Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
West Sussex

17 May 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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www.gov.uk/topic/population-screening-programmes. Twitter: @PHE_Screening
Blog: phescreening.blog.gov.uk. Prepared by: SQAS South.
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Executive summary

The NHS Breast Screening Programme aims to reduce mortality from breast cancer by finding signs of the disease at an early stage.

The findings in this report relate to the quality assurance (QA) visit of the West Sussex screening service held on 17 May 2017.

Purpose and approach to quality assurance (QA)

Quality assurance aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring of data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-visits to review pathology reports and slides, attend a multidisciplinary team meeting, and peer review for radiology/surgical performance
- information shared with the South regional SQAS as part of the visit process

Description of local screening service

The West Sussex breast screening service has an eligible population of 121,561 women aged 50 to 70.

The main service is located at the Worthing Hospital. It operates a static screening service as well as having four mobile units covering the defined population. All screening assessment clinics and wire localisations are conducted there with most pathology and surgery being performed at both St Richard’s Hospital and Worthing Hospital. However, there are a number of other trusts which receive referrals for a small number of surgical resections from this programme.

High risk screening is commissioned separately and delivered by East Sussex NHS Trust.

The screening programme is provided by Western Sussex NHS Foundation Trust. It is commissioned by NHS Surrey and Sussex. The geographic area covers Crawley, Horsham, Mid Sussex and Coastal Clinical Commissioning Groups (CCGs).

Findings

The immediate and high priority findings, and areas for shared learning, are summarised below. For a complete list of recommendations, refer to the related section within this report or to the list of all recommendations on page 10.

Immediate concerns

The QA visit team identified immediate concerns issues around Chichester breast pathology services. Three out of five pathologists in Chichester do not fulfil the NHSBSP requirements.

All pathology consultants reporting breast screening biopsies and resections are required to:

- participate in the national breast screening external quality assurance scheme
- report at least 50 primary cancer resections per year
- attend breast pathology related courses and comply with the Royal College of Pathologists guidelines regarding CPD

A letter sent to the Chief Executive on 18 May 2017, required confirmation within seven days that all reporting pathologists had registered with the EQA scheme, and an action plan was in place to address the remaining issues. Should it not be possible to resolve these issues, individual pathologists should cease reporting on breast screening specimens. Confirmation was received on 7 June 2017 that these issues had been addressed.

High priority

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

- the recently appointed lead radiologist requires a job description, with allocated sessional commitment for the role
- the service refers about 20% of screening patients for surgical treatment outside the West Sussex NHS Trust. Patient outcomes are not actively followed up by the centre
- there is insufficient mammography staffing to meet the demands of the screening and symptomatic services, and expanded roles
- there are not systems to appraise locum consultants used within the service to ensure their performance meet NHSBSP guidelines

- radiologists have to record clinical data onto NBSS and then separately onto the trust radiology information system during assessment clinics
- NHSBSP assessments guidance is yet to be fully implemented
- not all women are seen by a breast care nurse at the beginning of the assessment process

Shared learning

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

- the service shows evidence of very good patient experience from the audit of experience on the screening mobiles and assessment process, and positive patient feedback
- the unit demonstrated a good relationship with the trust picture archiving and communication system (PACS) team
- the service has taken on numerous health promotion activities including the learning disability project and working with the traveller community to increase screening uptake

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Ensure the lead radiologist attends quarterly senior management team and governance meetings	Service Specification No. 24	3 months	S	Revised terms of reference (TORs) and minutes to SQAS
2	Ensure surgical referral pathways for screening patients to the receiving hospital meet NHSBSP standards	NHS Public Health Functions Agreement No. 2015-16	6 months	S	Written confirmation and SLAs to SQAS
3	Implement a system for follow up of patients referred to other centres for surgery to ensure episodes are reviewed and closed on NBSS	NHS Public Health Functions Agreement No. 2015-16	3 months	H	Written confirmation to SQAS
4	Provide a job description, including sessional commitment for the lead radiologist	Service Specification No. 24	3 months	H	Job description and job plan with dedicated time for role

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
5	Implement routine review and audit of QMS work instructions	QA guidelines for A&C publication No. 47	6 months	S	Written confirmation to SQAS

