Screening Quality Assurance visit report

NHS Breast Screening Programme Portsmouth

30 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.

Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

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.

www.gov.uk/phe/screening
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
Prepared by: Screening QA Service (South).
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

© Crown copyright 2019
You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit OGL or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published: March 2019
PHE publications
gateway number: GW-193

PHE supports the UN
Sustainable Development Goals

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 Portsmouth breast screening service held on 30 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-visits to review pathology reports and slides, radiology and surgical performance, and attendance at a multidisciplinary team meeting
- information shared with the South regional SQAS as part of the visit process

Local screening service

The Portsmouth Breast Screening Service is located at the Queen Alexandra Hospital, Portsmouth, and provides a combined screening and symptomatic service. NHS England South (Wessex) commissions the breast screening service from Portsmouth Hospitals NHS Trust. The unit provides a service to women living in 3 Clinical Commissioning Group (CCG) areas: NHS Portsmouth City CCG, NHS South Eastern Hampshire CCG and NHS Fareham & Gosport CCG.

The Portsmouth breast screening service has an eligible population of 82,338 women aged 50 to 70 years. Portsmouth is part of the national randomised age extension trial which means it offers screening to women aged 47 to 49 years and women aged 71 to 73 years, in addition to those aged 50 to 70 years. The population including age expansion is 103,000.

The main screening service is located at Queen Alexandra Hospital. The Portsmouth programme operates an on-site screening service, as well as a single twin modality mobile unit covering the local population.

All screening assessment clinics take place at Queen Alexandra Hospital. Pathology services are undertaken at Queen Alexandra Hospital.

High risk screening and MRI (Magnetic Resonance Imaging) scans are performed on site at Queen Alexandra Hospital. Patients who need MRI guided biopsies are referred to Royal Marsden Hospital.

Findings

The Portsmouth breast screening service has undergone significant change and challenges over the past 18 months. The service experienced the sad and untimely demise of the director of screening earlier this year. Staffing shortages have impacted on capacity and performance, as well as staff workload and morale. In June 2018 a Contract Performance Notice was served by the commissioners due to persistent failure of the service to meet timeliness key performance indicators (KPIs).

The immediate and high priority findings, and areas for shared learning, are summarised below.

Immediate concerns

The QA visit team identified 2 immediate concerns. A letter was sent to the deputy medical director on 31 October 2018 asking that the following issues were addressed within 7 days:

- the specimen x-ray cabinet in theatre needs to have its picture archiving and communication system (PACS) connection enabled so that images can be stored and retrieved
- an assistant practitioner is working outside of the scope of professional practice and this needs to cease with immediate effect

A response from the deputy medical director was received within 7 days which explained that a plan was in place to address the first concern. The response assured SQAS that the second concern had been addressed and no longer poses a risk.

High priority

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

- it is not clear that the short-term plan for recovery is sustainable
- it was observed at the visit that there is a shortage of film readers and that the assessment clinic only has use of one fully functioning ultrasound room
- staff were unclear about the recovery plan, whether it had been formally agreed, and about the commitment expected from them for additional working hours
- a number of screening incidents were identified as not being reported to SQAS in line with the Managing Safety Incidents in NHS Screening Programmes guidance
- screening women and symptomatic women currently wait in the same area which may cause anxiety for the screening patients
- there appears to be insufficient PACS storage to support the recovery plan
- the unit is not following the national protocol for ceasing patients from screening
- local practice is not to repeat images taken during screening clinics even when there is a clear requirement for repeat - this practice needs review
- assessment clinic work instructions do not currently allow provision for a second opinion to be gained and recorded
- a number of practices and protocols are not in line with national guidance for management of lesions of uncertain malignant potential (B3)
- not all short term/early recalls are currently being reviewed at the multi-disciplinary meetings

Shared learning

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

- work undertaken by commissioners to integrate SQAS recommendations into the contract with the provider Trust
- there is a morning huddle to discuss staffing and worklists for administration and radiography staff which enhances communication
- pre-visits are offered to women with learning difficulties so that they may familiarise themselves with the unit before attending for screening and this can be very reassuring
- the double checking of the parameters for batch selection (the identification of cohort of women) reduces errors
- there is a very good quality management system (QMS) in place with a dedicated QMS manager The QMS system is ISO9001 registered, with 6 monthly external assessment

