Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
South West London Breast Screening Service

9 October 2018

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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.

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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**	Functions are shared with the pan-London administration Hub
Invitation and information	**Yes**	functions are shared with the pan-London administration Hub
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 (QA) visit to the South West London Breast Screening Service (SWLBSS) on 9 October 2018.

Quality assurance purpose and approach

Quality assurance aims to maintain national standards and promote continuous improvement in breast screening. This is to ensure that 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:

- routine monitoring data collected by the NHS screening programmes
- evidence submitted by the provider(s) and commissioner
- information collected during pre-review visits to the service - administration and clerical, radiography (including image review), radiology (including image review), medical physics, breast care nursing, pathology slide review, surgical case note review, observation of the multidisciplinary team meeting and a ‘right results’ walkthrough
- Information shared with SQAS (London), routinely and as part of the visit process

Local screening service

The SWLBSS is based in the Rose Centre at St Georges University Hospitals NHS Foundation Trust. The Rose Centre is dedicated to breast cancer diagnosis and follow-up.

The SWLBSS serves a total eligible population of 173,633 women, aged 50-70. The service participates in the randomised age-extension trial and screens selected women aged 47-49 and 71-73, which represents an additional cohort of approximately 51,271 women.

The SWLBSS covers 6 Clinical Commissioning Groups (CCGs) of South West London which are:

- Wandsworth
- Merton
- Kingston
- Richmond
- Croydon
- Sutton

The catchment population of SWLBSS is ethnically diverse and mobile, with a significant transient population (including the homeless population). The population includes a large proportion of women who speak English as their second language, as well as women with physical or learning disabilities. Wandsworth and Croydon CCGs have the greatest levels of deprivation, but there are pockets of deprivation in most of the CCG areas served. There are 3 prisons within the catchment area: HMP Wandsworth, HPM High Down and HMP Downview. Downview houses female offenders who are screened by SWLBSS.

The service undertakes digital mammography and provides screening at 7 static sites which are:

- Rose Centre, St. George's Hospital, Tooting
- Teddington Memorial Hospital, Teddington
- Surbiton Health Centre, Surbiton
- Edridge Road Community Health Centre, Croydon
- Robin Hood Lane Health Centre, Sutton
- Queen Mary's Hospital, Roehampton
- Purley Memorial Hospital, Purley

The service has no mobile screening units. Assessment clinics are held at St. George's Hospital. Screen-detected cases are treated at one of the following trusts: St. George's Hospital, Royal Marsden Hospital (RMH, Sutton site), Kingston Hospital (KH), Croydon University Hospital and West Middlesex University Hospital (WMUH).

During 2015 to 2016, NHS England (London) re-commissioned the provision of breast screening across London. Since 1 April 2016, the model has comprised a stand-alone pan-London call/recall administration 'Hub' provided by the Royal Free London NHS Foundation Trust and 6 clinical services, including SWLBSS. Prior to this, each breast screening service in London provided an end-to-end pathway which included the functions now provided centrally by the Hub.

Over the past 2 years, SWLBSS personnel have experienced sizable changes and have overcome many challenges. These include mobilisation to the centralised Hub call/recall model, major staff changes with a loss of senior staff, slippage in round length and re-writing the round plan, and managing the impact of a new national cohort identification system: Breast Screening Select (BS Select).

Findings

In the past year the service has lost senior and experienced staff in key positions (director of screening, programme manager) which impacted on the safe running and delivery of the service.

In the 3-year period from April 2014 to March 2017, the annual uptake rate for the service was below the national standard (≥ 70 %). The uptake rate was also below the national average during 2014 to 2017 but above the London average during 2015 to 2017 (see table below), owing to active local health promotion initiatives.

Uptake 50-70	2014-15	2015-16	2016-17
SWLBSS	61.6	65.7	65.4
London	62.6	64.9	63.9
National	71.3	72.1	71.1

Immediate concerns

The QA visit team identified no areas of immediate concern.

High priority

The QA visit team identified 5 high priority findings which were that:

- the Quality Management System (QMS) requires updating to include audits, version control and protocols that reflect actual practice
- the permanent appointment of a director of screening and a deputy director of screening has not been finalised – the QMS post holder is on long-term sickness
- appropriate training and support provided to new appointees is not formally in place
- the business case for equipment replacement is pending
- a signed data-sharing agreement is not in place and an agreement has not been reached regarding the administration of the age extension trial cohort

Further findings

SWLBSS is patient centred and delivered by a team which is motivated and works well across all disciplines.