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6	Ensure there is adequate flexibility and resilience within the administration team to manage service demands and unplanned absences	QA guidelines for A&C publication No. 47	6 months	S	Written confirmation and work plan to SQAS
7	Increase radiography staffing to the recommended levels for the screening service ensuring additional capacity for expanded roles and symptomatic service	NHSBSP radiography guidelines	6 months	H	Written confirmation to SQAS
8	Ensure locum staff meet NHSBSP standards regarding activity and that systems are in place to actively monitor performance	NHSBSP radiology guidelines	Immediate	H	Pre-employment check process. Performance management process
9	Ensure that there is sufficient film reading capacity and that activity is more evenly spread across film readers	Service Specification No. 24	6 months	S	Written confirmation to SQAS

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
10	Review current breast care nurse qualifications against guidelines and to arrange attendance on relevant courses	NHSBSP No. 29 Ref:3.1.1	6 months	S	Written confirmation to SQAS
11	Remove needles not in clinical use from the x-ray equipment menu for user QC purposes	NHSBSP No. 33	3 months	S	Written confirmation to SQAS
12	Risk assess the process of displaying client images on CRIS and reporting the same episode on NBSS for assessment clinics	NHS Public Health Functions Agreement No. 2015-16	3 months	S	Written confirmation to SQAS

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
13	Include the office manager in programme and clinical governance meetings ensuring feedback is provided to staff	NHSBSP Publication No.47 5.1.4	6 months	S	Written confirmation to SQAS
14	Develop a process for validation of clinical data entry by administrative staff onto NBSS to ensure data accuracy	NHS Public Health Functions Agreement No. 2015-16	3 months	S	Written confirmation to SQAS

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	Ensure all film readers achieve a minimum of reading 5000 films per year (including 1500 as first reads)	NHSBSP radiology guideline	6 months	S	Evidence shows in annual statistics

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Ensure all assessment clinic results are entered real-time into NBSS and streamline the process to reduce duplication and minimise human errors	Service Specification No. 24	3 months	S	Work Instruction to reflect change in process to SQAS
17	Implement the new assessments guidance to ensure a responsible assessor is documented on NBSS and clients returned to routine recall without biopsy are reviewed by another assessor	NHSBSP No. 49	6 months	H	Work Instruction to reflect adherence to the new standards to SQAS
18	Achieve UKAS accreditation for the West Sussex laboratory service	NHSBSP pathology guideline	3 months	S	Written confirmation to SQAS

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
19	Confirm all pathology consultants reporting screening biopsies and/or resections are registered and participate in the national breast screening histopathology EQA scheme	NHSBSP pathology guideline	Immediate	I	Written confirmation to SQAS
20	Confirm arrangements for all BSP reporting pathologists undertake adequate CPD	NHSBSP pathology guideline	3 months	I	Written confirmation to SQAS
21	Confirm all BSP reporting pathologists can meet the standard of reporting 50 primary breast cancer resection specimens per year	NHSBSP pathology guideline	6 months	I	Written confirmation to SQAS
22	Review all cases recorded as true false positives.	NHSBSP pathology guideline	3 months	S	Written confirmation to SQAS
23	Implement the new laboratory information management system LIMS and monitor the progress.	NHSBSP pathology guideline	6 months	S	Written confirmation to SQAS

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
24	Ensure patients receive non operative core biopsy results within 7 days.	NHS England NHSBSP radiology guideline	3 months	H	KPI shows standards are met

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
25	Ensure all women are seen by a breast care nurse at the start of the assessment process	NHSBSP No. 29 Ref 3.2.1	6 months	H	Written confirmation to SQAS and patient satisfaction audit
26	Review patient pathway to include holistic needs assessment is completed.	NHSBSP 29 3.1.1	6 months	S	Written confirmation to SQAS
27	Confirm provision of clinical supervision for breast care nurses with senior nursing team in the trust.	NHSBSP 29 3.1.1	6 months	S	Written confirmation to SQAS

I = Immediate
H= High
S = Standard

Next steps

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

SQAS will work with commissioners to monitor activity/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. After this point, SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.