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Update the terms of reference for the Hampshire Isle of Wight progamme board meeting to reflect changes to the commissioning footprint	Service Specification No. 24 2018/19	6 months	Standard	Terms of reference
2	Clarify governance and accountability arrangements within the Trust for the programme, including terms of reference for the local breast screening programme board	Service Specification No. 24 2018/19	3 months	Standard	Written confirmation of governance arrangements, and terms of reference for local board meetings
3	Clarify the relationship between the local and Hampshire Isle of Wight programme board meetings, with reference in both documents	Service Specification No. 24 2018/19	6 months	Standard	Terms of reference
4	Put in place a separate, clearly defined funding stream for screening	Service Specification No. 24 2018/19	6 months	Standard	Written confirmation from director of screening and directorate manager
5	Implement a sustainable screening slippage recovery plan, to include timely internal communications and engagement with all staff	Service Specification No. 24 2018/19	1 month	High	Written confirmation of staff engagement; agreed recovery plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	Formalise the terms of reference for the sub-speciality team meeting including feedback and outputs for staff	Service Specification No. 24 2018/19	3 months	Standard	Terms of reference
7	Align the Trust's internal incident reporting and management procedures with national guidance to ensure the timely reporting and investigation of incidents and sharing of lessons learned	Managing Safety Incidents in NHS Screening Programmes	3 months	High	Trust policy and process: evidence of communications and staff training (if required)
8	Explore reasons for Did Not Attend (DNA) appointments and address low uptake and local variations	Service Specification No. 24 2018/19	9 months	Standard	Written confirmation
9	Develop a formal annual audit schedule overseen at the Trust programme board meeting	Service Specification No. 24 2018/19	6 months	Standard	Audit schedule
10	Review and strengthen the health promotion plan in collaboration with local authority public health teams and commissioners	Service Specification No. 24 2018/19	9 months	Standard	Amended health promotion plan

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Review programme manager and administrative roles against new national leadership guidance	Breast screening: best practice guidance on leading a breast screening service 2018	3 months	Standard	Revised job descriptions

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Amend standing agenda for administrative team meeting to include national breast screening system (NBSS) updates, incidents, and complements and complaints	NHSBSP Publication No 47: November 2000 Quality Assurance Guidelines for Administrative and Clerical Staff	3 months	Standard	Meeting standing agenda
13	Review nursing staffing levels in line with national guidance	NHSBSP publication no. 29: interim quality assurance guidelines for clinical nurse specialists (2012)	6 months	Standard	Nursing staffing levels that meet national guidance
14	Amend clinic schedule to avoid, where possible, screening and symptomatic women waiting together	NHSBSP publication no. 49 Clinical guidance for breast cancer screening assessment (2016)	6 months	High	Evidence of new arrangement
15	Increase working space for administration staff to accommodate workforce	Service Specification No. 24 2018/19	6 months	Standard	Written confirmation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Amend local protocols to ensure appropriate testing of the ultrasound equipment	NHSBSP No 70 NHS Breast Screening Programme Consolidated standards April 2017	3 months	Standard	Revised protocols
17	Ensure the Faxitron MX20 is on the planned replacement programme for pathology and a review undertaken to assess if it is still fit for purpose	Service Specification No. 24 2018/19	6 months	Standard	Assessment outcome and confirmation that equipment is on replacement programme
18	Review and update Ionising Radiation (Medical Exposure) Regulations (IRMER) procedures	IRMER regulations 2017 & NHSBSP 75	3 months	Standard	Revised protocol
19	Ensure that the radiographers who are responsible for quality control (QC) of equipment have time to review results and complete QC tasks	NHSBSP Publications No 63: April 2006 Quality Assurance Guidelines for Mammography including Radiographic Quality Control	3 months	Standard	Revised job plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Develop a process for recording needle changes used in stereotactic equipment	NHSBSP Publications No 63: April 2006 Quality Assurance Guidelines for Mammography including Radiographic Quality Control	6 months	Standard	Local process
21	Develop a protocol for safe transfer of data to and from the mobile van and seek approval from the Trust information governance lead for this process	NHSBSP Guidance for breast screening mammographers (2017)	1 month	Standard	Confirmation at programme board
22	Investigate whether PACS storage is adequate for prompt access to historic images, and take action to increase storage if required	Service Specification No. 24 2018/19	3 months	High	Written confirmation
23	Enable a PACS connection for the specimen x-ray cabinet in theatre so that images can be saved and retrieved	Service Specification No. 24 2018/19	1 month	Immediate	Written confirmation that PACs connection is enabled

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Specify screening batches at 4 to 6 weeks to allow for turn around and notice of invitation for the women	PHE Assurance Guide 2018	1 month	Standard	Monthly assurance report

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Ensure the failsafe on the breast screening select (BSS) IT system runs on day 15 of each month	PHE Assurance Guide 2018	1 month	Standard	Monthly assurance report
26	Change the procedure for ceasing women from the screening programme to bring practice in line with national guidance	NHSBSP Good Practice Guide No 7: February 2004 Ceasing Women from the NHS Breast Screening Programme	3 months	High	Local protocol
27	Undertake an audit of women recorded as ceased on BS Select to ensure they have been ceased in accordance with national guidelines	NHSBSP Good Practice Guide No 7: February 2004 Ceasing Women from the NHS Breast Screening Programme	6 months	Standard	Results of audit

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Ensure that clinical data entry by the administrative staff is subject to continuous randomised audit	NHSBSP Publication No 47: November 2000 Quality Assurance Guidelines for Administrative and Clerical Staff	6 months	Standard	Audit results