Workforce issues were identified across all disciplines. Workforce numbers are not fully established in radiography, and there is a lack of clarity about roles and responsibilities.

Several risks were identified around reliance on customised crystal reports which may not adequately reflect National Breast Screening System (NBSS) updates.

There is under reporting in relation to technical recall rates.

There are discrepancies between the interval cancers documented on NBSS, and those identified by Screening History Information Manager (SHIM), but these are currently actively managed.

Areas of good practice

The lead breast care nurse now manages the reporting and investigation of screening safety incidents which has improved the quality of reporting and led to an improved culture over the last year.

The nursing team participates in a wide range of health promotion activities in the local community, and there are many examples of good practice.

The mammography team is hard working and images are of a good standard, despite staffing and other challenges.

Round length was delivered within target following major issues identified in the service.

Good systems are in place for imaging clients with special needs.

There is a high cancer detection rate.

The pathology services have good turnaround times despite a heavy workload.

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	The commissioners to make sure that SWLBSS and the Hub have a detailed operational policy in place between them that supports the signed Memorandum of Understanding (MoU)	National Service Specification No. 24	3 months	H	Signed copy of latest operational policy
2	The commissioners to make sure that the Hub and the clinical services in London agree on how the provision and administration of age extended cohort will be resourced	National Service Specification No. 24	3 months	H	Confirmation of agreement
3	Make sure annual report is reviewed outside of the divisional governance structure by the trust executive	National Service Specification No. 24	12 months	S	Confirmation that annual report (summary) has been shared with the executive team
4	Make sure there is continuous provision of the current clinical governance function for the service	National Service Specification No. 24	3 months	H	Staffing structure that includes governance reporting function
5	Formal appointment to director of screening and deputy director of screening roles	National Service Specification No. 24	3 months	H	Confirmation of appointments and updated accountability and governance structures within the breast imaging care group

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6	Trust to provide support for the development of the new leadership roles to include, programme manager, superintendent radiographer, deputy director of screening and director of screening	National Service Specification No. 24	6 months	H	Confirmation of training and support in place that is included in staff PDPs
7	Update relevant local policies to include reference to managing screening incidents in accordance with national guidance for managing Safety Incidents in NHS Screening Programmes	Managing Safety Incidents in NHS screening Programmes (2017)	1 month	S	Confirmation of updated ratified and approved policy in place
8	Finalise and implement an effective quality management system for the right results process and across the screening service	National Service Specification No. 24	6 months	H	Confirmation of an overarching Quality Management System (QMS) policy in place
9	Implement the use of National Breast Screening System (NBSS) standard reports within the right results process	National Service Specification No. 24	3 months	H	Confirmation and update of Standard operating procedure (SOP)
10	Agree a protocol for changing the passwords used on portable media (used to transfer confidential data)	Trust information governance policy	1 month	S	Protocol in place
11	Use SIRV to resolve any discrepancies between digital images uploaded on picture archiving and communication system (PACS) with women attending for screening	National Service Specification No. 24	3 months	S	Confirmation that SIRV is being utilized and work instruction (WI) to be updated

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
12	Risk asses current practices in relation to Image processing and picture archiving and communication system (PACS) processes	National Service Specification No. 24	3 months	S	Outcome of risk assessment for a. Stereo examinations that fall into exceptions and work with Phillips to resolve b. Identification of wrong markers c. Manual PACS' processes
13	Conduct audits for partial mammography and symptomatic recall from screening	National Service Specification No. 24	12 months	S	Result of audits
14	Clarify respective roles and responsibilities (with the Hub) in relation to completing KC62 and BASO returns	Right Results	12 months	S	Successful completion of next KC62 and BASO data returns

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	Make sure the QMS lead role is effectively covered	National Service Specification No. 24	3 months	H	Action plan detailing how the QMS lead role functions are covered
16	Assess the impact of staff shortage in the symptomatic service on screening service resource	National Service Specification No. 24	6 months	S	Feedback summary on progress of the business plan submitted to the trust

