NHS Breast Screening Programme

NHS Cancer Screening Programmes

Interim Quality Assurance guidelines for Clinical Nurse Specialists in breast cancer screening

Fifth Edition

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INTERIM QUALITY ASSURANCE GUIDELINES FOR CLINICAL NURSE SPECIALISTS IN BREAST CANCER SCREENING

Fifth Edition

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Document purpose (clinical/healthcare/social questions covered)	These guidelines set out the standards of practice for clinical nurse specialists (CNSs) working in the NHS Breast Screening Programme. They detail the role of the CNS in breast screening, arrangements for quality assurance (QA), and a protocol for assessing the performance of the CNS.
Population affected	Women recalled to attend the 2nd stage of Breast Screening
Target audience	Breast Care Nurses Professional groups providing a service to the NHSBSP or linked to the NHSBSP.
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One of the key aims of the Department of Health publication, *Improving outcomes: a strategy for cancer*, was to put the patient at the heart of cancer services by implementing the principle of 'no decision about me without me'. In keeping with the spirit of this recommendation, two patient representatives from London, Mairead MacKenzie and Jacqueline Coupland, gave valuable feedback on this document and helped to improve its recommendations, particularly in the areas of patient advocacy and face-to-face contact between women and Clinical Nurse Specialists. The National Coordinating Group would like to express gratitude for their invaluable assistance.

EXECUTIVE SUMMARY

These guidelines were produced by the National Coordinating Group for Nurses in Breast Cancer Screening, chaired by Margaret Casey, for the NHS Breast Screening Programme (NHSBSP). The document revises and replaces the fourth edition of the guidelines, published in January 2008. However, this guidance has an 'interim' status, because further research is currently being carried out in relation to the role of Clinical Nurse Specialists (CNS) (also known as 'Breast Care Nurses') in giving benign results.

This document provides important new guidance regarding:

- The role of the CNS in meeting women who have been recalled for further investigations.
- The role of the CNS in performing a physical/psychological assessment (not a clinical examination) before a woman commences further radiological investigations, to enable her history to be shared with the clinical team.
- The need for a pre-visit to all breast screening units to be completed by the Quality Assurance (QA) Nurse before a scheduled QA team visit.
- The need for Advanced Practice to meet academic and clinical standards where it is implemented.
- A revised questionnaire, to be implemented during each screening round by the unit and region, to allow national monitoring of the standard of care delivered by the CNSs employed within the screening unit.
- New mechanisms to allow implementation of changes to the service resulting from the questionnaire and audit findings.

Pathways are included in Appendices 1 & 2, and these are designed to be used as a model for care provision.

1 INTRODUCTION

1.1 Background

The process of breast screening runs from a woman's initial invitation to screening to the provision of her result.

Each year the NHSBSP offers routine mammography to over 2 million women aged from 50 up to their 71st birthday. The average attendance across England is 73%. An age extension to the programme is currently being rolled out in England, which will extend the age range covered to 47 to 73 years.

Currently, over 90,000 women are recalled for further assessment after their mammogram is read. About 40% of these women will undergo a needle biopsy procedure, and 18% of this subgroup will have breast cancer.[1,2] Therefore, a number of women receive 'false positive' results from their mammogram, meaning that they are recalled when there is nothing amiss.

1.2 Role of the Clinical Nurse Specialist

1.2.1 Reducing the anxiety associated with further investigation

Women who receive false positive results often suffer greater adverse psychological consequences than women who receive a clear result immediately.[3-6] Evidence shows that they can experience significant distress at every stage of the screening process,[7-10] including the period between receipt of the recall letter and attendance at the recall appointment.[11] Undergoing a biopsy deepens the level of anxiety that women experience,[12,13] and women may remain concerned about their health for some time after undergoing such a procedure. Consequently, a false positive result can adversely affect a woman's future attendance at screening appointments.[14,15] Over the whole screening process, the level of anxiety and distress suffered by women who receive a false positive is the same as that for women who receive a cancer diagnosis.[16]

The period of uncertainty between invitation for further investigation and receipt of the results of that investigation is recognised to be highly stressful, particularly for women who have had a biopsy.[12,17-19] The CNS aims to reduce the adverse effect of this anxiety by supporting all women through the recall process, thus assisting both those who are subsequently diagnosed with cancer, and those who have received a false positive result.

1.2.2 Communicating and providing information

A report published by the Advisory Committee on Breast Cancer Screening in 1991[20] highlighted the need to develop a specialist nursing service within the NHSBSP to provide women with additional patient support and information about the screening process.

The effectiveness of the subsequent service provided by the CNS was demonstrated by a 1997 study, involving 1493 women recruited from eight screening centres across England. This research concluded that '[women's] satisfaction with the information communicated to them was significantly higher for centres where a CNS provided women with the opportunity to talk in private before further investigations'.[21]

1.2.3 Improving the quality of cancer care

The CNS should be a core member of the multidisciplinary team (MDT)[22] and should play a crucial role in improving the overall quality of cancer care.[23] The QA guidelines for surgeons state that a breast care nurse specialist should be present when bad news is given to a patient and should provide ongoing support and information.[24] Studies have demonstrated the value of the CNS in identifying and reducing psychological morbidity in women diagnosed with breast cancer.[13,19,25] More recently, one of the most striking findings of the National Cancer Patient Experience Survey (2010) was the profound and positive impact of the CNS on patient experience and outcomes.[26]

1.2 Aim of this publication

These guidelines set out the standards of practice for clinical nurse specialists working in the NHSBSP. They detail the role of the CNS in breast screening, arrangements for QA, and a protocol for assessing the performance of the CNS.

The guidelines are reflective of other current NHS publications including:

- *National Cancer Patient Experience Survey.*[26]
- *Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer.*[27]
- *New Ways of Working.*[28]
- *Improving Outcomes: a Strategy for Cancer.*[29]
- *Advanced Level Nursing: A Position Statement.*[30]
- *Making a Difference.*[31]

2 GUIDELINES COVERING KEY ELEMENTS OF THE CNS ROLE AND WORKING ARRANGEMENTS

2.1 Philosophy

The wellbeing and care of women in the NHSBSP is dependent on the provision of a high quality, multidisciplinary service. As a member of the MDT, the CNS must ensure that women who are screened receive evidence-based care and information throughout the screening process, and more specifically during recall. This care and information should be delivered in a sensitive and dignified manner, at the appropriate time, with due regard to the woman's emotional, physical, and social needs.

