment | <br><br>3 months<br><br>3 months<br><br>3 months (rolling basis) | H | Confirmation of results of review and data entry on NBSS |

## Surgery

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 37 | Discuss all patients to be treated at Charing Cross Hospital in the symptomatic MDM | Clinical guidance for screening assessment, 49 (2016); Quality Assurance Guidelines for surgeons in breast cancer screening, 20 (2009) | 3 months | S | Confirmation of compliance with updated protocol(s) |
| 38 | Review factors impacting on timely provision of biopsy results to ensure women receive a biopsy result appointment within one week of biopsy | NHSBSP Clinical guidance for screening assessment, 49, 2016; NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009 Guidance for surgeons in breast cancer screening | 6 months | S | Outcome of review, summary of agreed actions and |
| 39 | Use typed referral proformas, ensure all fields and diagnostic information related to image findings are complete, send via secure email | NHSBSP Clinical guidance for screening assessment, 49, 2016; NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009 | 6 months | S | Summary of agreed actions |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 40 | Review 2016-17 caseload data when available to ensure individual surgeon surgical caseload is adequate | NHSBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009 | 6 months | S | Outcome of review |
| 41 | Ensure Lead Surgeon has agreed job description and appropriate protected activity (PA) allocation for the role | NSHBSP Quality Assurance Guidelines for surgeons in breast cancer screening, 20, 2009 | 3 months | S | Confirmation of job description and PA allocation |

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.