Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
North Nottinghamshire

25 April 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. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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

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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 North Nottingham breast screening service held on 25 April 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 to North Nottinghamshire breast screening service during March and April 2018
- information shared with the East Midlands regional SQAS as part of the visit process
- post visit review of 65 assessment cases and interim data on performance for the period 1 April 2017 to 31 March 2018 (KC62)

Some of the evidence routinely reviewed as part of the visit process was not provided by the service (details of clinical incidents and near misses in the previous 3 years and the service risk register). The reason for this non-submission was reportedly due to the service not being allowed to release the documents to the visiting team. Therefore, these elements of the service cannot be assessed.

Local screening service

The North Nottinghamshire breast screening service has an eligible population of 34,601 (women aged 50-70). The service is part of the national randomised age extension trial of women aged 47 to 49 and those aged 71 to 73. The eligible population rises to 44,187 when including the full age extension population (women aged 47-73). The total population of the area served is 279,759. This is below the

minimum population size of 500,000 as advised in the NHS public health functions agreement 2017-18 service specification number 24.

Sherwood Forest Hospitals NHS Foundation Trust delivers the breast screening service as a single NHS Trust provider based at King's Mill Hospital, Sutton-in-Ashfield. The service does not have any mobile vans; all women are screened and assessed at King's Mill. The Trust also provides surgery and pathology at King's Mill.

Findings

Immediate concerns

The QA visit team identified one immediate concern. A letter was sent to the chief executive on 26 April, asking that the following item is addressed within 7 days:

- agree the radiographic exposure setting to be used for women attending for breast screening

The service submitted a response the day after the visit which assured the visiting team the identified risk had been mitigated and no longer posed an immediate concern.

High priority

The QA visit team identified 9 high priority findings as summarised below:

1. The responsibilities of the director of breast screening, programme manager and lead radiologist were not clearly defined and there was evidence of inadequate management and oversight of the service.
2. The sharing of film reader codes and discussion with individual film readers about their data had not been actioned.
3. There is no formal management meeting into which the director of breast screening reports or escalates breast screening items.
4. There is no laterality correction process for transferring images to other Trusts to ensure the correct breast is imaged at assessment.
5. There is a lack of staffing resilience within imaging (radiography, advanced practice and radiology) so a staffing review is required. This is covered by 2 separate recommendations.
6. Assessment practice is not in line with national guidance.
7. The work instructions for identifying a woman do not include a 3 point identity check.
8. Provisional data for 2017/18 shows an apparent drop in cancer detection rates since April 2017. The standardised detection ratio and invasive cancer detection rate in the incident round have both dropped below minimum standard. Non-

invasive cancer detection is slightly above the minimum standard but has dropped noticeably.

9. The MDT does not have a single, validated MDT record used by all staff in subsequent clinical management.

Shared learning

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

- DoseWatch monitoring software has been implemented
- there are a wide range of oncoplastic surgical options

Recommendations

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

Each recommendation number in the tables below is a hyperlink to the relevant text within the report.

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Appoint a radiologist to the programme board	Service specification no. 24	6 months	Standard	Terms of reference of programme board and minutes to show attendance
2	Update organogram to show direct reporting line from director of breast screening to chief executive or medical director	NHSBSP 52	3 months	Standard	Organisational chart and escalation pathway
3	Director of breast screening to present the QA visit report at a Trust executive board meeting	NHSBSP 40	3 months	Standard	Trust executive board meeting minutes
4	Implement a job description for the director of breast screening	Service specification no. 24	3 months	Standard	Job description signed by the chief executive or medical director

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Review the management arrangements and responsibilities within the service	NHSBSP 52	3 months	High	Report of the outcomes of the review, including any changes to job descriptions and procedures
6	Develop an organisational accountability structure including detail of escalation routes for governance and performance issues	Service specification no.24	3 months	High	Copy of the structure and escalation routes
7	Director of Breast Screening to present the service annual report at a Trust executive board meeting	NHSBSP 40	3 months	Standard	Trust executive board meeting minutes
8	Amend relevant local policies to include details of how to identify, manage and report screening incidents in accordance with “Managing Safety Incidents in NHS Screening Programmes”	Managing Safety Incidents in NHS Screening Programmes	6 months	Standard	New/updated local policy or procedure
9	Review and document control all forms utilised within the quality management system (QMS) and link to relevant policies/protocols	NHSBSP 47	3 months	Standard	Index of forms demonstrating document number and version number and/or effective date

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Review the correct results process and consider use of a clinic control sheet for film reading	NHSBSP 55	3 months	Standard	Outcome of review and actions taken

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Ensure there is an adequate number of workstations and in a suitable environment for film reading	Service specification no. 24	6 months	Standard	Copy of agreed action plan
12	Medical physics to review and analyse the initial DoseWatch data from 2017 to ascertain the effect dose setting has had on the image quality of breast screening images	NHSBSP 54	6 months	Standard	Outcome of the review
13	Agree the radiographic exposure setting to be used for women attending for breast screening	NHSBSP 54	1 week	Immediate	Confirmation of the agreed exposure setting for breast screening
14	Medical physics to use DoseWatch software to confirm that the service have now standardised their exposure settings since January 2018	NHSBSP 54	3 months	Standard	Copy of DoseWatch summary data indicating the exposure used for each compressed breast thickness

