QUALITY ASSURANCE GUIDELINES FOR ADMINISTRATIVE AND CLERICAL STAFF

NHS BREAST SCREENING QUALITY ASSURANCE COORDINATION GROUP FOR ADMINISTRATIVE & CLERICAL STAFF

NHSBSP Publication No 47

October 2000

CONTENTS

ACKNOWLEDGEMENTS

The National Quality Assurance Co-ordinating Committee for Administrative & Clerical Staff would like to thank all the NHS Breast Screening Programme screening offices who have contributed to the preparation of these guidelines. In particular it would like to thank all the Quality Assurance Reference Centres (QARCs) and the national co-ordination team for all the help and guidance they have given to the authors.

GLOSSARY OF TERMS

Administration details

The basic administrative and demographic details relating to a screening office (SO), including SO code, address, telephone number, contact names, which are sent to a health authority (HA) prior to the commencement of screening, or whenever changes occur.

Area and address codes

Codes, originating from the HA system, that are used to annotate areas of residence within the HA boundary. These codes can be used to specify batches, denote a SO coverage area within a HA and are usually mapped by postcode boundaries.

Assessment clinics

Specific clinics set up with the intention to assess women who have an abnormal screening mammogram. Procedures such as further x-ray views, ultrasound, fine needle aspiration cytology (FNA), core biopsy (WBN), clinical examination may be carried out at an assessment clinic in order to diagnose whether a woman has breast cancer.

BASO guidelines

These guidelines, published jointly by the British Association of Oncologists (BASO) and the NHSBSP (currently under review), relate to the diagnosis and treatment of breast disease, including breast cancers diagnosed through the breast screening programme.

Batch

A term used to describe a defined group of women to be taken through the screening process. Each batch of women will be given a unique identifying number.

Batch default timescales

Standard timescale values used for every batch of women specified by a SO. These are set up on both the SO computer system and the HA computer system. The timescales documented include the number of weeks the prior notification list (PNL) should be prepared before the first woman in the batch is screened; the number of weeks prior to screening that the screening batch list (SBL) should be sent to the SO; the years of birth to be used in the batch specification parameters and the episode ignore flag settings.

Cease

The term used to describe a woman who is no longer included in the screening programme. See NHSBSP Guide to Good Office Practice, Call/Recall Status: Cease and Suspend, May 1997 (under revision). Issues of consent are covered in NHSBSP Good Practice Guide 1, Consent to Breast Screening, November 1998.

Client labels

Labels that are usually printed from the SO computer system, giving basic demographic data of each client. The client labels are used for a variety of purposes including client information sheets, screening packets, films etc.

Clinic control sheet

A list of women attending a screening or assessment clinic on a particular day. The clinic control sheet gives appointment times and the name of the woman attending with her screening number along with other user definable items. SOs operating the National Breast Screening Computer System (NBSS) most commonly use

this term.

Core biopsy

A core biopsy or wide bore needle biopsy (WBN) is a procedure used during the assessment process to obtain a pre-operative diagnosis for a woman who potentially could have breast cancer. The procedure involves inserting a wide bore needle into the area of uncertainty in a woman's breast, sometimes under ultrasound or x-ray control, and withdrawing a core of tissue from that area. The core of tissue is then sent to the histopathology laboratory for histological examination by a pathologist.

Coverage

The term used to define how effectively each service is screening their eligible population. Coverage is expressed as the percentage of women screened over the total eligible population in a three-year period. This information is obtained from the KC63 statistical tables.

Data Protection Act

The 1998 Data Protection Act, which came into force on 1st March 2000, covers the release, storage and collection of all personal data.

Data protection officer

The person in a hospital usually responsible for ensuring that the Trust and its employees uphold the principles of the 1998 Data Protection Act.

Data protection registrar

The person responsible for administering the 1998 Data Protection Act.

Deducted

A term used by health authorities to describe a client who is removed from their register. The most common reason for this is that the client has moved to another area. All screening information on women who are deducted from one HA is automatically transferred to her new HA across the network.

Defaulters from assessment

Women who attend for screening but when recalled for further investigations at an assessment clinic, refuse to attend.

Directory of screening sites

NHSBSP publication updated annually, listing all screening services with their screening sites (mobile and static). This is used by SOs to primarily to identify where previous films are held for women who have recently moved into their area.

Disaster recovery

A service usually purchased from computer Level 2 support teams enabling screening services to continue their core business if their computer system suffers a major failure. All services should have a strategy in place to ensure that the screening service can continue in the event of a major computer failure.

DNA

Abbreviation for "Did Not Attend". This applies to women who do not attend for their screening appointment.

DNA letter

A letter sent to a screening client who has failed to attend for screening, encouraging them to attend in the future.

Early recall

The term used to describe women who are asked to re-attend for assessment earlier than the routine three year recall. A common early recall interval is 1 year.

Eligible women

All women in the age range 50 – 64 who have a call/recall status of normal. Women over 65 are eligible to be screened if they self refer.

End code

The computer code used to describe the closure of a screening episode for a woman invited for screening. The end codes usually describe the outcome of the screening episode. See NHSBSP Good Practice Guide No. 3, March 2000 (National Breast Screening System Users).

Episode

The period of time, during which all screening activity associated with an eligible woman, takes place. In terms of the computer system, it is the storage medium for all the data associated with a woman's invitation and attendance or non-attendance for screening. It should be opened and closed within 6 months.

Estimated coverage

Information obtained from the HA analysis job – [AJ] [BCE] – Estimated screening coverage. This print provides information on the number of eligible women held on the HA database and can be displayed in several formats. (See Appendix 1).

Exeter system

The colloquial name for the HA computer system which operates in England and Wales. Written by the NHS Information Authority (NHSIA) based in Exeter, it is known as the Exeter System

Failsafe batch

A batch created with the specific intention of inviting women who for some reason have been missed out of routine screening batches. The failsafe batch is created by trawling through the HA database and selecting women who have not been invited for screening within the previous 36 months. Inviting women through the failsafe batch process ensures that those who have moved into the area etc. receive a screening invitation.

Family Health Service Authority (FHSA)

The FHSA ceased to exist as a separate statutory body from 1st April 1996. FHSAs were amalgamated with health authorities on that date and the FHSA function is now carried out from within the HA structure.

FNA

Fine needle aspiration cytology (FNA) is a procedure used during the assessment process to obtain a pre-operative diagnosis for a woman who potentially could have breast cancer. The procedure involves inserting a fine needle into the area of uncertainty in a woman's breast, sometimes under ultrasound or x-ray control, and withdrawing cells from that area. The cells are spread onto a slide, stained and examined by a cytopathologist.

GP labels

Printed labels containing GP name and address details. These can be used for sending GP reports out to each practice.

GP lists

A list of all current general practitioners with patients resident within the HA boundaries. The HA produces this list.

GP referral

A type of non-batch referral, used when a woman is referred for screening by her general practitioner outside the normal pattern of batches (see non-batch referrals).

GP reports

A report generated by the SO computer system and sent to general practitioners reporting the result of screening for each individual woman.

HA analysis job

HA analysis jobs are programmes run on the HA computer system to produce information for SOs or HAs in the form of printouts. A full list of all the analysis jobs available on the system is found in the NHS IA (Exeter system) manual. (See Appendix 1)

HA end code

The code applied to the screening episodes created on the HA breast screening computer system. End codes generated by the SO computer system are transmitted to the HA across the network. These are then translated into appropriate HA end codes which are automatically applied to the screening episodes on the HA computer system. No clinical information is stored on the HA system.

Integrity checker

Programmes run on both the SO and HA computer systems to check the integrity of the data held. A list of women who have not been invited for screening outside a user definable period of time is produced by the HA integrity checker [AJ] [BCSI] and forwarded to the SO.

Invitation letters

The letter sent to eligible women inviting them to attend for a screening mammogram.

Invitation stage

The date upon which the HA transmits the screening batch list to the SO across the network.

Level 2 support team

An external agency (usually a commercial company) that is contracted to manage the breast screening computer software for the SO staff (Level 1). This support includes installation of new software releases, advice and guidance on software and hardware issues, error fixing and liaison with the software producers, amongst others depending on the contract specification.

KC62 report

The annual return submitted to the Department of Health by every breast screening service in England. This

statistical table is generated by the SO computer system. It is from this report that the majority of outcome measures of a breast screening service are derived.

KC63 report

The annual return submitted to the Department of Health by every HA in England about its breast screening activity. Coverage statistics are derived from this statistical report.

NBSS

An abbreviation for the National Breast Screening Computer System which is operated by 60% of the breast screening services in England, Wales and Northern Ireland. This was originally written by the computer development team based at Oxford Regional HA and is colloquially known as the "Oxford System".

Network acknowledgement

The electronic acknowledgement sent to the originator of a transfer by the Network. Data sent across the network is automatically allocated a transfer number by the originators computer system. The network will automatically send an acknowledgement to the originator to tell them that the transfer has been received.

NHSIA

Abbreviation for the National Health Service Information Authority. The NHSIA is responsible for developing the HA computer system colloquially known as the 'Exeter System'.

Non-batch referral (NBR)

Non-batch referrals are screening episodes created by the SO for women outside the normal batch process. There are three types of non-batch referral episodes. These are self-referrals, GP referrals, and early recalls.

Non-participant

A woman who does not wish to participate in the NHSBSP.

Normal result

The result, usually in the form of a letter, sent to the woman, indicating that her recent NHSBSP mammogram showed no evidence of cancer. This letter is issued by the SO following authorisation by the reporting radiologist. It is also known as a routine recall letter.

National Vocational Qualification (NVQ)

National qualifications set up by the Government to enable people with little or no formal qualifications to obtain accreditation for the work that they carry out. NVQs take the form of evidence based learning rather than by examination.

Open episodes

An episode without an end code applied and therefore incomplete.

Outcome measures

Statistics used to monitor the performance of a screening service. Outcome measures are derived from the Department of Health statistical tables (KC62 and KC63).

Oxford system

The colloquial name for the national breast screening computer system (NBSS).

Paper acknowledgements

An acknowledgement of a data transfer received either by a HA or SO, sent on paper.

Personal development plan (PDP)

A plan, usually drawn up by an employee's line manager during the staff appraisal process. This documents the training and development needs of that individual.

Primary health care team (PHCT)

The team consisting of the general practitioner, practice nurse, district nurse and other health care professionals, who care for patients in the community.

Prior notification list (PNL)

The list of eligible women in a batch sent to general practitioners prior to the invitation for screening being issued. Instructions for completion are displayed on the front sheet, usually in the form of a letter. The PNL contains basic registration and demographic information about each woman due for screening.

Privacy markings

Markings on documents and envelopes etc., that indicate that the information contained within is confidential. 'PRIVATE & CONFIDENTIAL' are common privacy markings.

QA Reference Centre (QARC)

The administrative centre for the Quality Assurance Team, QA Director and QA Co-ordinator. The QARC administers the quality assurance aspects of the breast screening programme for which it is responsible.

QA visit

A visit by the Quality Assurance Team to monitor the performance of a screening service. The Quality Assurance Reference Centre (QARC) administers this process.

QA team

The Quality Assurance Team is group of professional representatives taken from the regional breast screening services. They represent all disciplines involved in the breast screening programme.

Quality management system (QMS)

The documented and controlled policy statements, procedures and work instructions of a breast screening programme, written to ensure a high quality service is available to every woman invited for screening.

Recall to assessment

A woman will need to be recalled to assessment if her screening mammogram shows an area of abnormality that requires further investigation. At an assessment clinic, further procedures will be carried out to ascertain the extent of the abnormality.

Registration changes list

This is a list of changes to the registration details of women eligible for screening. Changes to the registration details are sent via the network from the HA to the SO, and the SO database is automatically updated.

Responsible and non-responsible GPs

A 'responsible' general practitioner has the majority of his/her patients resident within the HA boundary where the practice is located. He/she will therefore be 'responsible' to that HA.