During screening, the CNS should identify the woman's level of anxiety at an early stage, and offer appropriate support and while she awaits the final screening result. Previous episodes of anxiety or depression[32-34], pessimism, poor family relationships, low social support, a lower level of education, stressful non-cancer life events, or poor social functioning,[35-38] are all predictors of anxiety and depression in patients diagnosed with cancer. By identifying individuals at risk and managing their anxiety and distress during the pre-diagnostic phase,[13] the CNS can pre-empt some of the problems that may arise when a woman at increased risk of psychological morbidity is diagnosed with breast cancer.[35]

The provision of comprehensive nursing care and support requires the presence of an appropriately trained CNS, whose knowledge and skills are continually updated. In order to ensure that high standards of practice are achieved and maintained, the care pathway should be subject to regular review, and amended or updated in response to emerging evidence.

2.2 Key Elements of the Role

The CNS works as a member of the multidisciplinary team in the screening unit, and provides specialist nursing advice, education, and support for women who are recalled to assessment. The CNS is also a professional resource for colleagues and other members of the multidisciplinary team, and for the wider primary care team.

Key elements of the role, including an explanation of its responsibilities and resource requirements, are described in this section.

2.2.1 Clinical

Women should have access to telephone support and information from a CNS from the point at which they receive a recall appointment for further assessment. The CNS should discuss the reason for recall and should outline the assessment pathway with each woman before she undergoes further investigations.

The appointment letter and accompanying leaflet should therefore indicate how to contact a CNS for further information. It is thought that that this contact may be less

about providing answers to specific questions, and more about assisting women to cope with the uncertainties of the situation.[9] However, distressed or very distressed women are significantly more likely to want further information about the reasons for recall than women with lower levels of anxiety.[40]

At the start of the assessment process, the CNS should identify a woman's physical, social, psychological, and spiritual needs and ensure steps are taken to provide appropriate support for those needs.

The CNS should pay particular attention to the woman's current and past history of anxiety/depression, and should also explore any current or recent life or health crises that may indicate she requires more specific support. Relevant support, information, education, and advice must be provided, and the CNS should refer the woman to specialist professional or voluntary services where necessary (e.g. a GP, counsellor, social worker, voluntary service, faith, or charitable body). These services may act at local or national level, and may be accessed by direct or indirect referral.

The CNS should develop and review appropriate written information for women participating in screening, with a particular focus on recall and biopsy procedures. All information resources provided by the CNS (whether written or verbal) should give women up-to-date, evidence-based information about management and treatment options throughout the screening recall process. The aim is to include women in the decision-making process and to facilitate informed choice.

Information and support are particularly important at the start of the recall process and following a biopsy procedure (see Appendix 1). Information may relate to any aspect of the treatment and management of breast disease, indeterminate risk breast lesions, and breast cancer. Information prescriptions can also be offered (NHS Choices):

http://www.nhs.uk/Planners/Yourhealth/Pages/Information.aspx.

The CNS should also review all written information at appropriate routine intervals to incorporate new evidence and best practice. All information produced by the CNS must be approved by the appropriate Trust.

It is important that information regarding diagnosis and treatment options is provided in a manner that is consistent with a woman's wishes, and that it enables women to make informed decisions about treatment and care. The CNS should encourage all women to participate in the decision-making process relating to their care.

Women who have had a benign outcome may also experience uncertainty and may need further reassurance.[41] They should be given written information regarding their screening outcome. Women who are returned to routine screening following assessment should also know how to contact a CNS should they wish to obtain further information or reassurance.

The CNS should be present when a woman receives a diagnosis of cancer from a clinician, or is referred for further investigation of a suspicious or indeterminate lesion. The CNS should also participate actively in MDT meetings and act as the woman's advocate in the decision-making process.

The CNS should keep appropriate nursing records[42] and ensure that data relating to the screening assessment process are retained on a woman's screening record, until such time as they can be recorded on the Clinical Module of the National Breast Screening System (NBSS) database.

The CNS should initiate and participate in audits relating to women's experience of the assessment process, and should participate in other clinical audits relating to the care pathway for women in screening.

The regular use of a CNS to chaperone medical staff or to assist with biopsies is **not** an appropriate or cost-effective use of CNS time.

2.2.2 Extended Role

It has come to the attention of The National Coordinating Group for Nurses in Breast Cancer Screening that some nurse specialists working in breast screening have been taking on tasks that were formerly carried out by doctors (e.g. conducting breast examinations and giving results). Concerns were expressed by some members of the Group that some nurse specialists are undertaking this work without appropriate accredited training, a breach of the Nursing and Midwifery Council's (NMC) Code of Practice.[48]

If nurses are to perform additional duties, this must be formally agreed by the nurse, the MDT, and the nurse's line manager. Extended duties must be adequately funded so as not to compromise the standard of existing supportive care for women.

A CNS must not undertake extended or advanced practice until accredited training has been undertaken. A Trust- and QA-approved protocol for the extended role must also be in place.[43,44] Those CNSs who extend their role must be made aware they will be legally responsible for their actions.

Examples of role extension for the CNS working in breast screening are:

- Giving benign results face-to-face or by phone. This aspect of extended role is now established practice in the majority of services. The expert opinion of the National Coordinating Group for Nurses in Breast Cancer Screening is that the pathway described in Appendix 2 must be followed if this practice is undertaken.
- Giving malignant results.
- Performing breast examinations.
- Performing fine needle aspiration cytology (FNAC) and core biopsies.
- Prescribing (as appropriate to screening).

Tasks must be delegated appropriately by the medical practitioner. This means that the person to whom the task is delegated:

- Is aware of their responsibilities as a health professional.
- Works within clear protocols and guidelines.
- Has undertaken accredited training.
- Is appropriately mentored and supervised.
- Audits their own work.
- Works to agreed clinical standards.
- Takes responsibility for their own actions.

Unauthorised procedures must not be carried out, and a CNS working in breast screening must be aware of the boundaries of their own knowledge and skills.

A framework has been developed by the Royal College of Nursing (RCN) which outlines the revised domains and competencies for those nurses working in advanced nursing roles.[45] The NMC is currently considering whether additional registration will in future be necessary for the Advanced Nurse Practitioner role.[46]

2.2.3 Education / Health Promotion

The CNS must respond to the educational needs of those involved in breast screening and breast care/oncology (medical staff, radiographers, assistant practitioners, students, GPs, community care staff, women, and the general public).

This includes the duty to ensure that appropriate educational material is available for all service users, which means that the CNS should write and review material for local users (see section 2.2.1). The CNS must therefore identify their own continuing development needs so that they are able to access appropriate training to ensure that their knowledge is up-to-date.

The CNS should initiate and actively participate in health promotion activities that are relevant to women's health, specifically those relating to breast screening and breast health.

This may include building good working relationships with service providers in primary and secondary care, as well as working with cancer teams and networks for a particular screening service. The CNS should also be prepared to provide advice on nursing and other relevant aspects of the NHSBSP to external bodies, including patient associations, service user groups, and voluntary groups.

2.2.4 Audit / Research and Development

The CNS should initiate and participate in research and should be able to evaluate outcomes to ensure that clinical practice, protocols, and standards of care are evidence-based.

