Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Greater Manchester Breast Screening Service

16 October 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 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. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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	
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 findings signs of the disease at an early stage.

The findings in this report relate to the quality assurance visit of the Greater Manchester breast screening service (GMBSS) held on 16 October 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

GMBSS is provided by the Manchester University NHS Foundation Trust (MFT). The total population of the area served is approximately 1,520,000. There are 174,000 eligible women in the age range of 50 to 70 and 224,000 when the age extended population is included. The screening service covers the geographical areas of Manchester, Salford, Tameside, Oldham and Trafford. Greater Manchester public health commissioning team is the commissioner for the service.

Screening is provided from 2 static sites in Withington and Oldham and there are also 4 mobile vans visiting 15 sites.

Assessment clinics are held in the Nightingale Centre at Manchester University NHS Foundation Trust (MFT) in Wythenshawe. Pathology and surgery services are also provided at MFT.

Findings

The service consistently meets the majority of performance standards. Governance structures within the newly formed organisation are clear, providing appropriate escalation routes for screening issues. The unit is well equipped with facilities and staff. There are only minor staff shortages in administration, radiography and pathology.

Immediate concerns

There were no immediate concerns identified during the QA visit.

High priority

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

- time allocation for the Director of Breast Screening (DoBS) role is insufficient
- there is no dedicated breast magnetic resonance imaging (MRI) coil
- breast care nurses are not present in assessment clinics
- there is insufficient time allocated for the plenary multi-disciplinary team meeting
- areas of surgical practice (magnetic seed localisation, staging computed tomography (CT) and cavity shaves) need to be audited
- theatre allocation is inconsistent and should be reviewed

Shared learning

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

- successful batch realignment project
- award winning IT initiative for breast care nurses (BCNs)
- behavioural insight work to improve uptake
- pilot of magnetic seed localisations

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1801	DoBS to be allocated 2 sessions per week and a deputy to be appointed	1	6 months	High	Job plans for DoBS and deputy

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1802	Install a dedicated breast coil in the magnetic resonance imaging (MRI) machine used for breast screening clients	2	6 months	High	Confirmation from trust
PMA1803	Implement process to identify and resolve unspecified/orphan images and laterality errors (prior to reading)	3	6 months	High	SOP of image review process

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1804	Review administration staffing to improve resilience	1	6 months	Standard	Workforce plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1805	GP feedback reports to be distributed 6 months post screening	9	6 months	High	Confirmation from Programme Manager (PM)
PMA1806	Implement additional failsafe process for high risk screening	1	3 months	Standard	SOP of failsafe process

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1807	Develop health promotion strategy	1	6 months	Standard	Strategy document with action plan approved and agreed with commissioners

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1808	Mammography staff to be increased by 2 whole time equivalent (WTE)	4	6 months	Standard	Workforce plan
PMA1809	Audit to ensure management of microcalcification meets standards as set out in NHSBSP Publication 49	7	6 months	Standard	Audit report with any identified actions
PMA1810	Audit of cases requiring arbitration and outcome to confirm use of second opinion documentation	7	6 months	Standard	Audit report with any identified actions
PMA1811	Policy to show how lessons learned from interval cancers are disseminated to film readers	10	6 months	Standard	SOP of interval cancer process for film readers

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1812	Audit to ensure post clip mammography is performed following insertion of marker clips	7	6 months	Standard	Audit report with any identified actions
PMA1813	Clinical Nurse Specialist (CNS) needs to be present in all assessment clinics and practice according to 2018 to 2019 service specification	5	6 months	High	Sample rota and confirmation from DoBS
PMA1814	Review laboratory leadership as part of merger and collaboration activity to ensure adequate staff support	6	6 months	Standard	Workforce plan

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1815	Plenary multi-disciplinary team (MDT) meeting to be extended to a full session to ensure quality of decision making can be maximised	7	6 months	High	Documentation of MDT arrangements
PMA1816	Morning MDT meeting to comply with all requirements and venue reviewed to ensure all clinical information, if required for decisions, is visible to all participants	7	6 months	Standard	Meeting minutes confirming review of MDT accommodation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
PMA1817	Data staff provision to be increased to support clinical audit	1	6 months	Standard	Workforce plan
PMA1818	Review practice of using MRI and staging computed tomography (CT) for screen detected early breast cancers to ensure investigation is clinically indicated	1	6 months	High	Audit report with any identified actions
PMA1819	Audit comparing magnetic seed localisations to fine wire guided localisations to determine effectiveness of new localization technique	1	6 months	High	Audit report with any identified actions
PMA1820	Ensure adequate theatre allocation for screening surgeons	8	1 year	High	Report of capacity mapping process outcomes with any identified actions
PMA1821	Audit to review variation in practice of cavity shaves and to ensure shaves are only taken when clinically indicated	1	6 months	High	Audit report with any identified actions

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.