A 'non-responsible' general practitioner is sometimes called a 'fringe GP'. The majority of his/her patients are resident within another HA boundary and he/she will therefore be responsible to that other HA.

Result letter

The letter sent to a woman after screening indicating the result of her attendance.

Screening batch default values

The values used by the SO for the majority of screening batches it specifies. The batch defaults are printed from the SO computer and set up on the HA computer system and used as the basis for all screening batches. (See also batch default timescales)

Screening batch list (SBL)

The list of women included in a batch. The SBL is transmitted from the HA to the SO via the network and contains registration and demographic details for each individual woman.

Screening batch specification

This details the parameters of a batch and is sent to the HA for action.

Screening cycle

The period of time between two screening episodes. The screening cycle for the NHSBSP is three years.

Screening episode

The period of time, during which all screening activity associated with an eligible woman, takes place. In terms of the computer system, it is the storage medium for all the data associated with a woman's invitation and attendance or non-attendance for screening. It should be opened and closed within 6 months.

Screening history

All information about a woman's previous screening episodes.

Screening Office (SO)

The administrative centre of the screening service.

SO Manager (SOM)

The manager of a breast screening service's administrative team and a member of the service's management team.

Screening packet

A medical record containing the mammograms and paperwork associated with a woman's screening attendance.

Screening round plan

The screening round plan documents how, where and when all eligible women will be screened by a screening service over a three year screening round.

Screening site

The site at which screening takes place. This can be at a mobile or a static unit.

Screening team

The team working within a screening service. This consists of radiologists, radiographers, administrative staff, surgeons, pathologists, nurses, etc.

Self referral

A type of non-batch referral episode for women who wish to self-refer for screening. (See non-batch referral)

Service level agreement (SLA)

A signed, written agreement between two parties detailing what each will provide to the other.

Slippage

A term used to describe the length of time a screening programme has slipped behind in the NHSBSP screening cycle.

Standard statistical reports or tables

The statistical programmes or tables that are available on the SO computer system. This will include the KC62, amongst others.

Suspend

The use of suspend has now been discontinued. It was a term used to suspend a woman from the screening programme for a defined period of time.

Technical recall and technical repeat

The terms used to describe a screening film which is not technically adequate for a report to be issued. Further information can be found in NHSBSP Good Practice Guide – Collecting, Recording, Monitoring and Reporting Technical Recall/Technical Repeat Examinations, April 2000.

Unscreened women

The term used to describe women who have not attended a screening appointment.

Uptake rate

The number of women attending for screening expressed as a percentage of those invited for a given time period and is usually derived from the KC62.

Abbreviations

A&C	Administration & Clerical
AJ	Analysis Job
BASO	British Association of Surgical Oncology
BSS	Breast Screening Service
DNA	Did Not Attend
DOH	Department of Health
FHSA	Family Health Services Authority (no longer in existence)
FNA	Fine Needle Aspiration
GP	General practitioner
HA	Health Authority
IT	Information Technology
NBSS	National Breast Screening Computer System
NHSBSP	National Health Service Breast Screening Programme
NHSIA	National Health Service Information Authority
PCG	Primary Care Group
PCT	Primary Care Trust
PDP	Personal Development Plan
PHCT	Primary Health Care Team
PNL	Prior Notification List
QA	Quality Assurance
QARC	Quality Assurance Reference Centre
QMS	Quality Management System
SLA	Service Level Agreement
SO	Screening Office
SOM	SO Manager
VDU	Visual Display Unit (monitor)
WBN	Wide bore needle (core biopsy
WTE	Whole Time Equivalent

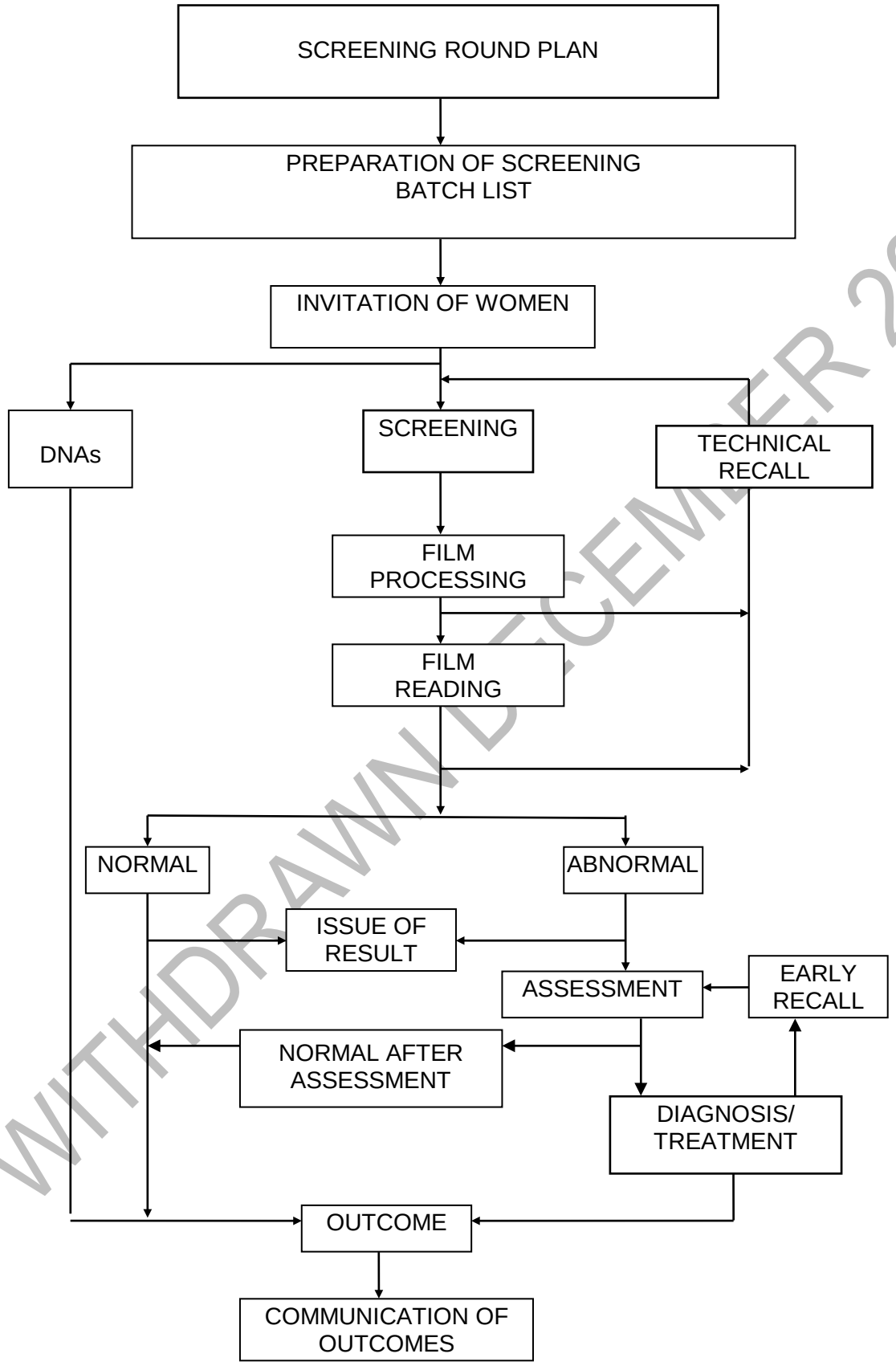
1.0 INTRODUCTION

The aim of quality assurance in the NHS Breast Screening Programme (NHSBSP) is the maintenance of minimum standards and the continuous improvement in the performance of all aspects of breast screening in order to ensure that women have access to a high quality service wherever they reside. These quality assurance (QA) guidelines have been produced by the National Health Service Breast Screening Programme QA Co-ordinating Committee for Administrative and Clerical Staff and whilst they focus on the administration aspects of breast screening quality assurance, they are in unison with and complementary to the QA guidelines produced by the other professional groups involved in the screening process.

These guidelines describe arrangements for quality assurance in administration in the NHSBSP. They set out operational policy and define standards. The operational policy is defined by processes necessary for the efficient and effective running of a screening office. The standards define the level of service expected, and provide a measure against which the service delivered by A&C staff can be audited. The role of Primary Care Groups (PCGs) and the subsequent Primary Care Trusts (PCTs) in the screening service is not yet clear. This relationship will develop over the next few years and these guidelines will be kept under review to reflect any resulting changes.

These guidelines also include information about implementing quality management systems in breast screening services

2.0 THE BREAST SCREENING PATHWAY



SECTIONS

3.0, 4.0, 5.0, 6.0, 7.0,12.0

3.0, 4.0, 5.0, 6.0 12.0

3.0, 4.0, 5.0, 6.0, 7.0, 12.0

5.0, 6.0, 7.0, 12.0

5.0, 6.0 7.0,10.0 12.0

6.0, 12.0

5.0, 6.0 7.0, 9.0, 12.0

5.0, 6.0,7.0, 9.0, 10.0 12.0

5.0, 6.0 9.0, 12.0

3.0, 4.0, 5.0, 6.0 7.0, 9.0 12.0

3.0 WORKING WITH HEALTH AUTHORITIES

3.1 SCOPE

The working relationship between the SO and the HA.

3.2 OBJECTIVE

To ensure timely and accurate exchange of information between the SO and HA.
To ensure that all women aged 50-64 are invited once every three years.

3.3 RESPONSIBLE PERSONS

Programme manager
Screening office manager (SOM)
A&C Staff at the SO
A named individual at the HA

3.4 DOCUMENTATION

Service Level Agreement (SLA)
Screening Batch Specifications
Prior Notification Lists (PNLs)
Screening Batch Lists (SBLs)
HA Analysis Jobs [AJ] (Appendix 1)
Non-batch Referrals
KC63
Quality Management System (QMS)

3.5 METHODS

3.5.1 Administration details

The HA should send its administration details to each SO it serves, prior to the commencement of screening, and again when any changes occur. This includes items such as, name of HA contact, correspondence address, telephone number(s), lists of responsible and non-responsible GPs with their local codes, local address and area codes and GP partnership codes. Much of this information can be produced by the HA using the HA system analysis jobs. (See Appendix 1)

Service level agreements (SLAs) should be drawn up between a SO and the health authorities it works with. These agreements should document the provision of service to the SO by the HA and vice versa, working timescales and the financial arrangements as described in this guidance document. They should also be signed and reviewed by both parties on an annual basis. These SLAs should be in addition to any SLA or contract negotiated and agreed between the commissioning HA and the screening service host Trust for the provision of breast screening for its residents. This SLA or contract should be negotiated on a 3 yearly basis with an annual review.

3.5.2 Defaults

The SO should send its own screening batch default values to each HA it works with, prior to commencement of screening, and again when changes in practice occur. These values can be documented, printed and transmitted by some screening office computer systems for the purpose of informing HAs.

3.5.3 GP lists, area and address codes

The HA should provide the SO with updated lists of new GP registrations, GP registration changes and terminated GP registrations of both responsible and non-responsible GPs at least monthly. Area and address code changes should be notified to the SO regularly along with any HA boundary changes as and when they occur in order that they can assess any potential impact on their screening population.

3.5.4 Estimated coverage

The HA should provide the SO with information relating to the population it is responsible for, including the number of eligible women for call and recall. This should be produced at least every six months, or as requested by the SO.

3.5.5 Women not on HA lists

Identification of eligible women not on HA lists needs close liaison with a variety of agencies, depending on the circumstances of the individuals concerned. Close liaison between the HA and the SO is required to ensure that all eligible women are offered screening. Further details can be found in Good Practice Guide No 1, Consent to breast screening, November 1998 and Good Practice Guide No 2, Screening policy for women not on health authority lists, June 1999.

