Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
East Cheshire and Stockport Breast Screening Service

3 July 2018

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy 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 4 UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

www.gov.uk/phe/screening Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
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Contents

Scope of this report

	Covered by this report?	If 'no', where you can find information about this part of the pathway
Underpinning functions		
Uptake and coverage	Yes	
Workforce	Yes	
IT and equipment	Yes	
Commissioning	Yes	Information relating to commissioning recommendations can be found in the QA visit report to NHS Bowel Cancer Screening Programme Cheshire 28 June 2018
Leadership and governance	Yes	
Pathway		
Cohort identification	Yes	
Invitation and information	Yes	
Testing	Yes	
Results and referral	Yes	
Diagnosis	Yes	
Intervention/treatment	Yes	

Executive summary

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

The findings in this report relate to the quality assurance visit of the East Cheshire and Stockport breast screening service held on 3 July 2018.

Quality assurance purpose and approach

Quality assurance (QA) 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 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-review visits
- information shared with SQAS (North) as part of the visit process

Local screening service

East Cheshire and Stockport Breast Screening Service (ECSBSS) is based in the New Alderley Building at East Cheshire NHS Trust. The total population of the area served is approximately 520,000 and the eligible screening population is 84,000. NHS England (Merseyside & Cheshire) is the lead commissioner for the service with NHS England (Greater Manchester) responsible for the Stockport element of the population.

Screening for the East Cheshire population is undertaken at the static screening site at Macclesfield District General Hospital (MGDH). Screening for the Stockport population takes place on a mobile unit. This currently rotates through 5 sites: Bramhall, Brinnington, Marple, Romiley and Shaw Heath.

There are 2 consultant breast radiologists, 2 consultant breast surgeons and 2 sub-consultant grade breast surgeons at East Cheshire NHS Trust. The Trust also employs 4 breast care nurses (BCNs). Histopathology is provided through a collaborative service with Mid Cheshire Hospitals NHS Trust and is based at Leighton Hospital, Crewe. Oncology input is provided by a visiting oncologist from the Christie

Hospital. Attendance by pathology and oncology for breast multi-disciplinary team (MDT) meetings is often via videoconference.

Findings

The service consistently achieves most national standards.

The screening programme is increasingly lacking in resilience which is impacting on staff morale due to:

- increasing workload pressures
- the physical constraints of the department
- no replacement plan for old equipment

Immediate concerns

The QA visit team identified one immediate concern. A letter was sent to the chief executive on 5 July 2018, asking that the following issue be addressed within 7 days:

One ultrasound machine is 10 years old and requires urgent replacement. The image quality has degraded beyond an acceptable level of usage in screening. The equipment should be removed from service for screening patients with immediate effect.

A response was received within 7 days which assured SQAS that the equipment was no longer being used for screening patients.

High priority

The QA visit team identified several high priority themes as summarised below:

- multi-purpose rooms are impacting patient experience, film reading and review of mammography during ultrasound procedures
- governance processes are not clearly defined or documented - there are no clear escalation routes for the service
- current MDT meeting arrangements are atypical and require formal documentation, review and agreement with key parties
- lack of staff resilience, particularly for consultant pathology

Shared learning

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

- good quality control (QC) work instructions
- comprehensive business continuity plan
- significant proportion of day case surgery
- use of therapeutic mammoplasty for breast conservation
- regular on site screening service at Styal prison
- various health promotion initiatives such as staff attendance at a local homeless shelter to promote breast screening
- local authority public health advisor working with GP practices to increase uptake

Recommendations

The following recommendations are for the provider to action unless otherwise stated.