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Medical physics provider to develop a user quality control (QC) spreadsheet for the service	NHSBSP 1303	6 months	Standard	Copy of the spreadsheet
16	Implement a system to keep error/ correction logs for PACS	Service specification no. 24	1 month	Standard	Copy of the implemented error log
17	Install e-contrast software onto at least one mammography machine	WHO Surgical Safety Checklist, NPSA 2009	3 months	Standard	Confirmation of e-contrast software in place
18	Implement a laterality correction process for transferring images to other Trusts	WHO Surgical Safety Checklist, NPSA 2009	3 months	High	Copy of the agreed protocol
19	Introduce a daily check of orphaned images	NHSBSP 55	1 month	Standard	Copy of work instruction

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Review high risk clients reported on BS Select to ensure they are included in the NBSS high risk screening programme	NHSBSP 74	3 months	Standard	Confirmation that all clients on BS Select are included in the programme

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
21	Review screening provision and flexibility of appointment availability. Undertake customer satisfaction survey to include questions regarding appointment availability	Service Specification no. 24	6 months	Standard	Copy of client satisfaction questionnaire and results from questionnaire
22	Review the current practice for obtaining previous images and agree responsibility for this function	Service Specification no. 24	3 months	Standard	Revised protocol for obtaining previous images
23	Develop and implement a health promotion strategy	Service specification no. 24	6 months	Standard	Health promotion strategy document

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Review radiographic staffing to ensure compliance with NHSBSP guidelines	NHSBSP Guidance for breast screening mammographers	3 months	High	Copy of staffing review. This should also cover staff bandings being appropriate to the tasks being carried out
25	Consider ways to reduce image blurring	NHSBSP Guidance for breast screening mammographers	1 month	Standard	Documented outcome of discussion with staff
26	GE applications specialist should visit the department to ensure that image quality is optimised	NHSBSP Guidance for breast screening mammographers	3 months	Standard	Confirmation of visit date
27	Update the mammography work instruction to ensure that it includes a 3 point identity check	NHSBSP Guidance for breast screening mammographers	1 month	High	Copy of revised work instruction

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Ensure technical recall/technical repeat reason codes are recorded accurately	NHSBSP Guidance on collecting, monitoring and reporting technical recall and repeat examinations	3 months	Standard	Evidence of review and discussion within mammography team of technical recall and repeat rates
29	Ensure all staff have access to workstations to undertake image review	NHSBSP 63	6 months	Standard	Confirmation that access to workstations are available for staff to undertake image review
30	Implement all changes that are required following the revision of IR(ME)R and IRR regulations	IR(ME)R 2018/ IRR 2017	3 months	Standard	Copy of Trust procedures and evidence of staff training
31	Audit how often screening clinics are cancelled	Service specification no. 24	1 month	Standard	Copy of audit results
32	Review radiology provision	NHSBSP 59	6 months	High	Details of progress with current plans
33	Review and monitor the film reading QA results	NHSBSP 59	6 months	Standard	Outcome of review of 2017/18 FRQA results

No.	Recommendation	Reference	Timescale	Priority	Evidence required
34	Implement a clinic control sheet to record outcome of film reading	NHSBSP 55	3 months	Standard	Copy of the implemented clinic control sheet
35	Document the additional imaging required at assessment at the time of film reading	NHSBSP 49	3 months	Standard	A copy of the updated sheet and date of introduction
36	a) Review the performance of the current team and the apparent drop in cancer detection rates. b) Develop a plan of action to monitor and improve cancer detection within the service and submit to SQAS.	NHSBSP 59	1 month 3 months	High High	Written confirmation that data review has taken place between radiology team and director of breast screening. Documented action plan for monitoring and improving cancer detection, approved by the director of breast screening and the head of imaging

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	No recommendations				

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
37	Provide breast care nursing support within assessment as per guidelines	NHSBSP 29	6 months	Standard	Confirmation that breast care nurses are present in all assessment clinics
38	Audit telephone calls received by CNSs	NHSBSP 29	12 months	Standard	Outcome of audit
39	Undertake at least 2 additional mammographic views at assessment for the work up of soft tissue abnormalities and calcifications. Consider magnification views for calcification instead of spot views if equipment suitable	NHSBSP 49	1 month	Standard	Copy of revised protocol
40	Review and update radiology procedures	NHSBSP 49	1 month	High	Copy of revised protocol

No.	Recommendation	Reference	Timescale	Priority	Evidence required
41	Ensure pathologists meet the caseload requirements of the NHSBSP	Service specification no.24	3 months	Standard	Evidence of caseload for each pathologist over the preceding 3 years
42	Ensure pathologists meet the continuing professional development (CPD) requirements of the NHSBSP	Service specification no.24	3 months	Standard	Confirmation of CPD undertaken for each pathologist over the preceding 3 years
43	Audit lympho-vascular invasion rates	NHSBSP 59	12 months	Standard	Outcome of audit
44	Review potential false positive cases		6 months	Standard	Outcome of reviews

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
45	Ensure there is a single, validated MDT record projected for all attendees to see	The Characteristics of an Effective Multidisciplinary Team (MDT) NCAT 2010	3 months	High	Confirmation that the MDT record is projected for all members to see, is validated in real time and the record immediately available to the team in clinical areas

No.	Recommendation	Reference	Timescale	Priority	Evidence required
46	Audit the patient pathway for women referred to another Trust for reconstructive surgery	ABS Oncoplastic Breast Reconstruction: Guidelines for Best Practice 2012	6 months	Standard	Outcome of audit
47	Review the local guidelines on the management of breast cancer and provide a revision date and future review dates	NHSBSP 20	3 months	Standard	A copy of the current local guidelines with the latest revision date and the intended future review
48	Undertake a review of sentinel lymph node biopsy practice and number of negative nodes removed	NHSBSP 20	12 months	Standard	Outcome of audit
49	Audit the frequency and weights of diagnostic specimens over the past 3 years	NHSBSP 20	6 months	Standard	Outcome 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/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.