3.5.6 Screening round plan

The SO must provide the HA with its screening round plan prior to commencement of each screening round. The plan should include as a minimum details of the method of selection, the location of screening, screening timescales and the timing of failsafe batches. Any updates to the screening round plan should be sent to the HA for information.

3.5.7 Batch specifications

The SO must provide the HA with batch specifications within its own batch default timescales. A batch specification from the SO should be actioned by the HA within 7 days of receipt. A copy of the batch creation print [AJ] [BCR] (See Appendix 1) should be forwarded to the SO for information and audit purposes.

3.5.8 Prior notification lists (PNL)

The HA must produce the prior notification lists (PNLs) from each batch at least 8 weeks prior to the commencement of screening and in accordance with the batch specification parameters (3.5.6) supplied by the SO. The HA should request the return of PNLs from GP practices at least 6 weeks prior to the commencement of screening of that batch, and keep a written audit record of the movement of PNLs between the HA and GP practices.

3.5.9 Screening batch list (SBL)

The HA should ensure that it transmits all SBLs via the network to the SO at least 4 weeks prior to the commencement of screening of that batch. It is important that the HA runs the appropriate analysis jobs within the batch specification timescales provided by the SO and when a batch has reached the invitation stage on the HA system, it is actioned within 2 working days.

3.5.10 Screening end codes

The SO should update the HA with the outcome of all screening episodes closed at least weekly or as the screening office computer system allows.

The HA should have all HA screening episodes closed with an appropriate end code within 6 months of the episode opened date. Open episodes on the HA system should be monitored at least every three months by using the outstanding open episodes analysis job (see Appendix 1). This print should be sent to the SO for actioning and the outstanding open episodes transmitted to the HA via the network or recorded manually on the analysis job print. If recorded manually on the analysis job print, it is important to include all the relevant information required by the HA to close the episode appropriately, ie. Date of first offered appointment, date of screening, date of early recall if appropriate and end code.

Network acknowledgement of receipt by the HA of any paper transfers of screening end codes e.g. non-batch referrals, is preferable to paper acknowledgements.

3.5.11 Registration changes and women who move

The HA should keep the SO informed of any client registration changes at least monthly, in accordance with the SO defaults set on the HA system. The HA should also inform the SO of screening women deducted from, and new registrations added to, the HA system at weekly intervals using the routine analysis jobs for this purpose (See Appendix 1).

Registration changes notified to the SO by women attending for screening should be sent to the HA via the GP, as the responsibility for changing registration details lies with the GP. However, other approved methods of updating the HA system can be agreed between the individual SO and HA.

3.5.12 Screening Cycle

The HA should provide the SO with a list of unscreened women through the integrity checker analysis job at least monthly. This print can be used as a tool to monitor the effectiveness of the failsafe batch process. It is important that the SO plan failsafe batches into their screening round plan at least once every three months to ensure that women are not missed and offered an appointment at the appropriate time intervals. This should be documented in the SLA between the HA and the SO.

3.5.13 Women who are ceased

The HA should provide the SO at least annually with an analysis job print that details all women who are ceased on the HA system. This print can be used to check the details and reasons for ceasing held on the SO system and also to refer any queries to the general practitioner. The SO should hold documented evidence on the reason for ceasing on file for every woman with a ceased status.

3.5.14 KC63

The HA is responsible for submitting the Department of Health annual return KC63 to the QARC in accordance with the set deadlines. It is the responsibility of the HA to ensure that the number of open episodes recorded in Table A2 of the KC63 is kept to a minimum and the HA must work with the SO to ensure that most, if not all open episodes are closed prior to submitting the final KC63 report to the QARC.

3.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure timely and accurate exchange of information between the SO and HA	Service level agreement drawn up between SO & HA The HA should provide the SO with the following analysis job prints (Appendix 1):	- Reviewed annually
	[AJ] [BGEN]- Administrative details	- Pre-screening set-up - When changes occur
	[AJ] [PHGC] - GP changes [AJ] [BGEN] - GP details GPLists/Postcodes/Areas/Address Codes	- At least monthly - As requested by SO - At least six monthly
	[AJ] [BCE] - Estimated Screening Coverage [AJ] [BCNS] - Uninvited Women	- At least six monthly - At least six monthly
	[AJ] [PHRC] - Registration Changes [AJ] [BSH] - Screening History [AJ] [BCSI] - Unscreened Women [AJ] [BSDB] – Changes to date of birth [AJ] [BCO] - Outstanding Episodes Episodes closed on HA system	- Weekly - Weekly - Monthly - Monthly - At least quarterly - Within 6 months
	[AJ] [BCX] - Deductions	- Weekly
	[AJ] [KC63] - DOH Statistics, Coverage	- Annually
	[AJ] [BSCW] - Ceased Women	- Annually
	Screening batch defaults should be identical on both HA & SO systems	- Reviewed annually
	Batch specification actioned by the HA	- Within 7 days of receipt
	PNLs sent to GP practices PNLs received back from GP practices	- At least 8 weeks prior to screening - At least 6 weeks prior to screening
	Screening batch lists transmitted to SOs	- At least 4 weeks prior to screening
	Screening end-codes transmitted to HAs	- At least weekly or as computer system allows

OBJECTIVE	MEASURE	MINIMUM STANDARD	TARGET
To ensure timely and accurate exchange of information between the SO and HA.	The number of open episodes displayed in Table A2 on KC63 expressed as a percentage of the total eligible population.	≤ 0.25%	0%
To ensure that all women aged 50-64 are invited once every three years.	The number of unscreened women less the number of unavailable or ineligible women expressed as a percentage of the total eligible population using [AJ] [BCSI].	≤ 0.5%	≤0.1%
	The number of uninvited women expressed as a percentage of the total eligible population using [AJ] [BCNS]	≤0.5%	≤0.1%

3.7 REFERENCES

3.7.1 *Breast Screening Reference Manual*. Exeter: NHS Information Authority

3.7.2 *National Breast Screening System User Guide*. Oxford: Hyder

3.7.3 *Guide to Good Office Practice, No 8, Call/recall status: cease and suspend*. Sheffield: NHS Breast Screening Programme 1997 (under revision)

3.7.4 *Guidelines on quality assurance visits.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication No.40) (under revision)

3.7.5 *Good Practice Guide, No 1, Consent to breast screening.* Sheffield: NHS Breast Screening Programme 1998

3.7.6 *Good Practice Guide, No 2, Screening policy for women not on health authority lists.* Sheffield: NHS Breast Screening Programme 1999

4.0 MANAGING CALL AND RECALL IN BREAST SCREENING

4.1 SCOPE

The identification of eligible women for screening

4.2 OBJECTIVE

To accurately identify all women in the age range 50-64.
To invite all eligible women for screening once every 3 years.
To ensure that all women receive their first invitation for screening before their 53rd birthday.
To enable women 65 and over to attend for screening.

4.3 DOCUMENTATION

Estimated screening coverage print
Screening round plan
Screening history print
Lists of unscreened women
Open episode print
Screening batch specification
Quality Management System
KC62
KC63

4.4 RESPONSIBLE PERSONS

SO manager
A&C team
A named individual at the HA

4.5 METHODS

4.5.1 Screening round plan

A screening round plan covering a 3 year period should be prepared using the estimated screening coverage print available from the HA. The plan must document the method of call ie. by GP practice, area code or age band, the sites of screening and the date and length of time at each site. Every member of the screening office team must have access to the plan in order to provide accurate information to women as and when required.

4.5.2 Screening batch specification

Using the screening round plan, the SOM or nominee must specify batches to ensure that the total eligible screening population is invited within each 3 year screening round. It is also important that batch specification follows the same pattern as for previous screening rounds, in order that individual women are recalled on, or prior to, their 36 month recall date.

4.5.3 Failsafe batches

The SOM or nominee must specify failsafe batches at least once every 3 months to ensure that all eligible women are invited. Failsafe batches must be included within the screening round plan of the unit. This is to ensure that all women are recalled within 3 years of their previous invitation. The effectiveness of failsafe batch planning can be monitored using lists of unscreened women produced by HA analysis jobs, to quantify the number of women not

receiving a screening invitation. The specification and timing of failsafe batches must be included in the SLA between the HA and SO.

4.5.4 Women who move

An eligible woman moving into an area must be identified using the appropriate HA analysis job print (See Appendix 1) and sent an appointment within 3 years of their last offered appointment. It may not be necessary to invite the woman for screening immediately as she may be picked up in a routine batch within the 3 year recall period. Women who move into the area without any previous screening history must be called immediately if they are aged 53 or older.

4.5.5 Recall period

The screening round plan and implementation of screening batches of women must be actioned to ensure that 90% or more of women are invited within 36 months of their previous screen. When a service achieves less than the 90% target, it is deemed to have slippage and an action plan should be prepared, in consultation with the commissioning HA and QARC, to ensure that the slippage is addressed. Additional resources may be required to achieve this.

4.5.6 GP or self referrals

Appointments must be made available for women who wish to self-refer. These will be women who are:

- Aged 65 and over.
- Eligible women missed from the PNL or SBL.
- Eligible women who respond to an invitation more than 6 months since their first offered appointment.

It may not be possible for these women to be offered an immediate appointment at the most convenient location for them, due to the location of mobile units etc. However, an appointment must be offered within 12 months of the request. Consideration must also be taken of the woman's round length in order to meet the 36 month recall target. Younger women entering the target age range for the first time are only guaranteed their first appointment before their 53rd birthday and should wait to be selected with their normal screening co-hort.

4.5.7 Women not on health authority lists

There are a number of categories of women in the eligible age range who are not registered with a GP and subsequently not called for screening as they are not on the HA database. Screening units have a responsibility to maximise coverage of eligible women in their target population and should therefore be accessible to women in this category. Examples of women in this category include:

- Diplomats
- UK residents temporarily working abroad
- Missionaries
- Armed forces personnel
- Residents of long stay hospitals

Further information on how to identify these women and the eligibility of foreign nationals can be found in NHSBSP Good Practice Guide 99/2.

4.5.8 Screening episodes

The HA must be kept up to date with the end codes from screening (including GP and self-referrals) via the network or other appropriate means, and monitored using the HA open episode print. Weekly transmission of results should take place or in accordance with the method used by the screening office computer system. All screening episodes must be closed within 6 months of the date of the first offered appointment. It is important to remember that women with open episodes on the HA system will not be invited for screening until all previous episodes are closed.

4.5.9 DNA's

Every eligible woman who fails to attend her first offered appointment must be given a further opportunity to attend, in writing. There is evidence to suggest that allocating women who do not attend another timed appointment yields better attendance results than asking women to contact the service for another appointment when convenient. This is a resource issue and each individual breast screening service should investigate fully the best course of action for them, given existing uptake rates and available resources.

4.5.10 Call/Recall Status

All women will have a call/recall status of 'Normal' unless ceased from the screening programme. Women can only be ceased from the programme for the following reasons:

- They are terminally ill.
- They have had a bilateral mastectomy.
- They have voluntarily withdrawn from the screening programme and have signed the appropriate withdrawal letter.

Once it has been established that a woman falls into one of these categories, her call/recall status must be amended on both the screening office computer system and the HA computer system to ensure that the woman is not called for screening again. Women with the call/recall status of 'ceased' should be audited annually on both the HA and screening office systems, to ensure that women have not been inappropriately ceased.