The CNS should be able to analyse research findings relevant to breast screening and breast cancer, including those relating to treatment options and psychological

care. When participating in research, they must ensure that women have sufficient information to make an informed choice regarding current research trials.

The CNS should audit their own clinical practice, pathways of care, and the woman's experience of assessment recall at least once every screening round. The results of this audit should be used to identify service improvements that may improve patient experience and outcomes.

Areas of good practice should be highlighted and shared at local, regional, and national level. This will be facilitated by attendance at twice-yearly meetings organised by the Regional QA Nurse, and by networking with CNSs in other Trusts in order to share learning and experiences.

2.2.5 Management

The CNS should generate and contribute to clinical standards, guidelines, and protocols within the screening service, particularly those that relate to the care pathway for women. The CNS should therefore be seen as a core member of the breast screening team.

The CNS must participate in annual reviews based on the performance outcomes of the unit.

The CNS must be aware of their responsibilities in relation to clinical governance, risk management, and information governance.

The last point includes the need to ensure confidentiality in relation to women's records (in line with Caldecott guidelines)[47] and the need to check that adequate staffing arrangements are in place to cover any periods during which the CNS is unavailable (these arrangements should be agreed with the CNS's line manager).

CNSs are accountable for their own professional practice, in accordance with the Code of Professional Conduct produced by the NMC.[48]

2.3 Working Arrangements

2.3.1 Support for the CNS

The CNS must be provided with relevant resources to ensure a continuing and effective service.

The CNS should be present during the assessment clinic, and should have access to a dedicated non-clinical room for private consultations. The CNS's manager must recognise the need to provide other necessary resources, including an office, a phone with voicemail, a computer, a bleep (if appropriate), dedicated clerical support, and arrangements for relief staff. Effective reflective practice/clinical supervision, as

well as psychological and peer support, are key resources for the CNS, and must be clearly identified by both the CNS and their line manager during the appraisal process.

2.3.2 Referrals

There must be agreed procedures for referring women to the CNS from both the hospital and community settings. The CNS must be able to contact professionals in other healthcare settings whenever necessary.

2.3.3 Communication and interprofessional relationships

Channels of communication should be established between all members of the breast team within the screening programmes. Existing networks should then be used to ensure effective liaison between the screening programme and other areas of healthcare provision.

2.3.4 Management

Professional lines of accountability through nursing services must be in place, including clear lines of clinical reporting (usually through the Director of the breast screening unit).

Where breast screening is allied to a symptomatic service, it is recommended that a designated lead CNS for screening is chosen.

2.3.5 Documentation

Systems for documenting the work of the CNS must be established, in line with NMC and Trust policy. This will ensure that accurate data are recorded for audit, QA, and research.

The CNS must accept responsibility for maintaining his or her own confidential records. The documentation for each case should include evidence of:

- Contact with the woman.
- Informal psychological assessment.
- The information provided to the woman (verbal and written).

2.3.6 Education and professional development

The CNS must be appropriately qualified for his/her role, and must have access to, and support for, continuing professional development (CPD).

A CPD plan should be agreed at appraisal. A list of training centres that provide breast care courses and professional training can be found in Appendix 3.

2.3.7 Audit of clinical practice

The CNS must be accountable for auditing his/her own clinical practice and must participate in the QA visit (see sections 4 and 5).

The audit should include the views of women who use the service that the CNS provides (see section 4.5).

2.4 Staffing levels

Experience from the NHSBSP suggests that a minimum of 0.1 WTE CNS per 10 000 screening population is required to fulfil the clinical part of the role outlined in section 2.2.1.

This is based on a May 2000 survey by the National Coordinating Group to investigate the nursing activity (assessment time and work generated by assessment) in 61 breast screening units. Other aspects of the role, and other elements of extended and advanced practice, are not included in this calculation and will require additional sessions, depending on the demands of the service.

3 STANDARDS FOR BREAST CARE NURSING IN BREAST SCREENING

3.1 Preparation to practice as a CNS in breast care (screening)

3.1.1 Standard statement

The standards outlined here are fully evidence-based. A literature search has been undertaken by the three authors of the guidelines across journal articles, nursing guidance, and Department of Health documents, to ensure that they are based on up-to-date and appropriate material.

Controversy remains over the delivery of benign biopsy results over the telephone by some Breast Care Nurses. This practice was raised at a meeting of the NHSBSP National Coordinating Group for Nurses in Breast Cancer Screening, and a majority of the group's expert members agreed that it was occurring in many units, despite the fact that it is not currently regarded as best practice. A project will be undertaken to study the effects of delivering benign results in this way, to clarify the position of the national office. Guidance will then be revised to reflect the findings of this research.

	Minimum Standard	**Outcome Measurement**
A	The CNS should be a Registered General Nurse (RGN) with relevant post-registration experience. Post-registration qualifications should include: • a breast care nursing course (at least 20 credits at first degree level or equivalent).[50] • an appropriate first degree.[3]	Appropriate qualifications/ evidence of qualifications (i.e. signed copies of educational certificates produced for QA visits).
B	The CNS should have advanced communication skills.	Minimum requirement: has undergone National Cancer Action Team-approved Advanced Communication Skills training.[29] Best practice: has obtained, or is prepared to undertake, a relevant counselling certificate (minimum 100 hours of training, to include theoretical and practice skills).
C	The CNS should have experience of working within breast care/oncology.	An oncology nursing certificate is desirable.
D	The CNS should have an annual appraisal and the opportunity to complete an annual CPD, in accordance with local protocols.	Time and funding are available to support CPD. Evidence of ongoing professional development.

E	Opportunities for effective reflective practice, arrangements for clinical supervision, and provision of psychological support for the CNS are in place.	The CNS's job plan should identify time for reflective practice. Clinical supervision/ psychological support should be provided.
F	Nurses undertaking roles at an advanced level must be competent to undertake the role.	Advanced Practice role must include the completion of the following training:[30] • An MA module in Advanced Practice award. • Clinical supervision by an appropriate trainer while gaining clinical competency. • Competency signoff by mentor. • A Protocol for practice performed. • Revalidation of competency. The Advanced Practice role must also be incorporated in the nurse's job description.

3.1.2 Rationale behind the standard

In order for a nurse to practice at this level, s/he must be adequately prepared. The CNS should therefore have completed academic study leading to a specialist qualification at no lower than first degree level. This requirement is endorsed by the *Skills for Health: Macmillan Nurse Specialist Career Framework*, Level 7.[49]

3.2 Standards of practice for a CNS in breast screening

3.2.1 Standard Statement

The role of the CNS in breast screening is to educate, inform, and support women throughout the screening process, with particular focus on the assessment pathway. The aim of the CNS is to alleviate and manage the anxiety and distress experienced by women during breast screening. This is achieved, in part, by providing appropriate, high-quality information, and by assisting individuals to interpret it so that they are able to make an informed choice.

