Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme Shropshire

4 October 2018

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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 four 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.

PHE Screening, Floor 2, Zone B, Skipton House, 80 London Road, London SE1 6LH
www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
Prepared by: East Midlands SQAS. For queries relating to this document, including details of who took part in the visit, please contact: kirsty.dare@phe.gov.uk

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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 Shropshire breast screening service held on 4 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:

- 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 Royal Shrewsbury Hospital and Princess Royal Hospital during September 2018
- information shared with the West Midlands regional SQAS as part of the visit process

Local screening service

Shrewsbury and Telford Hospital NHS Trust (SaTH) delivers the Shropshire breast screening service. The service screen within Royal Shrewsbury Hospital and Princess Royal Hospital, Telford. There are also 2 mobile screening units covering 7 screening locations. Assessment clinics are held at Royal Shrewsbury Hospital. Pathology is undertaken at Royal Shrewsbury Hospital. All surgery takes place at Princess Royal Hospital, Telford. Medical physics provision for the service is provided by the University Hospitals of North Midlands NHS Trust.

The Shropshire breast screening service has an eligible population of 71,002 (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 including the age extension population is 91,412. The total population of the area served is 482,125. This is slightly below the minimum population size of 500,000 as advised in the NHS public health functions agreement 2018-19 service specification number 24.

The service currently has 55 high risk women registered on the national breast screening system (NBSS). Women requiring mammography only are screened locally. Women requiring mammography and MRI are referred to South Birmingham breast screening service.

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 3 high priority findings as summarised below:

- review and increase assessment clinic capacity to ensure sufficient regular weekly capacity is available
- improve the effectiveness of the multidisciplinary team (MDT) meeting and ensure adequate time for MDT case discussion
- review the current service and ensure equal access for all women to oncoplastic and reconstruction surgery

Shared learning

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

- internal did not attend (DNA) audit against women who do not accept the offer of breast screening is undertaken
- the service refer the outcome back to the relevant GP practice to try and improve uptake
- near miss technical recall audit carried out
- information poster produced post new Ionising Radiation (Medical Exposure) Regulations guidance
- innovating practice to optimise radiology capacity
- annual workshop to discuss radiologically challenging cases including all interval cancers previously classified as possible or definite abnormalities and previously assessed cancers which on review had learning points or were classified as substandard
- post core biopsy care information leaflet developed
- live clinic booking at the multidisciplinary team meeting

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Clarify the internal governance structure and accountability for the programme	Service specification No. 24	3 months	Standard	Updated programme board terms of reference. A flowchart outlining internal governance of the programme board within the Trust
2	Update the organisational structure and include a reporting line from the director of breast screening directly to the chief executive	NHSBSP 52	3 months	Standard	Copy of the updated organisational structure and escalation routes
3	Director of breast screening to present the annual report at a Trust executive board meeting	Service specification No. 24	6 months	Standard	Trust executive board meeting minutes
4	Director of breast screening to present the QA visit report at a Trust executive board meeting	NHSBSP 40	6 months	Standard	Trust executive board meeting minutes
5	Ensure there is a process in place for the management of subcontracts	Service specification No. 24	3 months	Standard	Confirmation of process in place
6	Review and update the director of breast screening and programme manager job descriptions	Service specification No. 24	3 months	Standard	Updated job descriptions signed by the chief executive for the director of breast screening's job description and signed by the director of breast screening for the programme manager's job description

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7	Improve the flow of service wide communication and ensure appropriate escalation of incidents	Service specification No. 24	3 months	Standard	Confirmation of the process in place
8	Review and update the quality management system, including an audit schedule and the use of controlled forms	NHSBSP 47	6 months	Standard	Index of forms demonstrating document number and version number and/or effective date and date of next review date
9	Finalise the audit plan covering all parts of the programme	Service Specification No. 24	3 months	Standard	Agreed audit plan/schedule

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Undertake a radiographic staffing capacity review	NHSBSP Guidance for breast screening mammographers	3 months	Standard	Review of staffing levels, roles and responsibilities. Impact of symptomatic workload on staffing levels for delivery of the screening service
11	Agree an equipment replacement plan for all equipment	Service specification No. 24	6 months	Standard	Copy of the agreed plan
12	Review all documentation supporting Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) 2017	IR(ME)R 2017	6 months	Standard	IR(ME)R documentation
13	Appoint a user quality control radiographer	NHSBSP Guidance for breast screening mammographers	6 months	Standard	Confirmation of appointment