4.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To accurately identify all women in the age range 50-64	Monitor the number of unscreened women using [AJ] [BCSI]	Monthly
	Assess eligibility of women moving into the SO catchment area using [AJ] [BSH]	Within 7 days of receipt
	Assess eligibility of women with date of birth changes using [AJ] [BSDB]	Within 7 days of receipt
To invite all eligible women for screening once every 3 years	Perform an audit of ceased women on both HA and SO computer systems using [AJ] [BSCW]	Annually
	Failsafe batches documented in the screening round plan and actioned.	3 monthly or less
To ensure that all women receive their first invitation for screening before their 53rd birthday	Assess age of women moving into the SO catchment area using [AJ] [BSH] & [AJ] [BCSI]	Within 7 days of receipt

OBJECTIVE	MEASURE	MINIMUM STANDARD	TARGET
To invite all eligible women for screening once every 3 years	KC63 The percentage of eligible population invited for screening within the previous 3 years	≥85%	100%
To ensure that all women receive their first invitation for screening before their 53rd birthday.	KC62, Table A The sum of column 1, lines 1,2,&3 expressed as a percentage of column 1, line 9.	≥90%	100%
To enable women 65 and over to attend for screening if requested.	KC62, Tables E, F1 & F2 The sum of column 3, lines 6&7 expressed as a percentage of column 3, line 9	≥2%	≥3%

4.7 NATIONAL STANDARDS

OBJECTIVE	CRITERIA	MINIMUM STANDARD	TARGET
To ensure that women are recalled for screening at appropriate intervals	The percentage of eligible women whose first offered appointment is within 36 months of their previous screen	≥90%	100%

	The percentage of the eligible population screened within the previous 3 years (Coverage)	≥70%	≥70%

4.8 REFERENCES

4.8.1 *Guide to good office practice No 3: Procedures for women who move practice/district.* Sheffield: NHS Breast Screening Programme 1997 (under revision)

4.8.2 Annual KC63 Statistics, Department of Health

4.8.3 Pearson A. *Guide to KC62*. Sheffield: NHS Breast Screening Programme 1997

4.8.4 Faux AM, Lawrence GM, Wheaton ME, Wallis MG, Jeffery CL, Griffiths RK. *Slippage in the NHS breast screening programme: an assessment of whether a three year screening round is being achieved.* J Med Screen 1998;5:88-91.

4.7.5 *Guidelines on quality assurance visits*. Sheffield: NHS Breast Screening Programme 1998 (NHSBSP publication No. 40) (under revision)

4.7.6 Stead MJ, Wallis MG, Wheaton ME. *Improving uptake in non-attenders of breast screening: selective use of second appointment.* J Med Screen 1998;5:69-72.

4.7.7. *Good practice guide 99/2. Screening policy for women not on health authority lists.* Sheffield: NHS Breast Screening Programme 1999.

5.0 LIAISON WITH THE GENERAL PRACTITIONER & PRIMARY HEALTH CARE TEAM

5.1 SCOPE

Communication and exchange of information between the SO, GP and the PHCT.

5.2 OBJECTIVE

To enable GPs and PHCTs to understand the function & operation of the NHSBSP.
To enable GPs and PHCTs to promote breast screening effectively to their patients.
To ensure timely and accurate exchange of information between the GP, PHCT and the SO.

5.3 RESPONSIBLE PERSONS

GPs and the PHCT
Screening Staff
Health Promotion Staff

5.4 DOCUMENTATION

Screening round plan
Prior notification lists (PNLs)
GP Reports
Registration change notifications
Reports relating to the outcome of screening by GP practice
Quality Management System

5.5 METHODS

5.5.1 Screening round plan

All GPs must be informed as to when and where their eligible women will be invited for screening during each screening round. If possible, a copy of the screening round plan should be circulated each GP in the area for information.

5.5.2 Identification of GP practices to be screened

The SO must identify all GP practices with eligible women resident in their catchment area. This will involve close liaison with the HA to ensure that both responsible and non-responsible GPs are accurately identified. With the advent of PCGs and PCTs, from April 2001 all screening will be carried out on the basis of GP responsibility following PCG and PCT boundaries. Any changes to the screening round plan as a result of this new policy must be carefully monitored to ensure that women are not missed from screening.

5.5.3 Communication

Prior to commencement of screening, lines of communication with the GP practices involved must be established. This can be achieved by personal visit, telephone or written communication. Supplies of information leaflets, posters and promotional material should be provided for the practice during the screening period with any special instructions regarding women recalled for assessment, location of assessment clinics, names of breast surgeons etc.

5.5.4 Prior notification list (PNL)

The screening service must ensure that the GP practice is aware of the prior notification list and the appropriate action to be taken when checking the list. Every practice must be made aware that women can only be ceased from the programme for the following reasons:

- They are terminally ill
- They have had a bilateral mastectomy
- They have previously withdrawn from the programme and have signed an appropriate withdrawal letter.

Issues surrounding women with physical and mental disabilities must be dealt with on an individual case by case basis and full discussion should take place between the screening service, the GP and carers. Further advice on this issue can be found in NHSBSP Good Practice Guide – Consent to breast screening, No.1, November 1998.

5.5.5. Registration Changes Notifications

During the screening process, SOs will become aware of changes to the registration details of women registered with GP practices. It is ultimately the responsibility of the GP to inform the HA of these changes, however this may not be feasibly possible. It is therefore important that the SO works closely with both the GP and the HA to ensure that all the appropriate procedures are in place so that registration details can be updated quickly on all computer systems.

5.5.6 Information and Training

There are a number of NHSBSP publications that provide guidance on the information and training needs of GPs and PHCTs. Screening office managers play a substantial role in promoting the service to GPs, along with other members of the screening team. Breast screening study days for GPs and PHCTs have proved to be a highly successful method of promoting the service provided. Uptake by GP practice should be regularly monitored and those practices achieving less than 50% uptake should be encouraged to play an active role in encouraging previous non-attenders to attend for screening.

5.5.7 Progress of patients through screening

The SOM must ensure that GPs are informed in writing of their patients progress, at all stages of the screening process, in a timely manner. This includes:

- GP reports for women receiving routine recall results at least weekly.
- Women who are recalled to assessment at least weekly.
- The outcome of assessment for every woman assessed within 2 working days of the clinic attendance.
- Women who are recalled for technical reasons at least weekly.
- Lists of women who do not attend for screening at least weekly.
- Defaulters from assessment and technical recall appointments within 2 weeks of a second failed clinic attendance.

5.5.8 Reporting the Outcome

It is essential that GPs are informed of the outcome of screening their practice. At approximately 6 months after screening has been completed, a report should be issued to the practice informing them of the outcomes, ie. Uptake rate, numbers of screen detected cancers found, a list of women who did not attend etc. Screening offices using the national breast screening computer system have a specialist report for this purpose (breast screening feedback report).

5.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To enable GPs and PHCTs to understand NHSBSP and its function.	Monitor inappropriate referrals Supply detailed information about the screening programme to each practice Organise study days/seminars etc for PHCTs	Monthly Every screening round Every screening round
To enable GPs and PHCTs to promote breast screening effectively to their eligible patients	Monitor uptake of individual GP practices Identify practices with less than 50% uptake	Every screening round for comparison
To ensure a timely and accurate exchange of information between screening office, GPs and PHCTs	Monitor inappropriate referrals Information sent regularly to each GP practice:- • GP Reports • Recalls to assessment • Assessment outcomes • TRs • Defaulters from assessment and technical recall appointments • DNAs • Outcome Statistics	Monthly At least weekly At least weekly Within 2 working days At least weekly Within 2 weeks of a 2nd failed clinic attendance At least weekly Within 6 months of screening the practice

OBJECTIVE	MEASURE	MINIMUM STANDARD	TARGET
To enable GPs and PHCTs to promote breast screening effectively to their eligible patients	The percentage uptake for each practice screened	≥70%	≥70%

5.7 REFERENCES

5.7.1 *Messages About Breast Screening - Guidelines for Health Promotion Specialists, Primary Health Care Teams & Screening Unit Staff.* Sheffield: NHS Breast Screening Programme 1995 (NHSBSP Publication No 31)

5.7.2 Austoker J, Humphreys J. *Involving Primary Care Teams in the National Breast Screening Programme* CRC, University of Oxford, July 1990
5.7.3 Austoker J, Humphreys J. *Visiting Primary Care Teams to explain their part in the Screening Programme* . CRC 1989.

6.0 THE SCREENING PROCESS

6.1 SCOPE

The SO contribution to the process of screening every eligible women.

6.2 OBJECTIVE

To ensure that an appropriate, timely and accessible screening invitation is available to all eligible women.
To enable women who do not respond to a first invitation to have a further opportunity to attend.
To ensure that women receive the correct result.
To introduce a quality management system

6.3 RESPONSIBLE PERSONS

Programme Manager
Superintendent Radiographer
SOM
A&C staff
Radiographers

6.4 DOCUMENTATION

Screening round plan
Failsafe batch
Clinic control sheet
Invitation letter
Result letter
Registration changes to GP and HA
DNA letter
Client label
GP label
Quality Management System

6.5 METHODS

6.5.1 Screening round plan

Using the estimated screening coverage analysis job print from the HA, each screening unit schedule (mobile and static) should be drawn up to take into account all public and statutory holidays, planned equipment maintenance downtime, the re-booking of DNAs and GP and self referrals. In addition, every reasonable step must be taken to ensure all eligible women are invited every 3 years, by running regular failsafe batches.

6.5.2 Batch management

Batches of women eligible for screening should be created, documented and actioned within appropriate timescales. The order in which batches are created should be kept identical to previous screening rounds, to prevent delaying an individual woman's round length. If a

randomisation process is used, it is advisable to keep batches relatively small to avoid delaying an individual woman's round length by chance.

6.5.3 Screening clinics

The timings of clinics and appointment schedules should be arranged between the SOM and superintendent radiographer with appropriate feedback communicated to all staff. Appointment scheduling should ensure that at attendance no woman waits longer than 20 minutes after her appointment time before being seen.

6.5.4 Invitations

Letters of initial invitation must be checked regularly to ensure that they are posted at least 2 weeks prior to the appointment date. Every attempt should be made to offer a woman a convenient alternative appointment if required.

6.5.5 Previous screening films

It is good practice to ensure that women who have moved into the screening service area have their previous screening films available for the reporting radiologists when she is next screened. Local policy will dictate as to whether the previous screening film packet is obtained prior to screening or prior to film reading. The previous screening office code is documented on the screening history print obtained weekly from the HA (see section 3.0 and Appendix 1) and further information on the location and telephone numbers of screening offices and their screening sites can be found in the NHSBSP publication, Directory of screening sites, revised annually.

6.5.6 Clinic documentation

Clinic lists and documentation must be produced and checked against appropriate paperwork as near to the commencement of the clinic as is feasible. This will avoid women being screened without the appropriate accompanying paperwork due to last minute appointment changes.

All attendance's must be recorded on the clinic lists and on the computer system as appropriate. Special care should be taken if the clinic list contains women with the same or similar names. The screening team should be made aware of the same and similar names on the clinic list as appropriate.

Registration details including, name, date of birth, address, GP, must be checked for each woman's attendance on arrival, whilst ensuring client confidentiality.

6.5.7 DNAs

Every woman who is eligible who fails to attend her first appointment should be given a further opportunity in writing to attend, within a month of her original appointment.

If a woman attends within 6 months of her first offered appointment, her existing screening episode should be re-opened. If the woman attends outside this 6 months period, a new GP or self-referral episode must be created. Every effort must be made to offer the woman an appointment at an appropriate location, although this may not be the site originally offered.

6.5.8 Technical recalls

Women who, after the initial screening examination, are required to have a further screening examination due to a technical problem, should be recalled using an appropriately worded letter, within 1 month of their original screening examination. Women who choose not to return for this additional visit should be issued with an appropriate letter informing her that she will be recalled in 3 years time. Her GP should also be informed at the same time. Technical recall information should be appropriately recorded on the screening office computer system.

6.5.9 Assessment clinics

The number of assessment clinics and the timing of appointment slots should allow for all essential procedures to take place. Times should be agreed with the superintendent

radiographer, radiologist, and surgeon as appropriate. No woman should have to wait more than 20 minutes before being seen, without being given an adequate explanation. The GP must be informed in writing of any woman who fails to attend assessment after two consecutive appointments.