The CNS role has four main components: clinical, education/teaching, management, and audit/research. Minimum standards are provided for the first three of these components in this section.

Clinical

	Minimum Standard	Outcome Measurement
A	All women recalled for assessment are made aware that a CNS is available to them at the point of recall.	Contact details for the CNS are provided in the recall letter.
B	The CNS meets the woman at the start of the assessment process in order to manage anxiety and distress by providing appropriate information and psychological support	All women recalled meet the CNS at the start of the assessment process. Records reflect the involvement of the CNS.
C	A physical, psychological, and social history is taken by the CNS for all women seen at assessment. The CNS ensures that other members of the assessment team have access to this information.	There is documented evidence within the screening/nursing records of a history having been taken. Appropriate referral mechanisms are in place and are evidenced.
D	All women who undergo a needle biopsy at assessment speak with a CNS.	Documented evidence of discussion is available. Contact details for the CNS are given to women awaiting biopsy results.
E	Appropriate facilities are available for private consultation with the CNS.	Evidence that appropriate private facilities are available.
F	The CNS assesses the woman's information requirements and offers appropriate verbal and written information.	The records reflect the information given by CNS. User experience surveys reveal that the information received was appropriate.
G	The CNS discusses ongoing care and treatment options with women and provides support through the decision-making process.	Records reflect the CNS's involvement in this area of care.
H	The CNS is present when women are given a diagnosis of cancer. The CNS assesses the woman's requirement for information and offers appropriate verbal and written information.	The records reflect the information provided by the CNS.
I	The CNS is a core member of the multidisciplinary team and contributes to discussions regarding the ongoing care of the woman.	The meeting register for the MDT records the regular presence of the CNS. The outcome of MDT discussions is recorded

J	Appropriate documents exist to record details of the support and information provided. This information is shared with the symptomatic CNS to enable ongoing care of the woman after assessment.	CNS records reflect the information and support given, including evidence of referral to a symptomatic CNS.
K	The unit ensures that all women who return to routine screening following assessment know how to contact a CNS.	The results letter given to the woman includes the CNS's contact details.
L	Nursing protocols are incorporated within the Quality Management System for the service	Nursing protocols are documented and reviewed

Education/teaching

M	The CNS contributes to the overall development of the breast screening programme through his/her involvement in teaching and education, particularly in relation to psychological care and information giving.	Evidence of formal/informal teaching. Evidence that appropriate study days/courses have been undertaken.

Audit/research

N	The CNS is able to demonstrate evidence-based practice	Evidence of relevant audits relating to care pathways, e.g. surveys of women's experience.

3.2.2 Rationale

Recall for breast assessment has been found to increase anxiety[3-10] and a poor assessment experience may deter a woman from attending for subsequent screening.[12-15] The CNS enhances the acceptability of breast screening to women by providing information and psychological support.[21] When anxiety and depression are recognised by a skilled CNS, and referral to an appropriate person is made, emotional distress can be reduced.[13, 21]

Each assessment clinic should have a CNS present throughout the assessment process. Research has shown that giving patients adequate information in accordance with their needs can decrease anxiety and enhance the individual's ability to cope with the recall process.[25,26] A skilled and knowledgeable CNS should therefore be effective in assessing the need for information and should be able to probe the woman's understanding of that information in a sensitive manner. The CNS should also be involved in discussions with the woman regarding treatment options, and should provide information and support during the decision-making process.

4 QUALITY ASSURANCE FRAMEWORK

4.1 Responsibilities for QA

QA in breast care nursing (screening) operates at national, regional, and screening unit level:

- At national level, the National Coordinating Group for Nurses in Breast Cancer Screening coordinates QA activities.
- At regional level, the QA Nurse audits nursing in breast screening units and participates in QA visits to assess professional nursing performance.
- At unit level, the CNS audits his/her own performance against the standards described in Chapter 3, and participates in the assessment of nursing performance described in Chapter 5.

4.2 National coordination

The National Coordinating Group for Nurses in Breast Cancer Screening represents nursing professionals working in the NHSBSP. It advises the NHSBSP on the provision of nursing and the contribution that it can make to the care of women who attend for breast screening. The group is formed of representatives (QA Nurses) from each English QA team and observers from Wales, Scotland, Northern Ireland, and the Republic of Ireland. Members of the group work with other organisations, such as the RCN Cancer and Breast Nursing Forum, the Advisory Committee on Breast Cancer Screening, the Association of Breast Surgery (ABS), and the National Evaluation Group.

The group is responsible for coordinating QA activities across the profession and providing a dynamic nursing contribution to the breast screening programme. Specifically, the group:

- Sets and reviews the standards to be achieved by each CNS working in the NHSBSP.
- Advises the NHSBSP on development, implementation, and review of guidance.
- Makes recommendations for the education and training needs of nurses who work in the NHSBSP.
- Fulfils a consultative role on proposed and completed audit/research relating to breast care nursing in the NHSBSP.

The constitution for the National Coordinating Group is shown in Appendix 4.

4.3 Regional QA Nurse

The Regional Director of QA for Breast Screening appoints a CNS to act as the professional Nursing QA Coordinator for the region. The QA Nurse is a member of the regional QA team and represents the region on the National Coordinating Group for Nurses in Breast Cancer Screening.

The role of the QA Nurse is to:

- Act as a coordinator between other CNSs who work in local screening units in the region, represent their interests at national level, and report to them any local and national developments.
- Take responsibility for the region-wide audit of breast care nursing standards and report the findings to the regional QA Director.
- Provide advice on breast care nursing education and training in the region to ensure and maintain an agreed level of care.

On completion of the period of appointment, there should be a handover to the newly appointed QA Nurse, either by the outgoing Nurse or by a relevant person at the Quality Assurance Reference Centre (QARC).

4.4 QA visits

As a member of the regional QA team, the QA Nurse participates in QA visits to breast screening units in the region.[52] The QA visit is an opportunity to review the whole screening process on a multidisciplinary basis, and to assess the effectiveness of teamworking in the breast screening unit. The protocol for assessing the professional performance of the CNS in breast care is given in Chapter 5.

4.5 Audit of individual practice

In order to achieve a high standard of care for women, it is important that the standards of practice set out in Chapter 3 are followed and monitored. The CNS should therefore review his/her practice regularly.

In order to audit his or her individual practice, the CNS should seek the views of women who attend for breast screening assessment. Questionnaires should be developed (with guidance from the QARC) and agreed locally. It is recommended that such surveys should be conducted once every screening round. Ideally, they should be conducted simultaneously across a region, so that the QARC can coordinate the results.