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
17	Develop an administrative and clerical (A&C) staff training and development plan	National Service Specification No. 24	3 months	S	A&C Staff development plan
18	Risk assess Edridge Road premises to ensure accommodation/premises in use meets the specification, guidance and needs of service users	National Service Specification No. 24	6 months	S	Confirmation and outcome of risk assessments for screening service at Edridge Road
19	Trust IT should provide assurance that the National Breast Screening System (NBSS) server is robust and provide details of the plan to move to a new server	National Service Specification No. 24	3 months	S	Confirmation that risk to the service is appropriately recorded on the risk register
20	A laptop should be provided for use at Edridge Road until full NBSS connectivity can be arranged	National Service Specification No. 24	1 month	H	Confirmation that a laptop is available and that paper based entry has stopped
21	Develop a plan to review and replace the ageing mammography equipment with trust oversight	NHSBSP Publication 59 – Quality Assurance Guidelines for Breast Cancer Screening Radiology	6 months	S	Schedule for equipment replacement
22	Undertake training for radiographers on the function of the Siemens PRIME software that is in use in the breast unit	NHSBSP Guidance for breast screening mammographers. Also NHSBSP Publication 75 – Guidance for the implementation of the Ionising Radiation (Medical Exposure) Regulations (2000,2006)	3 months	S	Confirmation that this training has taken place

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
23	Update IRMER Employer's Procedures in light of recent regulatory changes	Ionising Radiation (Medical Exposure) Regulations 2017	12 months	S	Amended procedures and protocols
24	Increase Medical Physics Expert (MPE) involvement with equipment performance testing and fault reporting	NHSBSP Publication 33 Quality Assurance Guidelines for Medical Physics Services. Also The Ionising Radiation (Medical Exposure) Regulations 2017	3 months	S	Confirmation that this has occurred
25	Examine the monitors used by pathology and surgery for viewing images and ensure that they meet the current NHSBSP standard/are fit for purpose	Guidance on image display equipment for use in breast screening: NHSBSP publication no 71 (December 2010)	6 months	S	Confirmation that this has taken place
26	Implement new quality control (QC) testing spreadsheet for recording results	NHSBSP Equipment Report 1303 Routine quality control tests for full-field digital mammography systems	3 months	H	Copy of spreadsheet and confirmation of use
27	Action should be taken and recorded when QC results are out of tolerance	NHSBSP equipment reports 1303 Routine quality control tests for full-field digital mammography systems	Immediate	H	Copy of review results

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
28	Put tolerance values in place for ultrasound QC testing	NHSBSP Publication 70 Guidance Notes for the Acquisition and Testing of Ultrasound Scanners for use in the NHSBSP.	3 months	H	Copy of review results
29	Reinstate the ability to use DIMEX if there is a loss in IT connectivity, at all sites	National Service Specification No. 24	3 months	H	Confirmation of contract

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
30	Arrange access to 2 screens when using Breast Screening Select (BS Select and National Breast Screening System (NBSS) in combination	National Service Specification No. 24	3 months	S	Confirmation of 2 screens
31	Review capacity for MRI screening	National Service Specification No. 24	6 months	H	Confirmation of required capacity and submission of business case to trust

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
No Recommendation					

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
32	Undertake a staffing capacity review for the radiography staff and explore the appropriateness of the job descriptions for relevant roles	National Service Specification No. 24	3 months	H	Copy of review results
33	All mammographers should regularly take part in assessment clinics	National Service Specification No. 24	3 months	H	Completed action plan (including for example, radiographers rotated through screening and assessment clinics)
34	Review the roles and responsibilities of the superintendent radiographer and how this fits with the deputy superintendent radiographers and programme manager	NHSBSP 52	6 months	H	Accountability structure for the breast screening unit to be submitted Share outcome of the review
35	Minimise repetitive strain injuries in the mammography workforce	NHSBSP “Quality Assurance Guidelines for Mammography, April 2006, publication no 63	12 months	S	Risk assessment and action plan completed
36	Consider including a mammographer in the weekly planning meeting with the Hub to even out activities, improve use of SMART clinics and utilise comments from radiographers’ feedback form	NHSBSP “Quality Assurance Guidelines for Mammography, April 2006, publication no 63	12 months	S	Inclusion of mammographer in weekly planning meetings with the hub