6.5.10 Early recall

National policy states that women should only be recalled earlier than three years following a visit to an assessment clinic. Early recall from screening should not be carried out. A mechanism must be in place in the screening office to ensure that women requiring an early recall visit to an assessment clinic are duly invited on time. Women needing an early recall from assessment appointment must also be informed of when and where they will be recalled.

6.5.11 Procedures for recording results

It is vital that there are written, up to date instructions, known to all staff involved, ensuring that all women requiring assessment following screening are recalled to an appropriate assessment clinic within 3 weeks of screening. Due to the diversity of operation of breast screening services, it is impossible to be prescriptive, however, as a bare minimum the following must be carried out:

- Women who attend for screening must be documented on the daily clinic list and this list must tally with the mammograms loaded onto the viewer for reading. This daily batch of films must be documented and able to be audited.
- Once this daily batch of films has been read, the appropriate clinic paperwork must be completed by the film reader(s) for all women returned to routine recall. It is important that each individual woman's paperwork is individually signed.
- Women requiring assessment from this daily batch of films must be removed from the viewer by the film reader and placed in a separate area before the routine recall films are unloaded from the viewer. This must be documented and be able to be audited.
- Women requiring a technical recall appointment must be removed from the viewer by the film reader and placed in a separate area before the routine recall films are unloaded from the viewer. This must be documented and be able to be audited.
- The films of women returned to routine recall can then be unloaded and they must tally with the original daily clinic list. This must be documented and be able to be audited.

In addition to the above, written procedures must be in place to ensure that the correct mammograms are filed in the correct film packets and that the data stored on the computer system relating to the screening episode is regularly audited for accuracy and completeness (see section 9.0). It is important to ensure that all women whose episodes are closed showing a 'normal' result, are correct and that only **those** women receive a letter reporting that 'no evidence of cancer was detected in their recent mammogram'. All services should have a documented mechanism for ensuring that when normal results are entered into the screening computer system, the resulting routine recall letter is checked against the film packet to confirm everything is correct, prior to posting.

To meet national standards, women must be issued with their result within 2 weeks of screening and attend an assessment clinic if required, within 3 weeks of screening.

6.5.12 Retention of mammograms and screening records

The Advisory Committee for Breast Cancer Screening has agreed that films and paperwork relating to normal screening results should be kept for a minimum period of 8 years from the date of the mammogram or the date of death. This is based on guidance from health circular HC(89)20 and HSG(96)18. Screening units may of course keep records for a longer period if they wish to. Further advice may be found in Good Practice Guide, Retention and disposal of mammograms, August 2000 (in press).

6.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure that an appropriate, timely and accessible screening invitation is available to all eligible women.	Preparation of a 3 year screening plan Monitor waiting times in screening and assessment clinics	Every 3 years Monthly
To ensure that women receive the correct result. To introduce a quality management system.	Written procedures in place and available for every staff member to work to.	Audit daily or when results issued

OBJECTIVE	MEASURE	MINIMUM STANDARD	TARGET
To ensure that an appropriate, timely and accessible screening invitation is sent to all eligible women.	The percentage of screening invitation letters giving at least 2 weeks notice of the appointment date. The percentage of women requiring a technical recall appointment invited within 1 month of their original screen.	≥95% ≥95%	100% 100%
To enable women who do not respond to a first invitation to have a further opportunity to attend.	The percentage of women re-contacted in writing within one month of failing to attend their initial appointment.	≥ 95%	100%

6.7 NATIONAL STANDARDS

OBJECTIVE	CRITERIA	MINIMUM STANDARD	TARGET
To ensure that women are recalled for screening at appropriate intervals	The percentage of eligible women whose first offered appointment is within 36 months of their previous screen.	≥90%	100%
To minimise anxiety for women who are awaiting the results of screening	The percentage of women who are sent their result within two weeks.	≥90%	100%
To minimise the interval from the screening mammogram to assessment	The percentage of women who attend an assessment centre within one week of the decision that further investigation is necessary and within three weeks of attendance for the screening mammogram.	≥90%	100%

6.8 REFERENCES

6.8.1 *Guide to good office practice No 6 The right result.* Sheffield: NHS Breast Screening Programme 1995. (under revision)

6.8.2 *Systematic management of quality for breast screening units, parts I & II.* Sheffield: NHS Breast Screening Programme 1999 (NHSBSP Publication No 34)

6.8.3 *Guidelines on quality assurance visits.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication No. 40) (under revision)

6.8.4 *Directory of screening sites.* Sheffield: NHS Breast Screening Programme 1999.

6.8.5 *Good Practice Guide.* Retention and disposal of mammograms. Sheffield: NHS Breast Screening Programme 2000 (in press)

7.0 COMMUNICATION WITH WOMEN

7.1 SCOPE

All written correspondence with women including promotional literature used within the service. Telephone and face to face communication with women.

7.2 OBJECTIVES

To ensure that all women receive high quality, up-to-date, accurate, appropriate and timely written correspondence and literature from breast screening services.

To promote effective telephone and face to face communication with women thereby ensuring clear and unambiguous information is given about breast screening and the processes involved.

7.3 RESPONSIBLE PERSONS

SOM
Clerical staff
Reception staff
Superintendent radiographer
Health promotion staff

7.4 DOCUMENTATION

Screening round plan
GP lists
All letter texts
Leaflets and promotional material
Screening site maps
NHSBSP training package for A&C staff
Quality Management System

7.5 METHODS

7.5.1 Presentation of letters to women

The presentation of all letters produced by a breast screening service must be of the highest quality possible. Texts should be grammatically correct without spelling errors and produced on single sheet fed pre-printed headed notepaper using a laser or equivalent printer. In addition, high quality, pre-printed mailer letters can be used. Information contained within the text should be clear, to the point and easily readable and printed using a font size of 10 or greater. The layout must be consistent in style with important details such as appointment date, time and location easily visible. All correspondence should be Fogg score (or equivalent) rated before use to ensure the most appropriate language and terminology is used. All women should receive personalised correspondence, generated as described above. The use of photocopied letters with information filled in by hand is not acceptable.

All letter texts should be reviewed annually to ensure that the content is still relevant, appropriate and up-to-date.

7.5.2 Letter texts and types

The content of letters issued by breast screening services is currently under review by the National Advisory Committee and further guidance will be issued.

Appointment letters: All outgoing appointment letters must include the letter, map of the screening or assessment site and an information leaflet. In addition to this, initial invitation letters should also include the telephone number of the SO in order that women can telephone to

change their appointment. Many services include a reply paid card allowing women to change their appointment by post or let the service know that they will not be attending for screening. This not only reduces the number of phone calls received by the SO but also maximises appointment slot usage.

Letters recalling women for assessment should include the detailed information described in NHSBSP publication, No, 38 and account should be taken of any future revision of this advice. It is very important that recall to assessment letters are not posted out to women to arrive on a Saturday when there is unlikely to be anyone available from the screening service or GP practice to discuss the findings of screening with them.

Every eligible woman who fails to attend her first offered appointment must be given a further opportunity to attend, in writing. Evidence suggests that offering a further appointment to women who DNA does increase uptake, however this is may not always be possible and is dependent on the resources available at each individual screening service.

Normal result letter: Following screening, approximately 95% of women will receive a routine recall letter. Further advice on the text of this letter is awaited.

It is good practice for services to post out together, normal routine recall letters and recall to assessment letters for women screened on the same day. This ensures that women are not left with an anxious wait whilst others have received their results.

Routine recall following assessment letter: Women returned to routine recall following assessment should receive an informative letter or leaflet at or after the assessment visit explaining the clinical findings at the clinic. It should also inform them that they will be recalled for screening in 3 years time. Women put on early recall following assessment should be informed in writing as to when and where they are to be recalled.

Technical recall letter: Women who need to be recalled for technical reasons should be re-invited for screening at an appropriate location. The letter should be a different text to the recall to assessment letter and must contain a contact telephone number to enable women to discuss any anxieties they may have over the repeat examination.

Early recall invitation letter: Women required to be recalled early following assessment are to receive an informative letter inviting them to re-attend an appropriate assessment clinic on their early recall date. Further information can be found in NHSBSP Publication No. 38 and account should be taken of any future revision of this advice.

Non-participants: Once written confirmation that a woman never wishes to participate in the NHSBSP Breast Screening Programme has been received, a copy of the withdrawal letter must be forwarded to the HA, her General practitioner and the original retained on file. The woman's call/recall status on the HA and SO systems must then be changed to "ceased" and appropriately marked that a withdrawal letter has been received.

7.5.3. Leaflets and promotional material

The screening team must ensure that all leaflets and promotional material used by the breast screening service are reviewed at least annually to ensure they are still relevant, appropriate and up-to-date.

7.5.4 Verbal communication with women

All SO staff must have easy access to the following documentation:

- Screening round plan
- List of GPs and GP practices with addresses
- List of screening sites and the geographical area covered by the screening service
- Written invitation policy and procedures

This ensures that A&C staff have all the relevant information necessary to answer queries when communicating with women either on the telephone or face to face. In addition to this A&C staff must attend appropriate and relevant communication training courses as part of the induction process for new staff and regular updates for existing staff. Key skills necessary for effective verbal communication with women are:

- Listening skills
- Questioning skills
- Responding skills
- Non-verbal communication
- Building rapport
- Telephone skills
- Handling callers with a complaint

Further information can be obtained from NHSBSP Teaching Package for A&C Staff.

On no account should SO staff give results of screening or further investigations to women over the telephone.

7.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure that all women receive high quality, up to date, accurate, appropriate and timely written correspondence and literature from breast screening services.	Letter texts scored for readability Review of all letters and leaflets used for continued appropriateness against current publications and national advice	When any change occurs to the text Annually
To promote effective telephone and face to face communication with women thereby ensuring clear and unambiguous information is given about breast screening and the processes involved.	Appropriate training for A&C staff	At induction for new staff Continually reviewed for existing staff

7.7 REFERENCES

7.7.1 Patnick J, Austoker J, Wolff T. *Revision of NHS Breast Screening: The Facts an Evaluation.* J Med Screen 1995 2:15-17

7.7.2 *Guide to Good Office Practice No 8, Call/recall status: cease and suspend.* Sheffield: NHS Breast Screening Programme 1997. (under revision)

7.7.3 *Evaluation of the written information sent to women who are called back for further investigation of breast screening in the U.K* Health Education Journal 1996; 55: 413-429.

7.7.4 Ong G, Austoker J, Brouwer A. *Guidelines on Improving the Quality of written information sent to women who are recalled for assessment.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication No: 38)

7.7.5. *Guidelines on quality assurance visits.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication No.40) (under revision)

8.0 BREAST SCREENING COMPUTER SYSTEMS

8.1 SCOPE

The hardware and software associated with computer systems necessary for the efficient running of a breast screening office.

8.2 OBJECTIVE

To ensure each SO has up to date, reliable computer systems in place
To ensure each SO has suitable computer hardware/software combinations

8.3 RESPONSIBLE PERSONS

Programme manager
SOM
SO staff
IT staff
Level 2 support team

8.4 DOCUMENTATION

Service level agreement
Internal and external support contracts
Maintenance contracts for hardware
Quality Management System

8.5 METHODS

8.5.1. Level 2 support

Every breast screening service operating a breast screening computer system must purchase software support provided by an expert team who have access to the software either on-site or from a remote location. This software support must be covered by a written contract or agreement detailing the following:

- Method of installation of new releases of software within appropriate timescales
- Help desk facility with availability during SO opening hours
- Response times to problems
- Escalation procedures
- Ability to give advice and guidance
- Site visits at agreed times
- New release training
- Use of the report generator
- Exclusions from the contract

Services may also wish to purchase additional services from the software support team. These may include:

- Operating software support
- Disaster recovery
- Utility software

8.5.2 Breast screening computer software releases

Breast screening computer software releases must be installed and available for use at the SO within 8 weeks of a new release being issued by the software developers. It is the responsibility of the SOM to ensure that all appropriate staff receive training on any new software developments included within that release. The user guide must also be updated and any appropriate new documentation circulated to all staff.