The survey should be aimed at women who attended an assessment clinic, and who were subsequently returned to routine recall. An example of an appropriate questionnaire is shown in Appendix 5.

When conducting the survey, best practice should be followed:

- The questionnaire should be piloted, and then reviewed and revised in the light of the data collected.
- A starting date should be agreed between the QA Nurse and the local QARC, avoiding main holiday periods.
- The QARC should post a questionnaire to 50-100 women who have attended the assessment clinic in the last four to six weeks, and who were subsequently returned to routine recall.

- A covering letter of explanation, together with a stamped addressed envelope (to be returned to the QARC) should be enclosed with the questionnaire.
- The QA Nurse and QARC should arrange a meeting for the CNSs who participated in the audit to discuss the results. The aim is to identify good practice where it exists and to recommend changes where gaps in the service are identified.
- The QA Nurse should feed back the audit results to the National Coordinating Group for Nurses in Breast Cancer Screening, identifying good practice and recommending improvements in areas where practice is not in keeping with the guidelines.

5 ASSESSING THE PERFORMANCE OF THE CLINICAL NURSE SPECIALIST IN BREAST SCREENING

5.1 QA visit questionnaire

The performance of the CNS should be reviewed by the QA Nurse (or deputy) at the QA visit. The QA Nurse (or deputy) must therefore have a clear understanding of the role of the CNS in breast screening. To ensure consistency in the review of the nursing role and its responsibilities, a nationally developed questionnaire should be used (for an example see Appendix 6). The completed questionnaire should be available to the CNS before the visit. During the QA visit, the completed questionnaire should be reviewed alongside the standards described in Chapter 3.

The aims of the questionnaire are:

- To review the performance of the CNS against national standards of practice.
- To confirm that the CNS has gained relevant qualifications or is working towards them.
- To ensure that a high standard of care is achieved by regular auditing and monitoring of practice, according to the NHSBSP standards of care.
- To ensure that the CNS participates as a member of the multidisciplinary team.
- To provide an opportunity for the CNS to demonstrate working practices and to raise any specific issues relating to QA that the QA team or Trust may need to address.
- To provide a tool to facilitate discussion about issues that affect quality, e.g. workload.
- To disseminate good nursing practice.
- To discuss and agree recommendations/actions and timeframes where NHSBSP nursing standards are not being achieved.

5.2 Action by the QA Nurse

5.2.1 Pre-QA visit observation in an assessment clinic.

The QA Nurse should carry out a visit to an assessment clinic to observe the care pathway from a woman's arrival to completion of her assessment process.

5.2.2 Day of QA visit

The QA Nurse should ideally meet with all the CNSs and nurses involved in the assessment process. S/he should give feedback on the earlier observational visit, and should highlight any discordance between what was observed and what was documented in the questionnaire.

The QA Nurse should identify any concerns or areas where the standards of practice are not being achieved, and should inform the QA Director and the QA team of these. The QA Nurse, QA Director, and QA team should plan a course of action with the CNS, the CNS's line manager, and the Clinical Director of Breast Screening to address these concerns. The proposed plan of action should be clearly documented

in the QA visit report, and the responsibility and timescales for any future actions must be identified. Confidentiality should also be maintained.

It should be noted that, in most situations, the areas of concern will be addressed at local level. However, unresolved issues must be reported to the QA Director, who will decide on the most appropriate course of action.

5.3 QA visit reports

Following each QA visit, the QA Nurse (or deputy), should submit a written report to the QA Director within a specified time. All recommendations should relate back to the guidelines. The risks associated with not following the recommendations in the report should also be outlined.

6 CONCLUSION

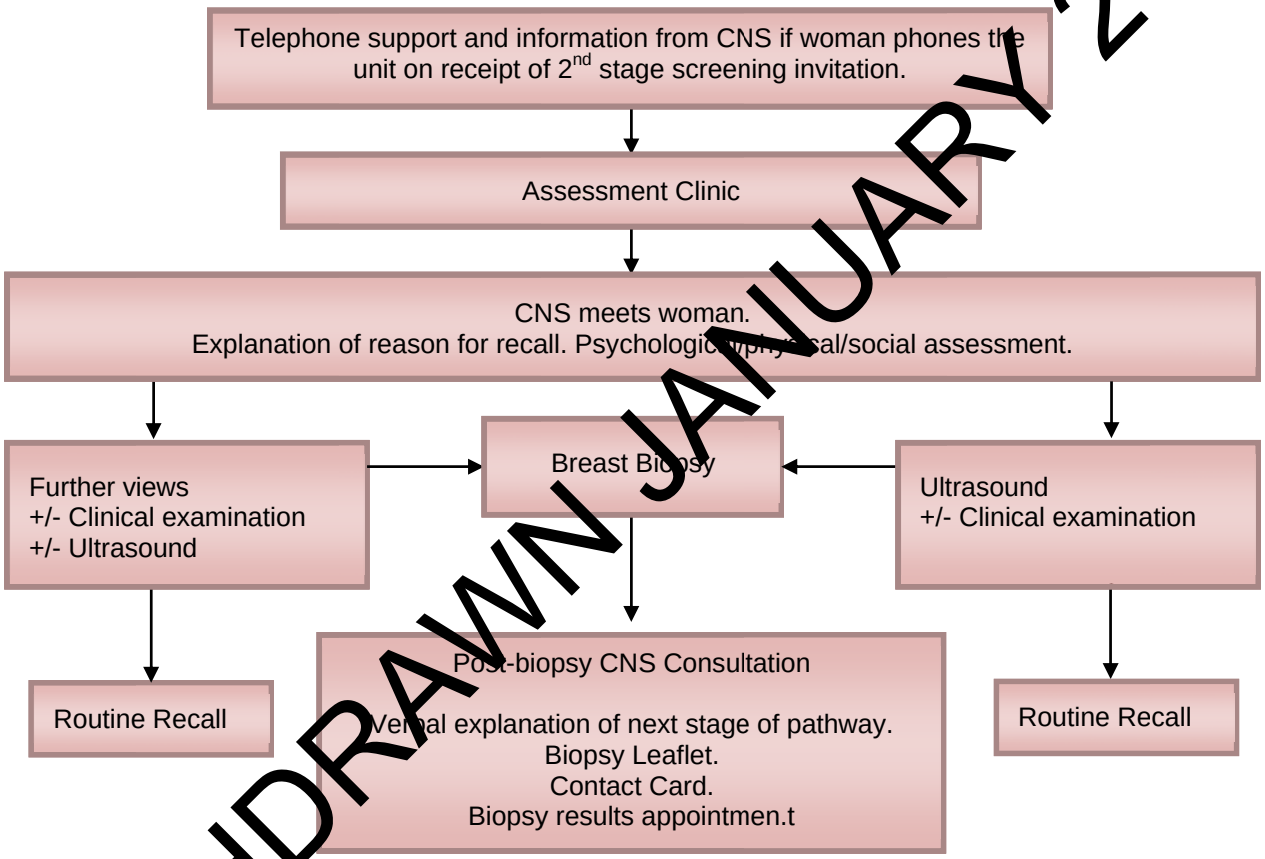
The anxiety that can be induced by screening, in particular by recall for further investigation, has long been recognised as one of the harms associated with the NHS Breast Screening Programme. Recent publications have argued that this anxiety, combined with the likelihood of overtreatment, mean that the breast screening programme causes harm to well women.†

However, the negative effects associated with high levels of anxiety can be mitigated by an effective CNS, making this role pivotal to the provision of a high-quality breast screening service. Good nursing practice can promote an overall positive experience for women participating in the NHSBSP and it is therefore important to ensure high nursing standards.