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Audit the process of recording cases as partial mammography	Good practice guide to partial or incomplete screening mammography	6 months	Standard	Audit results
31	Develop and implement a local policy for repeat images	NHSBSP Guidance on collecting, monitoring and reporting technical recall and repeat examinations	3 months	High	Local policy and evidence of communications and training for staff
31	Ensure there is Trust clinical governance approval for assistant practitioner's practice of performing assessment images	Society of Radiographers	1 month	Immediate	Confirmation of change of practice
32	Undertake an ergonomics risk assessment for mammographers prior to the commencement of the recovery plan	NHS Breast Screening Programme Guidance for breast screening mammographers December 2017	3 months	Standard	Risk assessment results and agreed actions on findings
33	Conduct a risk assessment with medical physics of the 2 older ultrasound machines for clinical risk of missing pathology	NHSBSP No 70 NHS Breast Screening	3 months	Standard	Risk assessment report and agreed actions

No.	Recommendation	Reference	Timescale	Priority	Evidence required
		Programme Consolidated standards April 2017			
34	Review job plans for film readers in order to meet the minimum number of mammographic reads required	NHSBSP No 59 Quality Assurance Guidelines for Breast Cancer Screening Radiology	6 months	Standard	Film reading numbers for individual readers meeting national standards
35	Conduct an appraisal to determine whether an additional 2 reporting stations will help the service to meet screen to results waiting time targets	NHSBSP No 59 Quality Assurance Guidelines for Breast Cancer Screening Radiology	3 months	Standard	Written confirmation
36	Ensure the level of suspicion on mammograms is recorded by the readers on the recall to assessment cases by an M1 – M5 scoring system	NHSBSP publication no. 49 Clinical guidance for breast cancer screening assessment (2016)	6 months	Standard	Work instructions; and audit of practice 3 months after new work instructions introduced

No.	Recommendation	Reference	Timescale	Priority	Evidence required
37	Ensure the director of breast screening has assurance that all breast screening staff are appraised annually by their line manager, and the appraisal process includes NHS BSP professional measures and standards	Breast screening: best practice guidance on leading a breast screening service	6 months	Standard	Written confirmation from director of screening

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
38	Review formal work instructions for assessment clinics to clarify in what circumstances a second opinion will be obtained and recorded	NHSBSP publication no. 49 Clinical guidance for breast cancer screening assessment (2016)	3 months	High	Amended work instruction for assessment clinics
39	Audit the non-operative ductal carcinoma in situ (DCIS) diagnosis rate in the prevalent round and work with the pathologists to develop a pathway to improve this	Service Specification No. 24 2018/19	6 months	Standard	Audit results; evidence of improvement in rate
40	Develop local arrangements for implementation by radiologists, pathologists and surgeons of B3 guidance at assessment, multidisciplinary team meeting (MDM) discussion and vacuum excision stage	NHSBSP publication no. 49 Clinical guidance for breast cancer screening assessment (2016)	12 months	Standard	Work instructions for this pathway

No.	Recommendation	Reference	Timescale	Priority	Evidence required
41	Develop a consistent process for short term/early recalls and ensure that all such cases are reviewed in the MDM; audit practice at one year	NHSBSP publication no. 49 Clinical guidance for breast cancer screening assessment (2016)	1 month	High	Work instructions for this pathway; written confirmation that relevant cases are discussed in MDM; audit results
42	Ensure all individuals reporting breast pathology participate in External Quality Assurance (EQA)	NHSBSP publication no.2 Quality Assurance guidelines for breast pathology services (2011)	3 months	Standard	Written confirmation from lead pathologist
43	Implement B1 category reporting in line with national guidance	NHSBSP publication no.2 Quality Assurance guidelines for breast pathology services (2011)	3 months	Standard	Local protocol

No.	Recommendation	Reference	Timescale	Priority	Evidence required
44	Audit individual pathologists' B1 rates when 2015 to 2018 data becomes available	NHSBSP publication no.2 Quality Assurance guidelines for breast pathology services (2011)	6 months	Standard	Audit results
45	Conduct an audit of B3 and B4 cases from 2016/2017 jointly with radiologists	NHSBSP pathology guideline	9 months	Standard	Results of audit and agreed actions
46	Conduct monthly pathology team meetings for review of B3 cases	NHSBSP pathology guideline	3 months	Standard	Written confirmation

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	No recommendations				

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
47	Ensure the pathway for women attending assessment clinics includes a structured assessment of psychological, social and physical needs at the start of the appointment	NHSBSP publication no. 29: interim quality assurance guidelines for clinical nurse specialists (2012)	6 months	Standard	Local SOP
48	Ensure that all women are seen by breast care nurses after biopsy for support, information and guidance	NHSBSP publication no. 29: interim quality assurance guidelines for clinical nurse specialists (2012)	3 months	Standard	Local SOP
49	Undertake a satisfaction survey of assessment clinics and benign results clinics, reviewing specifically the nurses' service	QA guidelines for Clinical Nurse Specialists 2012	12 months	Standard	Survey results

No.	Recommendation	Reference	Timescale	Priority	Evidence required
50	Ensure breast care nurses audit their own clinical practice to identify service improvements that may improve patient experience	NHSBSP publication no. 29: interim quality assurance guidelines for clinical nurse specialists (2012)	12 months	Standard	Evidence of audit

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 and 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.