8.5.3 Suitable software/Hardware combinations

Breast screening computer system software and hardware in use in every SO must be capable of performance compatible with meeting the standards required by the NHSBSP. Printers, PCs and VDU purchases must be compatible with the breast screening computer system and should only be purchased following advice from the Level 2 support team. Communications via modems must be maintained adequately and have appropriate security measures built into their operation. Connections via the NHSNet should be encouraged in order to comply with the NHS code of connection. Printed material produced by SO printers must be legible and the printers regularly serviced and replaced as necessary. VDU's and their work stations must comply with Health & Safety regulations. Access to all computer systems in use in the SO must be password protected. All SOs must have at least one PC with up to date software capable of producing correspondence as described in section 7.0. This PC should also be capable of receiving downloads from the main breast screening computer system enabling analysis of breast screening data in other software packages.

8.5.4 Maintenance contracts

All SOs must have ongoing maintenance contracts for both hardware and software relevant to their computer systems and hold current licences for their operating systems. All SOs must have a written disaster recovery strategy in place and should consider purchasing disaster recovery from their Level 2 support team. This is particularly relevant if the physical location of their computer hardware is not in a controlled environment.

8.5.5. Back-up procedures

Documented back-up procedures for the breast screening computer system and all PCs used in the SO must be in place. Advice should be sought from the Level 2 support team about the back-up schedule and rotation of tapes. Back-up tapes must be replaced regularly and disposed of if they are older than two years. A back-up log must be kept. All back-up tapes must be kept in a remote location and if this is not possible, be protected by a fireproof safe.

8.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure each SO has an up to date, reliable computer system in place	Level 2 support contract in place	Contract negotiated for a period of no less than 1 year.
	Installation of new releases of software when available	Within 8 weeks of general release
	All staff receives training on new releases of software.	Within 10 days of installation of new release
	Data back up carried out	Daily of breast screening system At least monthly of PCs
	Disaster recovery strategy in place	
To ensure each SO has a suitable computer hardware/software combination	Monitor unplanned computer downtime	Less than 2 working days per annum

8.7 REFERENCES

8.7.1 *Guidelines on quality assurance visits.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication No. 40) (under revision)

9.0 DATA QUALITY AND AUDIT

9.1 SCOPE

The data held by the Breast Screening service

9.2 OBJECTIVE

To ensure accurate data is held by the screening service
To enable the service to produce accurate outcome measures

9.3 DOCUMENTATION

Computerised records
Screening packets
KC62
KC63
Standard statistical tables
Audit records
NHSBSP Good Practice Guides
Quality Management System

9.4 RESPONSIBILE PERSONS

SOM
Clinical director
Data clerks

9.5 METHODS

9.5.1 Data consistency and accuracy

The SOM must ensure that the data held on the breast screening computer system is accurate, consistent and complete. Open episodes must be checked and closed at least on a monthly basis and episode end codes transmitted to the HA on a weekly basis or as dictated by the breast screening computer system. Data entry errors should also be assessed regularly by using the report generator facility generally available on breast screening computer systems. In addition, regular audit as suggested below will also help maintain the integrity of the data.

9.5.2 Routine recall results

A random sample of routine recall results input by SO staff onto the breast screening computer system should be audited for accuracy on a regular basis. This audit must involve both the screening packet and the computer records. An audit schedule should be drawn up by the SOM and agreed with the SO staff and should detail the percentage sample to be audited. All SO staff should be involved in this process and be available to audit each other's work. The results of the audit should be documented and reported back to the SO staff at least on a monthly basis. The audit should examine the following areas:

- Percentage of open episodes in sample
- Percentage of inaccuracies in sample
- Comparison of computer records vs screening packet
- Completeness of information contained within the screening packet, i.e. screening form, any letters, number of films
- Completeness and accuracy of breast screening forms including signature of the reporting radiologist(s)/film readers
- Organisation of screening packet

9.5.3 Assessment Results (returned to Routine Recall)

The screening packets and computer records of women attending for assessment who are returned to routine recall should be subject to regular audit as described in 9.5.2. In addition the following checks should be made:

- Women who require assessment have been invited and attended assessment
- Women who have not attended assessment have been followed-up as described in section 5.5.7 and 6.5.8.
- Women returned to routine recall have closed episodes

9.5.4 Referrals for surgery

Manual or computerised records of all women referred onto surgery following screening and assessment should be kept to enable the outcome measures of a screening service to be audited.

The screening packets and computer records of **all** women who have been referred for surgery should be audited in a similar manner to those described in sections 9.5.2 and 9.5.3. In addition the following audit checks for completeness and accuracy of information should be made:

- Correct assignment of diagnostic or treatment surgery marker for each surgical procedure carried out
- Any treatment surgery is correctly identified and completed on the computer system
- Specimen weight, size, nodal status, excision margins etc. as described in the BASO guidelines are all completed correctly
- FNA/Core biopsy details correctly recorded
- The manual records of women with screen detected cancer match those counted on the KC62
- The manual records of women with benign open biopsies match those counted on the KC62
- Benign open biopsies carried out at the request of the woman only are not counted on the KC62, but are correctly recorded on the computer system.

9.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure accurate data is held by the screening service	Regular data audit schedule in place and documented	At least monthly
	Open episodes checked	At least monthly

OBJECTIVE	MEASURE	MINIMUM STANDARD	TARGET
To enable the service to produce accurate outcome measures	Number of open episodes on KC62	0	0
	Part 5, Table T, KC62 Percentage data incompleteness in all columns	<1%	0%

9.7 REFERENCES

9.7.1 *Guide to good office practice No: 6 - The right result.* Sheffield: NHS Breast Screening Programme 1995. (under revision)

9.7.2. *Guide to good office practice No. 5 – Recording biopsy type.* Sheffield: NHS Breast Screening Programme 1996. (under revision)

9.7.3 *Quality assurance guidelines for surgeons in breast cancer screening*, Sheffield: NHS Breast Screening Programme 1996 (NHSBSP Publication No. 20) (under revision)

9.7.4 *Guidelines on quality assurance visits*, Sheffield: NHS Breast Screening Programme 1998. (NHSBSP Publication No 40) (under revision)

10.0 CONFIDENTIALITY AND DATA PROTECTION

10.1 SCOPE

All information, including personal data, held by the breast screening service.

10.2 OBJECTIVE

To ensure that all SO staff are aware of the confidential nature of **any** information that they may acquire during the course of their job
To ensure that all SOs comply with the terms of the 1998 Data Protection Act

10.3 RESPONSIBLE PERSONS

SOM
Programme Manager
Whole screening team

10.4 DOCUMENTATION

All information held by a SO
Quality management system

10.5 METHODS

10.5.1 Data Protection Act Registration

All screening services must be registered under the terms of the 1998 Data Protection Act. Registrations are placed with the Data Protection Registrar via the local Data Protection Officer

10.5.2 Protection of Information

Written guidelines on the protection of information held by the SO must be available for SO staff to view. All SO staff must be aware of who they are authorised to give information and who they are not. Any queries must be passed onto a senior member of staff before disclosure. All SO staff must be aware of the principles of the Data Protection Act and should be trained accordingly.

10.5.3 Release of Information

Confidential information must not be released by SO staff to unauthorised individuals. Disclosure of any information about an individual outside the screening service is strictly prohibited. In general, no personal information, including screening and assessment results, must not be released over the telephone by SO staff. Screening office staff must satisfy themselves by using the appropriate questioning techniques that women telephoning the screening office are entitled to the information they request. Lists of screening women with or without names and addresses should only be released to authorised individuals.

Privacy markings must be used to protect information which might cause administrative or personal embarrassment if it were improperly disclosed.

Confidential information should where appropriate, be give the privacy marking “In Confidence” and conveyed only to those who need to know it. Files and papers bearing the privacy markings must be kept under lock and key when not in use.

Papers not requiring preservation must be destroyed by a secure method such as shredding or incineration.

10.5.4 Security of data (computerised)

All computer equipment containing screening information and personal data must be housed in a secure environment. There must be adequate physical security for equipment, particularly PCs which should be secured to the desk and password protected. In particular any removable data storage such as magnetic tapes and floppy discs must be securely housed. Data and programmes should be regularly backed-up in accordance with local policy and stored in a fireproof safe or in a location separate to the SO. VDUs and PCs must be logged off when not attended. All hardware should be security marked, and secured to fixed objects where possible. There should be a disaster recovery strategy in place. All personal data must be removed from equipment before it is removed for servicing or repair. Password protection for all application software must be changed at least every 60 days.

10.5.5 Printouts, documentation and screening packets

All printouts, documentation from any screening office computer system, and screening packets must be securely stored when not in use and destroyed by a confidential and secure method when no longer required. Records of any type containing identifiable patient information must not be kept for any longer than absolutely necessary.

10.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To ensure that all members of staff working in the screening office are aware of the confidential nature of any information they may acquire during the course of their job	All staff to receive appropriate training on data protection issues.	Part of induction process for new staff Review existing staff regularly
To ensure that all screening offices comply with the terms of the 1998 Data Protection Act	Registration under the terms of the Act	As appropriate

10.7 REFERENCES

10.7.1 *Good Practice* Guide - *Guidance on the protection of data and patient information.* Sheffield: NHS Breast Screening Programme (in preparation)

11.0 TRAINING

11.1 SCOPE

Training of A&C staff working within the NHSBSP

11.2 OBJECTIVE

To achieve administrative quality standards within the NHSBSP by increasing skills and knowledge.
To retain skilled and highly motivated A&C staff within the NHSBSP.

11.3 RESPONSIBLE PERSONS

SOM
A&C staff

11.4 DOCUMENTATION

NHSBSP Training Package for A&C staff
NHSBSP Good Practice Guides
Personal training logs
Quality management system

11.5 METHODS

11.5.1 New Staff

All new A&C staff must receive induction training. Every service should have an induction package available for new staff which should include information about the employing Trust, the screening service and staff matters. In particular a programme of induction activities should be set up using a checklist format, to be carried out within a given timescale, for the new member of staff to follow. Once this checklist has been completed and signed off, the new member of staff will join in with the regular staff appraisal process. Further information can be found in NHSBSP Guide to Good Office Practice No 7, Induction Guide for New Breast Screening Managers, March 1997.

11.5.2 Appraisal and personal development

Every SOM should be trained to operate an appraisal system for all SO staff on an annual basis or as individual Trust policy dictates. The appraisal interview should be formally documented and actions agreed and signed by both parties. Using the appraisal documentation as the basis, individual training needs and development logs can be drawn up and followed by SO staff over the coming year. The SOM should review the training logs at six monthly intervals to monitor progress. The SOM should also take part in the appraisal process and be appraised by his/her line manager as above.

11.5.3 Staff Training

It is important that SO staff, including the SOM, are trained to do the job for which they are employed but it is also important that A&C staff have the opportunity to develop their skills and progress along their chosen career path. Apart from ensuring that staff are funded for and attend the most appropriate in-house and external training courses in order that they can perform the tasks associated with their job, other types of training should be considered. Breast screening is a team based activity and ensuring that all staff members are aware of their roles and responsibilities within that team is of paramount importance. Viewing a mammogram being taken, visiting a pathology laboratory, helping out at an assessment clinic, visits to the operating theatre, watching a wire localisation are just some examples of the training activities that could be employed if appropriate. In addition, giving staff the opportunity to spend a day at a neighbouring screening office on an exchange basis, to bring back and implement 'good practice' is another way of developing staff skills.

11.5.4 SO staff roles

Many services unwittingly allow SO staff to develop great expertise in certain fields, particularly in terms of the breast screening computer data entry. This is commonly the practice where only one member of staff is able to 'implement the batches' or 'input biopsy and treatment data'. Whilst it is probably more accurate and quicker for that member of staff to continue in that exclusive role, this practice puts the screening service at risk and should be avoided. The SOM must therefore ensure that all SO staff are trained appropriately in all SO activities, including computer data entry. This can be managed through the staff appraisal process and will prevent problems occurring when staff leave or take a break from the screening service.