This review of the Nursing Guidelines will ensure that nurses working in breast screening are familiar with standards of practice, and are aware that these are based on the best evidence currently available.

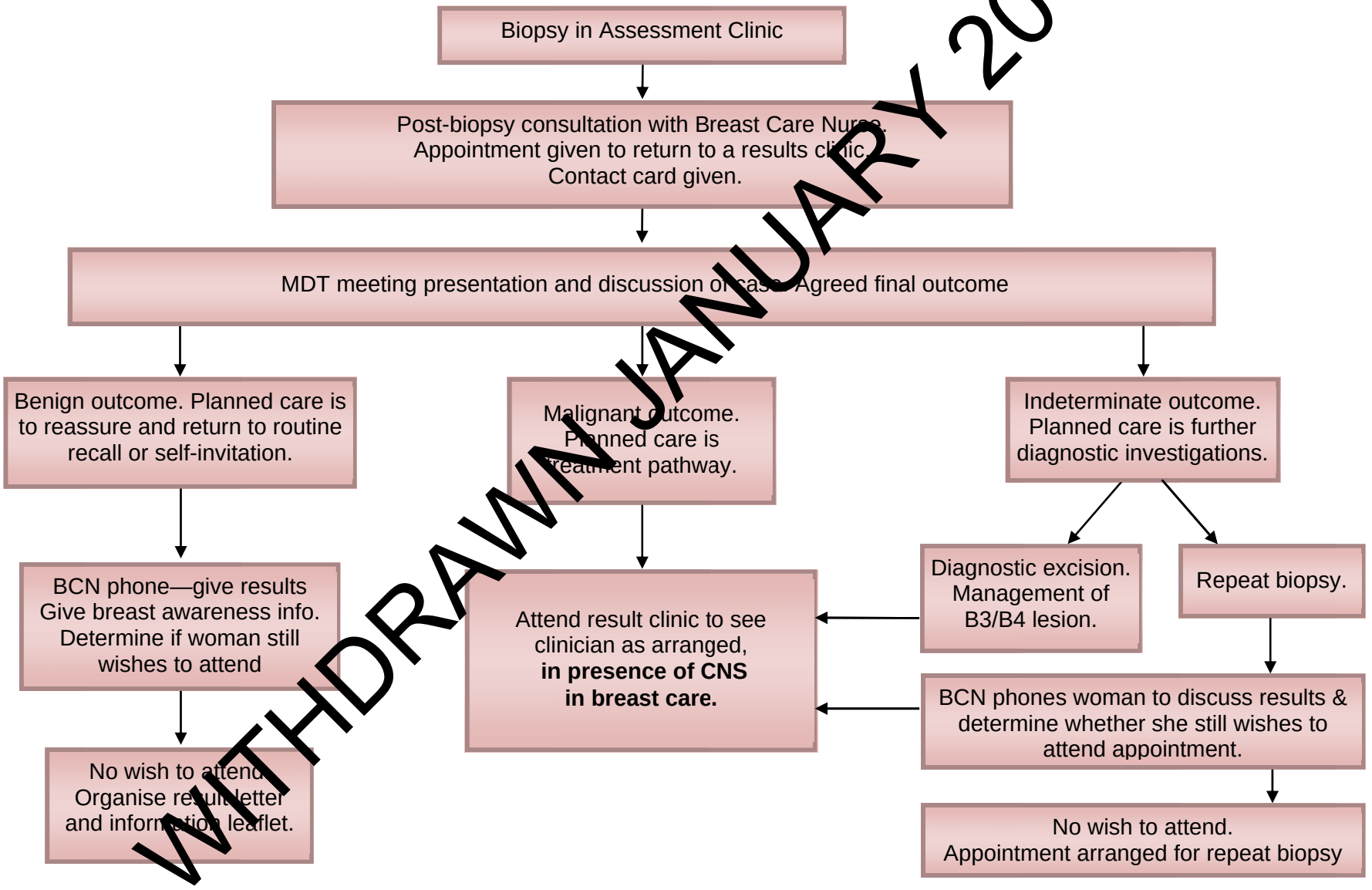
†A well woman is defined as a woman who has no self-detected physical signs or symptoms which require investigation to diagnose or exclude breast cancer.

APPENDIX 1: NHSBSP Breast Assessment Pathway for CNS



NB The woman should have access to a CNS at every stage in the pathway, and should be advised how to contact CNS after her return to routine recall.

APPENDIX 2: Benign results from MDT meeting



NHSBSP December 2012

APPENDIX 3: CURRENT TRAINING CENTRES FOR BREAST CARE COURSES

These are available at
https://www.gov.uk/guidance/breast-screening-education-and-training

APPENDIX 4: NATIONAL COORDINATING GROUP FOR NURSES IN BREAST CANCER SCREENING: CONSTITUTION

A 1.1 Membership

- A nursing representative from each English QA team, and observers from Scotland, Wales, Northern Ireland and The Republic of Ireland.
- A cooption to represent the RCN Cancer and Breast Nursing Forum.
- A representative of the NHSBSP national team.
- A chairperson, elected from the group, and approved by the national office for a period of three years.
- A secretary, elected from the group for a period of three years.

A1.2 Representation

- The QA Nurse Coordinator is a CNS appointed by each of the breast screening QA Directors in accordance with *EL (97)67 Cancer Screening: Quality Assurance and Management.*[53]
- The QA Nurse representative should fulfil the competencies and criteria for a CNS in breast screening.
- This representative must work in an assessment clinic and with patients who have screen detected lesions.