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1801	Local operational breast group to be established with screening and immunisation team (SIT) representation	1	3 months	Standard	ToR and confirmation of meetings held
NMA 1802	Review governance arrangements for Breast Business Group meetings to ensure all commissioner requirements are met and escalation routes are clear through to the Trust executive	1	3 months	High	ToR and documented escalation route
NMA 1803	SLA with Stepping Hill to be updated with reference to NHSBSP standards	1	6 months	Standard	Copy of SLA
NMA 1804	Programme Manager (PM) job plan to be reviewed to ensure sufficient management time. Consider formal deputising arrangements	1	6 months	Standard	Job plan for PM

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1805	Strategic plan for surgery needs to be developed with the screening service	1	6 months	Standard	A costed 5 year forward plan for the development of surgery within the breast screening pathway. To be agreed by breast surgeons, director of breast screening and Trust management
NMA 1806	Pathology polices to be updated to Royal College of Pathology (RCPath) 2016 Guidance	13	6 months	Standard	Updated policies

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1807	Conduct a capacity review and consider reconfiguration of the unit to improve patient and workforce flow	1	6 months	Standard	Report of capacity review and approved action plan
NMA 1808	Lighting control to be installed in the film reading room	2		Standard	Confirmation that controllable lighting is in use
NMA 1809	Managed equipment services (MES) servicing performance to be included in the contract performance review	1	12 months	Standard	Copy of amended contract
NMA 1810	Local rules for ionising radiation to be revised to comply with new legislation	3	3 months	High	Confirmation from PM

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1811	For biopsy needle accuracy tests; X,Y, Z accuracy to be recorded as the distance from 0,0,0 Tolerances X $\leq$ 1mm Y $\leq$ 1mm Z $\leq$ 3mm	4	3 months	Standard	Documented X, Y, Z tolerance recording
NMA 1812	Paper QC record sheet to be revised. Where QC results are not immediately transferred to the spreadsheet, results to be calculated straight away and compared to baselines	5	3 months	Standard	Revised QC record sheet
NMA 1813	Magnetic Resonance (MR) QC to be confirmed and implemented if not already in place	6	6 months	Standard	Confirmation from medical physics service

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1814	Review the admin workload to ensure all functions are carried out in line with NHSBSP guidance	1, 7	6 months	Standard	Output of review with approved action plan for changes

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1815	Audit current and high contrast setting reporting between 1st and 2nd readers to establish ductal carcinoma in situ (DCIS) detection and user satisfaction. Medical physics to engage with reporting staff to optimise image display	8	6 months	Standard	Audit report and approved action plan
NMA 1816	Arbitrate all recalls in the prevalent round	9	3 months	Standard	Confirmation from Director of Breast Screening (DoBS)
NMA 1817	Review and categorise interval cancers and false negative assessments within 3 months of identification to meet duty of candour (DoC) guidance	8, 10	3 months	Standard	Report to the safety quality standards meeting and provide assurances the DoC guidance is being met
NMA 1818	Mammographic images to be available in ultrasound rooms when ultrasound is performed	9	3 months	High	Minute from operational group or programme board

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1819	Ultrasound machine to be removed from service for screening patients	11	Immediate	Immediate	Confirmation from Chief Executive Officer (CEO)
NMA 1820	Develop a single risk assessment for all activities within ultrasound room 2	9	3 months	High	Risk assessment report and approved action plan
NMA 1821	Audit randomly selected assessment cases to improve assessment standards	9	6 months	High	Audit report and approved action plan
NMA 1822	Develop an MR biopsy service level agreement with Manchester Foundation Trust (MFT)	1	3 months	Standard	Signed service level agreement (SLA)

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1823	Outline options and agree actions to improve the patient experience for needle localisation	1	6 months	Standard	Report of the review and approved action plan
NMA 1824	Risk assess consultant pathology resilience	12	3 months	High	Risk assessment and approved action plan
NMA 1825	Implement use of datasets/proformas for pathology reporting of breast cancers	13	6 months	Standard	Dataset/proforma with confirmation of use from lead pathologist

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NMA 1826	Current MDT arrangement to be formally documented and agreed between the DoBS, SQAS and commissioners. As workloads increase these arrangements should be kept under review	9	3 months	High	Documentation of MDT arrangements and confirmation of agreement

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 after the report is published. 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.