11.5.5 NVQs and other formal qualifications

A&C staff should be encouraged to obtain NVQs and other formal qualifications in order to standardise the skill levels across the service nationally.

11.6 SUMMARY OF ADMINISTRATIVE STANDARDS

OBJECTIVE	PROCESS	FREQUENCY
To achieve administrative quality standards within the NHSBSP by increasing skills and knowledge.	Induction checklist introduced for new staff. A&C staff have access to appropriate training as documented in their training and development logs.	Completed within 3 months Monitored 6 monthly by SOM
To retain skilled and highly motivated A&C staff within the NHSBSP	Staff appraisal system in place	Annually

11.7 REFERENCES

11.7.1 *Teaching package for administrative and clerical staff.* Sheffield: NHS Breast Screening Programme 1995 (NHSBSP Publication No.)

11.7.2 *Guide to Good Office Practice No: 7 - Induction Guide for New Breast Screening Managers,* Sheffield: NHS Breast Screening Programme 1997

12.0 QUALITY MANAGEMENT SYSTEMS

12.1 SCOPE

Quality is the key to achieving customer satisfaction. Quality can also reduce operating costs. Surveys show that organisations frequently waste as much as 25% of turnover on ineffective or inefficient processes that result in errors and waste. A quality organisation therefore focuses on understanding and controlling its activities so as not to produce errors or waste.

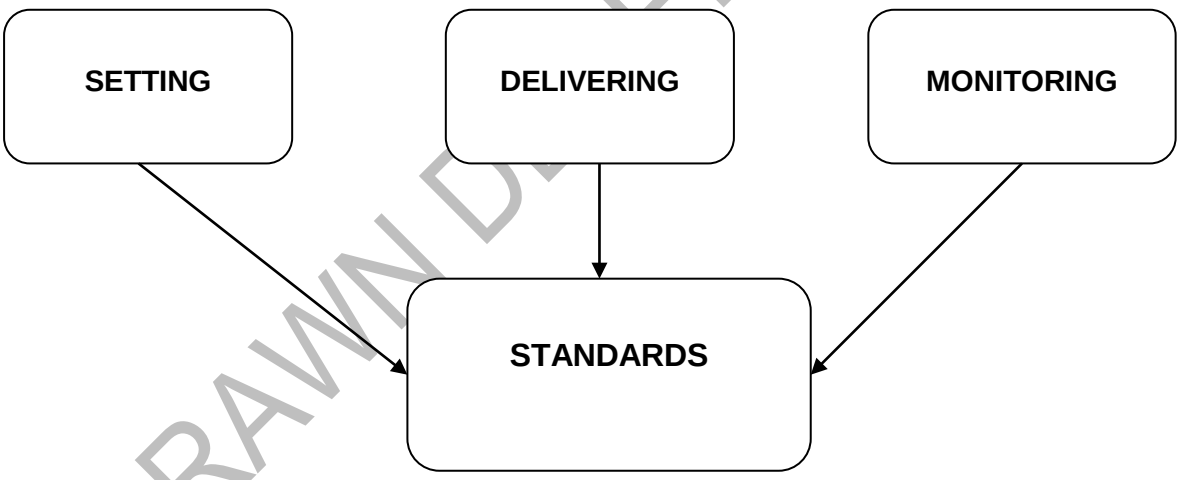
A Quality Management System is the key to improving performance and involves:

- Understanding customers' requirements.
- Having the know-how to understand customer's requirements
- Understanding how to organise and control the breast screening process, thus minimising errors and waste.

'The new NHS will have quality at its heart. Without it there is unfairness. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality.'

The New NHS: Modern. Dependable, December 1997

There is a new emphasis on quality at all levels in the NHS with the introduction of clinical governance.



Clear standards of service will be set to ensure dependable local delivery to the patient which, in turn, will be monitored and reviewed. This is exactly the same way in which an effective quality management system (QMS) is implemented.

12.2 INTRODUCTION

Customers are not just those who purchase or commission breast screening services. Within a hospital Trust the term 'customer' includes everyone that the breast screening service works for or in co-operation with, for example:

- HAs
- other Trusts,
- other departments within the Trust
- eligible women
- patients
- visitors
- the Trust Board

- QARC and QA Team

The interests of all these customers have much in common; they all wish to see the breast screening service work efficiently, effectively and at minimum cost. In adopting the principles of the ISO 9000 standard, a quality management system can be implemented that can be simple, cost effective and efficient and which addresses the needs of all of the customers of the breast screening service. A QMS based on the principles of ISO 9000 is good management systems and practice with quality assurance built in.

Each breast screening service will have a unique QMS, as every service is different, however the common features of a QMS are:

- It must be based on understanding breast screening processes, the customers and their requirements.
- It must be management led.
- It must involve all employees in its implementation.
- It must focus on preventing errors rather than just detecting them and correcting them.
- It must be able to evolve as the breast screening service changes and develops.

12.3 METHODS

Several methods have evolved to achieve, sustain and improve quality. They are known as quality control, quality improvement and quality assurance, collectively known as quality management. Quality management is not the preserve of one manager but all managers. Quality is achieved through a chain of processes, each of which has to be under control and subject to continual improvement. The chain starts with the management team expressing a firm commitment to quality.

12.3.1 Key requirements

The key requirements for an effective QMS are:

- Commitment from the management team
- A representative responsible for the integrity of the QMS with sufficient resources to support him/her.
- Documented procedures and records
- Periodic rigorous review of the system

All of these issues must be clearly addressed in the documentation.

12.3.2 ISO9000

ISO9000 is a family of over 20 international standards on quality management and quality assurance. A QMS is not a product standard, it contains no product requirements. ISO 9000 is itself not a quality system, it is a generic standard for quality management systems. An ISO 9000 audit will demonstrate that an organisation has the capability to meet specified requirements. It has been claimed that ISO 9000 certification allows suppliers to produce rubbish. This is not true. A QMS based on ISO 9000 requires an organisation to establish a quality system that will ensure that it meets its customer needs and expectations.

12.4 THE NEED FOR QMS

Implementing a QMS enables a service to achieve better performance by ensuring that the right capabilities and resources are in place to meet customer needs and expectations. All breast screening processes are designed and implemented to promote conformity and prevent non-conformity. Any deviations or problems are promptly resolved and prevented from recurring and continual improvement in performance becomes a routine. Evidence of performance is available through the system and is used to make informed decisions by the management team. In addition, customer needs and expectations are continually satisfied. A QMS therefore:

- Brings all operations under control
- Prevents non-conformance
- Focuses on customer satisfaction

- Pursues continual improvement
- Provides confidence to employees
- Provides confidence to customers

12.4.1 Documentation

Unless great care is taken in what is documented, far too many detailed documents describing operational procedures are generated. A QMS needs to be designed around the **business** processes of a breast screening service.

12.4.2 Before implementation

It is extremely important that a QMS project is not started until the breast screening management team agrees the need for a QMS and its objectives. The team will need to participate in the project and provide resources and provide and promote the framework within the service for a change in culture and practices. They will also have to agree to steer the project and allocate it sufficient priority for it to progress within designated timescales.

If the breast screening management team is not prepared to support and carry out these actions, implementation of a QMS will fail. Any system produced will be a burden that does not fulfil its promise and looses credibility.

12.4.3 Resources required

A breast screening service will need:

- An able person to manage the project
- A steering group to direct the project
- Process owners to manage the processes
- A tool to aid document management
- Reporting tools for audits customer complaints, non-conformities etc.
- Trained internal auditors
- NHSBSP Publication no 34 parts I and II
- A copy of ISO 9000 standard if applying for certification

12.4.4 The starting point

The breast screening service needs to be considered as a whole, establishing its purpose, mission and core processes. The following actions should then be carried out:

- Analyse breast screening processes using flowcharts
- Gather together any operational policies and capture existing documentation
- Carry out a gap analysis by linking existing documentation to the screening processes
- Develop procedures to control each process which define **who** does **what, where, when** and **how**
- Develop a document development plan
- Document and format the system
- Implement the QMS

12.4.5 The minimum required

The quality management system should not be fixed or inflexible and should be easily changed and updated. It should contain:

A quality policy: a short statement of how the Director and staff understand the setting and maintenance of the services' quality aims.
A quality manual: a description of the whole system.
Internal quality audit: an assessment of the system and procedures by trained members of staff.
Procedures: a detailed description of how the work is done. These are likely to change with the service.

As well as procedures based on the core screening programme, the QMS should also contain as a minimum, the following procedures:

- Document development and control
- Training
- Internal quality audits
- Management review meetings
- Corrective action
- Preventive action

12.5 AFTER IMPLEMENTATION

Once a QMS has been implemented, the process of continual improvement begins. Through the cycle of internal audits, procedures are continually reviewed, updated and improved. Each documented procedure should be audited annually by a trained internal auditor who does not carry out the procedure in the course of their normal work. Services must have regular management review meetings where the management team measures the effectiveness of their QMS and see if it is still suitable for the service. Issues such as customer complaints, the results of internal audits, training issues that have arisen from audits, the performance of the service against the NHSBSP standards are all discussed, actions with timescales agreed and documented. Progress is reviewed at the next meeting. Changes to documentation must then be communicated to all staff through the agreed communication channels. This rigorous review process ensures quality is upheld and continually improved.

12.6 QA VISITS

The implementation of QMS into breast screening services will be monitored through the QA process and progress against implementation measured at the QA visit.

12.7 REFERENCES

12.4.1 *The new NHS. Modern. Dependable.* London: The Stationery Office Limited 1997.

12.4.2 *Systematic management of quality for breast screening units, parts I & II.* Sheffield: NHS Breast Screening Programme 1999 (NHSBSP Publication 34).

12.4.3 *Guidelines on quality assurance visits.* Sheffield: NHS Breast Screening Programme 1998 (NHSBSP Publication 40) (under revision)

13.0 QUALITY ASSURANCE IN SCREENING OFFICE ADMINISTRATION

13.1 INTRODUCTION

Quality assurance in screening office administration operates at three levels, namely in the screening office, at a regional level and at a national level. The SOM is responsible for ensuring that all A&C staff working within the administrative function of the screening service carry out tasks in accordance with the administrative standards in this document. At a regional level, the professional A&C Co-ordinator should audit the A&C role in screening services within the region and participate in quality assurance visits to assess the professional A&C performance. The NHS Quality Assurance Co-ordinating Committee for Administrative and Clerical Staff co-ordinates quality assurance activities at national level.

13.3 THE SCREENING OFFICE

The SOM is part of the multidisciplinary integrated team providing services within the breast screening service. She/he will:

- Work in close liaison with the HAs to ensure all their residents are invited for screening
- Manage the call and recall system for eligible women
- Liase with and inform general practitioners and the PHCT about breast screening issues
- Ensure that women are screened efficiently
- Ensure that all A&C staff communicate effectively with women
- Audit the breast screening data to ensure quality outcomes are achieved
- Maintain confidentiality and data protection
- Train all A&C staff to a high level of competence
- Participate in implementing QMS

A sample job profile is at appendix 2.

13.4 REGIONAL LEVEL

Each regional director of quality assurance for breast screening appoints an administrative representative to act as professional co-ordinator for the region. The professional co-ordinator is a member of the regional quality assurance team for the NHSBSP and represents the region on the NHS Breast Screening QA Co-ordinating Committee for Administrative & Clerical staff. She/he will:

- Act as co-ordinator for other SOMs and A&C staff in the region who work in local screening services, and represent their interests at regional and national levels, reporting to them about regional and national developments.
- Provide support, advice and information to ensure A&C QA standards are met.
- Facilitate the exchange of knowledge and ideas, and to encourage productive networking in order to foster developments in quality.