A1.3 Remit

- To maintain and improve the standard of nursing within the NHSBSP throughout the UK by ensuring the nurses working within the screening units maintain the QA guidelines for nurses.
- To advise the NHSBSP on nursing matters and provide feedback and information relevant to nursing in the NHSBSP to the regional QA Director and other members of the QA team.
- To ensure dissemination of relevant information in order to develop and support the CNS within their local region. In particular, to establish networks and facilitate information exchange between nurses working within breast screening locally.
- To ensure dissemination of relevant information both to and from the National Coordinating Group, by meeting with the nurses working in screening within the region.
- To identify the educational needs of the CNSs working in breast screening, and to assist in developing educational programmes to meet these needs.
- To advise regional QA Directors and Programme Managers of the educational and training needs of nurses working in the screening programme.
- To advise the NHSBSP and to act as a resource to the NMC in relation to the training needs of nurses working in the screening programme.
- To identify ways in which links with the private sector and other non-NHS screening providers can be developed and maintained.
- To define, agree, and audit professional standards of nursing care relevant to breast screening, against which the quality of the service can be measured.
- To agree, implement, evaluate, and update guidelines for nurses working within the screening programme.
- To identify research needs and facilitate, coordinate, and promote collaboration in audit/research and development activities.

- To have annual appraisal with the QA Director and produce a personal development plan.
- To evaluate and update these terms of reference and the guidelines for the group at least every three years.

A1.4 Meetings

- To achieve the above remit, at least two meetings will be held per annum. Working parties may be convened to address specific issues.

A1.5 Financial guidelines

- The QA representative is funded from the QA budget.
- Travel to QA meetings and visits and to the national meetings should be reimbursed from the QA budget.
- National working parties will be reimbursed from the QA budget.
- Additional expenses incurred as a result of QA work duties should be negotiated with the QA Director.
- These guidelines will be reviewed in the event of changing circumstances.

This constitution will be reviewed at least every 3 years.

APPENDIX 5: QA QUESTIONNAIRE

NHS Cancer Screening Programmes

Dear Participant,

The NHS Breast Screening Programme sets out a number of national standards that breast screening services have to meet. In particular, breast care nurses must ensure that you receive evidence-based care and information throughout the screening process, and especially if you are recalled for an assessment. Nurses are expected to deliver this service in a sensitive manner, at an appropriate time, and with due regard to your emotional, physical, and social needs.

The Breast Screening Quality Assurance Reference Centre works with your local breast screening service to make sure that high quality services are offered to all women who participate in breast screening. We are writing to ask for your views on your recent experience of care at a screening centre. Your response is valuable to us and will influence changes to the care provided.

We would be very grateful if you would spend a few minutes answering this questionnaire. All of the questions refer to your views and experiences of breast care nurses during your assessment visit. Please answer the questions as truthfully as you can. There is no right or wrong answer to any question and we are interested in all of your opinions. There is no need to give your name as all responses are completely anonymous.

When you have finished answering all of the questions, please return the survey in the pre-paid envelope provided.

Thank you very much for assisting us to develop breast screening services.

BREAST CARE NURSES - YOUR OPINIONS

Please answer the questions on all **3** pages.

1. Before your visit did you use any resources to gain information? (Tick all that apply)

Contacted breast screening unit ☐ Spoke to a Breast Care Nurse ☐

Looked on the internet ☐ Spoke to GP ☐ Spoke to family/friends ☐

Read books/leaflets ☐ Other ☐ (please specify)_____

2. Did/do you know how to contact a breast care nurse should you need to?

Before you arrived at the hospital? Yes ☐ No ☐

After you left the hospital? Yes ☐ No ☐

3. Were you aware that you would meet a breast care nurse during your assessment?

Yes ☐ No ☐

If yes, how were you made aware of this?

Invitation letter ☐ Leaflet ☐ Told verbally ☐ Sign in clinic ☐

☐ Not sure

4. On arrival at the clinic, did you feel?

Not anxious ☐ Anxious ☐ Very Anxious ☐

5. Were you given a clear explanation as to why you were being recalled to an assessment clinic?

Very clear ☐ Vague ☐ Not clear ☐

If vague or not clear, is there anything you think can be done to improve this?

_____

_____

6. At what point did you speak to a breast care nurse during your visit to the assessment clinic? (Tick all that apply)

On arrival at the assessment clinic ☐ During assessment ☐

Before you left the assessment clinic ☐ Not at all ☐

7. If you <u>did</u> speak to a breast care nurse, was this?

Very helpful ☐ Helpful ☐ Fairly helpful ☐ Not at all helpful ☐

If you answered 'Not at all helpful', why do you feel this was?

_____

_____

8. If you did <u>not</u> speak to a breast care nurse, was this because……?

Breast care nurse not available ☐ I did not want to ☐

Not aware that I could ☐ Other (please specify)_____

9. If you saw a breast care nurse at any point during your assessment did you feel that your discussions were held in an appropriate environment?

Yes ☐ No ☐

If you answered 'No', why do you feel this was?

_____

_____

10. During your discussions with a breast care nurse, was the verbal information given to you…….?

Appropriate ☐ Not appropriate ☐

If you answered 'Not appropriate', why do you feel this was?

_____

_____

_____

11. If you <u>did not</u> see a breast care nurse during any part of your assessment, would you have liked to?

Yes ☐ No ☐ Don't know ☐

Not appropriate as saw a Breast Care Nurse ☐

12. What procedure(s) did you have during your assessment visit? (Tick all that apply)

Breast Examination ☐ Further mammograms (x-rays) ☐

Needle biopsy ☐ Ultrasound ☐

13. Whether or not you saw a breast care nurse, were you given any written information? (e.g. leaflets)

Yes ☐ No ☐

If yes, was this information……? (Tick all that apply)

Clear to read ☐ Confusing ☐ Friendly ☐

Frightening ☐ Well explained ☐ Didn't read it ☐

Too brief ☐ Too long ☐ Not relevant ☐

Other (please specify)

_____

14. Did the verbal and/or written information you were given meet your needs?

Yes ☐ No ☐

If you answered 'No', why do you feel this was?

_____

_____

15. Do you have any suggestions for how the breast care nurse service provided could be improved?

_____

16. On leaving the clinic, did you feel?

Not Anxious ☐ Anxious ☐ Very Anxious ☐

Please use this space for any additional comments you have about your experiences of breast screening

_____
_____
_____
_____
_____
_____
_____

Thank you

APPENDIX 6: BREAST CARE NURSING QUALITY ASSURANCE TEAM PROFORMA

Instructions for completion of this proforma: The lead CNS (breast screening) should complete this proforma in collaboration with the other CNS/BCNs in the screening team. The form can be completed electronically, but one copy must be printed and signed by the lead CNS (breast screening) and returned to the QARC. Any CNS/BCN screening can complete a separate proforma if they have a particular concern. Alternatively, they can contact the QA Nurse.

Tel: …….. Email: ……

The lead CNS (breast screening) is responsible for attaching and sending copies of educational certificates for each nurse. S/he must sign on the reverse of the copy to confirm that it is a true copy of the original.