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
37	Improve communication and information sharing through setting up regular team meetings between the screening management and radiography teams (based in screening and radiology)	National Service Specification No. 24	3 months	S	Evidence of team meetings taking place (terms of reference, agenda, minutes) agreed actions to improve communications and information sharing
38	Assistant Practitioners must not supervise students doing the certificate in mammography	Assistant Practitioner Scope of Practice	3 months	H	Confirmation that this practice has ceased
39	Screening continuing professional development (CPD) requirements for mammographers should be met by the service	National Service Specification No. 24	3 months	H	CPD plan detailing how staff are kept up to date with screening programme developments and scope of practice
40	Technical recall (TR) rates should be adequately reported, monitored and action plans put in place for any that are found outside of acceptable standards	National Service Specification No. 24	3 months	H	Procedure for recording and auctioning TR Anonymized action plan for staff members who are outside of standards to be submitted for review

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
41	Service to reinstate clinical updates that ensures that the correct reports are produced monthly, analysed with feedback given to the radiographers	National Service specification No. 24	3 months	S	Confirmation that clinical updates have been re-instated
42	Make sure all staff are trained in the Eklund technique to the level required of the NHSBSP and that this training has been recorded for all staff	National Service Specification No. 24	6 months	H	All staff to sign training sheet and this should be audited. Confirmation that this is taking place.
43	Minimize delays in reading	National Service Specification No. 24	3 months	H	Confirmation of formalised process for consensus reading
44	Provide breast screening information system (BSIS) access to the Lead Radiologist	National Service Specification No. 24	Immediate	S	Confirmation that access has been given
45	All film readers should have access to BSIS and film reader data	National Service Specification No. 24	6 months	S	Confirmation of access to BSIS Confirmation of how information is used to improve performance

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
46	The Royal Marsden Hospital (RMH) to provide national external quality assessment (NEAQA) reports for steroid hormone receptors and HER2	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	3 months	S	A copy of the NEAQA report
47	Kingston Hospital (KH) to submit confirmation of EQA participation of KH pathologist who joined the scheme in 2017	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	3 months	S	Certificate of participation
48	KH departmental lead to provide evidence of attainment of the 50 primary cancer resection specimens a year as per national requirement	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	H	Outcome of audit
49	Departmental leads to confirm the attainment of the 8 breast pathology-specific continuous professional development points a year requirement for 3 KH and 1 Royal Marsden Hospital (RMH) pathologists	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	H	Confirmation of participation in Continuing Professional Development (CPD)
50	Attendance of breast pathology update courses by pathologists that have not attended in last 2 years (3 KH and 2 RMH)	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	H	Confirmation of participation in update courses

No.	Recommendation	Reference	Timescale	Priority	Evidence required
51	B3 / PPV B3 audit including departmental and individual analysis	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	H	Outcome of audit
52	Critical review of South West London pathology departmental and individual figures on B1 and B2 rates when 2015-2018 data will become available	Quality Assurance Guidelines for Breast Pathology Services, 2nd edition, NHSBSP Publication No 2, July 2011	12 months	S	Outcome of audit

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
No Recommendation					

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
53	Where a treating surgeon has not been present at a screening Multidisciplinary teams (MDT), make sure that the patient referred to the local hospital is discussed in that hospital's local MDT	Clinical guidance for screening assessment, 49 (2016); Quality Assurance Guidelines for surgeons in breast cancer screening, 20 (2009)	3 months	H	Standard operating procedure (SOP) to evidence the requirement for all screening patients to have had discussion at local MDT if treating surgeon not present at screening MDT

Surgery

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
54	Audit of the practice of frozen section for sentinel lymph nodes at St George's Hospital to include accuracy of the technique and to assess impact of this practice on pathology workload	Clinical guidance for screening assessment, 49 (2016); Quality Assurance Guidelines for surgeons in breast cancer screening, 20 (2009)	6 months	S	Outcome of audit
55	Make sure there is consistency of marking specimens for orientation for each pathology laboratory.	Clinical guidance for screening assessment, 49 (2016); Quality Assurance Guidelines for surgeons in breast cancer screening, 20 (2009)	3 months	H	Written protocol in place

I = Immediate priority recommendation
H = High priority recommendation
S = Standard priority recommendation

Next steps

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

SQAS will work with commissioners for 12 months to monitor activity and progress in response to the recommendations following the final report. SQAS will then send a letter to the provider and the commissioners summarising the progress and will outline any further action needed.