A sample job specification and person specification for a regional quality assurance co-ordinator for administration and clerical staff can be found at appendix 3 and appendix 4.

13.5 NATIONAL LEVEL

The NHS Breast Screening QA Co-ordinating Committee for Administrative & Clerical staff represents all A&C staff working within the NHSBSP. It advises and reports to the NHSBSP on the provision of administrative and clerical services for the programme. The mission statement of the committee can be

found at appendix 5. The committee is made up of representatives from each English health region, Wales, Scotland, Northern Ireland and the private sector. The committee's responsibilities are to co-ordinate quality assurance activities in all screening offices. Specifically it:

- Devises and reviews the standards to be achieved by SOs and the A&C staff who work within them.
- Identifies the training and education needs of A&C staff
- Monitors, documents and audits A&C QA standards across the NHSBSP
- Offers comment and advice on any research relating to the administrative function of the NHSBSP

13.3 QUALITY ASSURANCE VISITS

As a member of the regional quality assurance team, the A&C QA co-ordinator will participate in quality assurance visits to breast screening units. A protocol for the assessment of administrative and clerical performance in the breast screening programme is found in the NHSBSP Guidelines on quality assurance visits with includes detailed guidance on the organisation of quality assurance visits.

13.4 SCREENING OFFICE STAFFING LEVELS

In order to meet the required standards as laid down in this document, SO staffing levels must meet a minimum standard. It is therefore recommended that every SO has 1 WTE member of A&C staff for every 12,000 eligible women invited for screening with at least one member of staff at a management/supervisory grade to take overall responsibility for the day to day running of the SO. This figure is based on an average screening unit of approximately 45,000 total eligible population and does not take into account any symptomatic imaging work that may be carried out within the same service. Any A&C staffing requirement for symptomatic work must be over and above that required for breast screening. The use of A&C staff for tasks usually associated with radiography helpers must not be included in this calculation. Caution should be exercised when using this calculation for either very small or very large screening services, as minimum staffing requirements and economies of scale will apply, particularly when all service targets are being met.

APPENDIX 1

SCHEDULE OF HA SYSTEM MANAGEMENT SCREENS AND ANALYSIS JOBS AT RELEASE R

THE BREAST SCREENING SYSTEM

System Management Screens

AK	allows you to check and maintain the acknowledgement system
BC	records details of the breast screening contact at your Health Authority
BI	used to list transfer information
BL	used to set up and check letters issued by your Health Authority
BM	used to clear mismatches after receiving information via the Network/Kermit from the Screening Office
IS	displays a summary of some or all of the batches on the system
IW	allows inspection of individual women in a screening batch
SB	used to specify screening batches (4 pages)
SE	used to display and create screening episodes
SH	records all changes to a woman's screening status
SO	used to set up the address, default, GP group and area group details for each Screening Office
SS	used to specify whether or not a GP is to be involved in the screening programme
SW	records call/recall status, trial status and `Patient Notes' for an individual woman

Analysis Jobs

AJ-BAP	prints information relating to the acknowledgement system - ***use once a month***
AJ-BCA	produces a report of screening coverage in your Health Authority area (refer to the Statistics section) - ***use when required and at the same time as producing KC63 statistics***
AJ-BCB	prints details of an individual batch - ***use if requested by the Screening Office***
AJ-BCD	deletes/prints screening episodes and other information related to individual women - ***use when required***
AJ-BCE	provides an estimate of the number of women who will fall into the target age range over a specified recall period (refer to the Statistics section) - ***use when requested by the Screening Office***
AJ-BCL	re-creates an existing screening batch list, or creates a batch list for non-batch referrals (ie GP referrals, self referrals etc) - ***use when required***
AJ-BCMI	provides a facility to transfer BCA information to a micro for importing into a MIS, spreadsheet etc package (refer to the Statistics section) - ***use when required***
AJ-BCNS	provides a list of those women not screened during the regular call/recall process - ***use when requested by the Screening Office, normally prior to specification of a failsafe screening batch***
AJ-BCO	prints details of outstanding open episodes - ***use once a month,***

especially before running a statistics analysis job

AJ-BCP	processes batches through various stages of screening - ***use once a week if many batches exist, or when an individual batch stage is due***
AJ-BCR	creates screening batches following specification on the SB screen - ***use after a batch has been specified***
AJ-BCS	prints Screening Office address, default, GP group, area group and letter details - ***use whenever details change***
AJ-BCSI	the breast screening integrity checker - ***use after AJ-RIC during the regular integrity checker cycle***
AJ-BCSX	BSS download to a Unix file or CJ-4 - ***run as required***
AJ-BCX	transfers/prints screening details of women who have been deducted - ***use at least once a week***
AJ-BGEN	prints GP, address code and Health Authority contact details - ***use when any of these details change***
AJ-BIN	processes incoming Network/Kermit transfers from the Screening Office - ***use when information has been transferred in (identified from the PHCN print)***
AJ-BSCW	produces a list of live women who are ceased or suspended - ***use at least once every three months***
AJ-BSDB	produces a list of live women who have had a change to their date of birth which could affect their eligibility for screening – ***use at least every three months***
AJ-BSH	use to transfer women's screening histories to a new Screening Office - ***use when required***
AJ-CIN	processes incoming Network preventative healthcare details - ***runs automatically***
AJ-C121	processes the receipt of the short screening batch list from the Screening Office - ***runs automatically after AJ-CIN***
AJ-C124	creates screening records at the new Health Authority from details received (across the Network) from the old Health Authority, and produces cards for exceptions - ***runs automatically after AJ-CIN***
AJ-C131	processes the receipt of non-batch referrals from the Screening Office - ***runs automatically after AJ-CIN***
AJ-C300	processes the receipt of electronic acknowledgements - ***runs automatically after AJ-CIN***
AJ-KC63	produces KC63 statistics, and provides the facility to transfer the information to a micro (refer to the Statistics section) - ***use at the end of each financial year***
AJ-PHCN	collates all Network control reports into a single print file on the print queue - ***runs automatically***
AJ-PHGC	produces a printed report of changes to GP/Partnership details - ***use at least once a week***
AJ-PHRC	transfers women's registration changes to the Screening Office across the Network, or produces as a paper print - ***use when required***
AJ-PHTC	initially processes screening batch list results sent from the Screening Office by tape - ***runs automatically***

Statistics

AJ-BCA	produces a report of screening coverage in your Health Authority area - ***use when required and at the same time as producing KC63 statistics***
AJ-BCE	provides an estimate of the number of women who will fall into the target age range over a specified recall period - ***use when requested by the Screening Office***
AJ-BCMI	provides a facility to transfer BCA information to a micro for importing into a MIS, spreadsheet etc package - ***use when required***
AJ-KC63	produces KC63 statistics, and provides the facility to transfer the information to a micro - ***use at the end of each financial year***

APPENDIX 2

JOB PROFILE FOR A SCREENING OFFICE MANAGER

Title	Screening Office Manager
Suggested Grade	A&C Grade 5 or local equivalent
Accountable to	Programme Manager/Clinical Director of Breast Screening
Expected qualifications /experience	Educated to 'A' Level or equivalent standard Minimum 5 years general office experience Supervisory management training Computer literate
Person specification	In addition to the above qualifications/experience it is expected that the individual can demonstrate: 1. Problem solving skills 2. Data management and interpretation skills 3. The ability to self direct and self motivate 4. Good communication skills 5. Training skills
Objective	The efficient management of the breast screening office and the administrative function of the service.
Key tasks	Manage the breast screening office, ensuring sufficient staffing levels to provide and maintain an efficient, effective, high quality service. Provide a central administrative base to facilitate the organisation and collection of all necessary data, implementing new information technology where appropriate. Provide a breast screening statistics support function to the Clinical Director and other service managers and health care professionals. Organise efficiently the screening activity concerned with inviting, screening, assessing and informing women and/or other health care professionals during the screening process. Operate an effective induction and training programme for all screening office staff, ensuring that an appraisal system is in place for all staff managed. Ensure that a good communication system exists within the breast screening office. Maintain confidentiality and data protection.

Ensure that all quality standards are monitored and maintained in order to improve the quality and total care of those who come into contact with the breast screening service.

Uphold and maintain the employing Trusts policies and procedures.

APPENDIX 3

SAMPLE JOB SPECIFICATION FOR THE ADMINISTRATION & CLERICAL QUALITY ASSURANCE CO-ORDINATOR/QUALITY ASSURANCE TEAM MEMBER

Job Title Administration & Clerical Quality Assurance Co-ordinator

Job Purpose To co-ordinate and monitor quality assurance activities for the administration & clerical profession in the Breast Screening Programme in the XXXXXX region.

Represent administration & clerical staff at national, regional and local level. Effectively communicate and disseminate relevant information.

Provide support, advice and information to ensure screening office quality assurance standards are met.

To facilitate the exchange of knowledge and ideas, and to encourage productive networking in order to foster developments in quality.

Key Tasks Support, monitor and advise breast screening units on all aspects of data protection, collection and quality.

Advise the Regional Director of Quality Assurance on the screening office performance of the programme, units and individuals; with due regard for confidentiality.

Through the Regional Director of Quality Assurance, provide Health Authorities and trust management with advice on screening office performance.

Co-ordinate and monitor the local implementation of national guidelines for the profession.

Participate in quality assurance visits, including completion of appropriate documentation, and assist in the nomination of a substitute when appropriate.

Undertake individual unit visits as appropriate.

Ensure that the NHSBSP guidelines for administration and clerical staff are known and understood and address underperformance as laid down in the guidelines.

Encourage and participate in appropriate training and development for screening office staff, including regional study days.

Encourage per review and inter unit exchange visits.

Develop and manage initiatives through research to improve the quality of the service to women and the programme as a whole.

Chair the regional administration and clerical co-ordinating group, held at least bi-annually, and attend relevant regional and national meetings.

Co-ordinate discussion on appropriate aspects of screening office quality assurance with other professional co-ordinating groups.

Represent the views of the profession in the region at the national co-ordinating group and report back to screening offices.

Contribute where necessary to the identification of quality issues arising in other disciplines and assist the Regional QA Director as required in addressing these, in accordance with guidelines to be developed.

Appointed by Regional Director of Quality Assurance

Accountable to Regional Director of Quality Assurance

Reports to Regional Director of Quality Assurance

Funding Minimum of 2 sessions/week (1 day) at a minimum of A&C Grade 6 or local equivalent. Funding allocation to enable attendance at relevant regional and national meetings.

APPENDIX 4

SAMPLE PERSON SPECIFICATION FOR THE A&C QUALITY ASSURANCE CO-ORDINATOR/QA TEAM MEMBER

Person Specification	Senior professional currently working in the breast screening programme in the XXXXXX region. Ability to command the respect of their professional colleagues in the region.	
Skills & Attributes	Communication skills	Report writing/record keeping skills
	Leadership skills	Analytical skills
	Team worker	Tact and Diplomacy
	Negotiation skills	Committee chairmanship
	Motivational skills	Training and development skills
	Ability to manage change	Audit skills
	Data handling/management skills	Computer literate
Experience	Screening office Manager/Programme Manager with at least 2 years experience in a screening office.	
Training & Development	Able to demonstrate attendance and appropriate training at local, regional and national levels.	
Special Knowledge	NHSBSP NHSBSP professional standards NHS IA (Exeter) computer system Screening office computer system KC62 & KC63 Department of Health returns Screening programme planning	
Personal Circumstances	Willingness to travel potentially long distances out of normal office hours.	
Attitudes	Commitment to the aims and objectives of the NHSBSP.	

APPENDIX 5

MISSION STATEMENT FOR ADMINISTRATIVE AND CLERICAL STAFF WORKING WITHIN THE NHSBSP

To take the professional lead in the NHSBSP on the management and provision of high quality administrative services and to inform national policy on such services