(QA to insert logo QARC region)

Date of QA team visit:

Name: _____ (please print) Signature _____

(Lead CNS breast screening)

Breast screening unit:

Hospital:

CNSs/Breast Care Nurses (BCN) in attendance (to be completed on the day):

QA Nurse:

Please return the completed form by: to:

CNSs involved in breast screening:

Please complete both sections for each CNS/BCN involved in breast screening

Name	Job title	AFC* band	WTE† Screening/symptomatic /combined	Accountable to	
				Professionally: name and title (e.g. senior nurse)	Clinically: name and title (e.g. clinical director)

Name of CNS	RGN‡	Advanced Breast Care Course	Counselling certificate (100 hours)	Advanced Communication Skills Training	Relevant degree	Teaching certificate	Oncology course	Others (please state) including Advanced Practice	Signature of QA Nurse on verification of certificates

*Agenda for Change band (AfC) †Whole time equivalent (WTE) ‡Registered general nurse

QA Team (Nursing) Visit Proforma

Topics for review		QA standard or reference	Comments
1.0	**Facilities**		
1.1	Does each CNS/BCN have access to a private designated counselling room within the breast screening unit?	3.2.1 (E) 2.3.1	
	(i) a bleep/mobile telephone?		
	(ii) access to secretarial support?		
	(iii) a computer/email?		
	(iv) a contact card?		
	(v) an answer phone?		
	(vi) adequate office space?		
2.0	**Assessment**		
2.1	(i) How many assessment clinics are held each week? (ii) What is the approximate start time of the clinics? (iii) What is the approximate finishing time of the clinics? *i.e. number of hours spent in clinics per week by the CNS/BCN*	3.2.1 (B)	
2.2	How many assessment clinics have a CNS/BCN present in them each week?	3.2.1 (B)	
2.3	(i) What is your current screening population size? (ii) How many CNS/BCN hours are contracted to the NHSBSP each week?	2.4	
2.4	Does your unit's Service Level Agreement state this number of hours?	2.4	
2.5	Are women provided with: (i) the telephone number of a CNS/BCN before attending the assessment clinic?	3.2.1 (A) 2.2.1	

	(ii) the name and number of the CNS/BCN at the assessment clinic? Please attach a copy of the recall letter with this completed proforma.		
2.6	Please outline the woman's pathway throughout your assessment clinic. This should run from the moment she arrives until she leaves. You should state the responsibilities of the CNS/BCN during this time. Please continue on a separate sheet if necessary.	3.2.1 (B) 3.2.1 (C) 3.2.1 (D) 3.2.1 (F)	
2.7	(i) Do you refer women to the CNS in symptomatic clinics? (ii) Do you refer women to other hospitals/Trusts or to the private sector? (iii) If women are not treated locally, to whom do you refer, and how is this done? (iv) Please explain the referral mechanisms for all the above questions.	3.2.1(G) 3.2.1(H) 3.2.1(J) 2.3.2	
2.8	(i) Is written literature/information available for women in the assessment clinic? (ii) Please list the titles of all written information routinely offered. At the QA visit please provide evidence of this information.	3.2.1 (F)	
2.9	(i) Does the CNS/BCN undertake a psychological, social, and physical assessment of the women seen at assessment? If so, please explain. (ii) Do you have easy access to a counsellor or psychologist for the women?	3.2.1 (C)	
3.0	**Record keeping**		
3.1	Does the CNS/BCN record a psychological, social, and physical assessment of all women seen at assessment? Please have evidence available for QA visit.	3.2.1 (C) 3.2.1 (F)	
3.2	A random sample of nursing notes will be reviewed by the QA Nurse.		

4.0	**Patient choice**		
4.1	Do women have a choice of the following: (i) CNS? (ii) Consultant surgeon? (iii) Hospital? (iv) Treatment centre?	2.3.2	
5.0	**Multidisciplinary team meetings**		
5.1	Describe how the CNS participates in the multidisciplinary team (MDT) meetings. (i) How often are the meetings? (ii) How long do they last? (Please state times). (iii) How many cases are discussed at the meetings?	3.2.1 (I)	
5.2	Is a CNS present at every MDT? Yes/No	3.2.1 (I)	
5.3	What records are kept of the meetings i.e. is there a record of the result recorded in the nursing notes and screening packet/hospital notes?	3.2.1 (I)	
5.4	Does the CNS have documented evidence of the MDT discussion when she sees women with their results?	3.2.1 (I) 3.2.1 (J)	
6.0	**Audit activities**		
6.1	Has the CNS participated in audit? (i) CNS activity in the screening service? (ii) Regional QA audit for nursing? (iii) Local audit?	3.2.1 (N) 2.2.4	
6.2	What changes have been implemented/considered based on the outcome of audits in the last three years?	3.2.1 (N)	
6.3	Are CNSs involved in any audit/research related to screening?	3.2.1 (N)	

7.0	**Professional development**		
7.1	Does every CNS have a professional development plan (PDP)? Have these been updated in the last 12 months? If not, when is an update planned?	2.3.6 3.2.1 (M) 3.1.1 (D)	
7.2	Does every CNS have the opportunity for ongoing education?	2.3.6	
7.3	Is ongoing education/training supported by the Trust?	2.3.6	
8.0	**Working arrangements**		
8.1	(i) Is there cover available for sick leave/study days/annual leave? (ii) Has your CNS team had a significant sickness record in the last 12 months (defined as >50 days total)?	2.3.1	
8.2	(i) What reflective practice/clinical supervision do CNSs have? (ii) Is reflective practice/clinical supervision identified in your PDP?	3.1.1 (E)	
8.3	(i) Do CNSs have an annual appraisal? (ii) Name and job title of appraiser(s).	3.1.1 (D)	
8.4	Are CNSs involved in teaching formally/informally? If yes, please provide evidence/details.	3.1.2 (M)	
8.5	Are CNSs involved in health promotion activities? If yes, please provide evidence/details.	2.2.3	
8.6	Does your unit undertake any form of succession planning for CNSs? (Please specify)	2.4	
9.0	**Working relationships**		
9.1	Are the CNS satisfied with working relationships within the team? Please comment.	2.3.3	

10.0	**Other comments**		
10.1	Are there any initiatives or problems relating to the assessment process that are likely to have a negative impact on the woman's experience? Please specify.		
11.0	**Advanced Practice**		
11.1	(i) Masters Module in Clinical Examination if performing breast examination. (ii) Supervision by an appropriate trainer. (iii) Competency sign off by mentor. (iv) Protocol for practice undertaken. (v) Role incorporated within job description. (vi) Revalidation of competency.	3.1.1 (F)	
12.0	**Points of good practice** *(to be completed at the QA visit)*		
13.0	**Recommendations** *(to be completed at the QA visit)*		
	(i) Actions within three months		
	(ii) Actions within six months		
	(iii) General recommendations		

All recommendations to be signed by the QA Nurse

Name:

Signature:

Date

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