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Clarify the clinical and administration roles and responsibilities to support the picture archiving and communication system (PACS) within breast screening	Service specification No. 24	3 months	Standard	Confirmation of the agreed action plan

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Undertake an IT infrastructure review to understand the issues resulting in the slow running of IT systems (particularly NBSS)	Service specification No. 24	3 months	Standard	A demonstrated improvement in IT system speed
16	Ensure high risk clients reported on BS Select are included on NBSS and invited as part of the NHSBSP high risk programme	NHSBSP 74	3 months	Standard	Confirmation that all clients on BS Select are included in the programme
17	Review the current process for accepting high risk referrals	NHSBSP 74	6 months	Standard	Copy of the revised process

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Review the availability of out of hours screening	Service specification No. 24	6 months	Standard	Outcome of review
19	Evaluate the health promotion strategy. Review the impact of key actions and inform future work to maximise uptake	Service specification No. 24	6 months	Standard	Outcome of evaluation and review

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Review lines of accountability and individual job plans for advanced clinical practitioners	NHSBSP Guidance for breast screening mammographers	3 months	Standard	Confirmation that job plans have been reviewed and agreed by all staff
21	Undertake the consultant radiographer's appraisal and performance development review	NHSBSP 59	1 month	Standard	Confirmation that the appraisal has been undertaken
22	Risk assess lone working and develop a policy which covers all sites	Society of Radiographers - Violence and Aggression at Work (including lone working)	6 months	Standard	Confirm the risk assessment has been undertaken and provide a copy of the agreed lone working policy
23	Ensure women with significant relevant signs and symptoms are recalled to assessment	NHSBSP 49	3 months	Standard	Copy of written policy and confirmation that this has been applied to practice
24	Implement a standard policy for film reading and the recall processes	NHSBSP 55	6 months	Standard	Copy of film reading policy and standard operating procedure
25	Optimise referral to assessment rates to ensure that cancer detection is maintained	NHSBSP consolidated standards	6 months	Standard	A copy of the action plan in place
26	Ensure all women placed on short term recall have bilateral breast imaging at assessment	NHSBSP 49	1 month	Standard	Copy of short term recall policy. Evidence of communication to all assessors and confirmation that guidance is being followed

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Review assessment clinic capacity to ensure sufficient regular weekly capacity is available	Service Specification No. 24	3 months	High	Outcome of review and evidence of achieving the screen to date of first offered assessment appointment standard

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Ensure that all women have access to a clinical nurse specialist	NHSBSP 29	3 months	Standard	Confirmation of plan to cover periods of leave. Confirmation of succession planning
29	Ensure that pathologists attend a recognised NHSBSP multidisciplinary course	NHSBSP 02	6 months	Standard	Evidence of attendance
30	Ensure that pathologists attend the regional QA meeting as per guidelines	NHSBSP 02	6 months	Standard	Confirmation of attendance from the lead pathologist
31	Ensure oestrogen receptor (ER) and progesterone receptor (PR) reporting follows national guidance	NHSBSP 02	3 months	Standard	Copy of standard operating procedure for ER/PR reporting.
32	Implement a standard pathology reporting proforma	NHSBSP 02	6 months	Standard	Standardised reporting proforma

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
33	Revise the wording of the benign results letter	NHSBSP 29	3 months	Standard	Copy of the revised letter
34	Improve the effectiveness of the multidisciplinary team (MDT) meeting and ensure adequate time for MDT case discussion	Service Specification No. 24	6 months	High	Outcome of review
35	Ensure there is a single, validated MDT record which is used in all clinical settings	Service Specification No. 24	3 months	Standard	Confirmation that the MDT record for all cases is validated in real time and that there is only a single record of the outcome
36	Ensure biopsy results are received within one week of biopsy	Service Specification No. 24	6 months	Standard	Confirmation of plan in place
37	Implement national guidance on the management of B3 lesions	NHSBSP 49	3 months	Standard	Confirmation that B3 guidance is followed
38	Review the current service and ensure equal access for all women to oncoplastic and reconstruction surgery	Early and locally advanced breast cancer: diagnosis and management NICE 2018 Guidance for the commissioning of oncoplastic breast surgery ABS 2018	6 months	High	Outcome of review and confirmation of plan in place
39	Ensure the use of magseed is evaluated	Best practice guidelines for surgeons in breast cancer screening ABS 2018	1 month	Standard	Confirmation of evaluation and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
40	Ensure all specimen X-rays have a radiological review at the MDT meeting if not at the time of surgery	Best practice guidelines for surgeons in breast cancer screening ABS 2018	6 months	Standard	Copy of revised policy
41	Ensure that all surgeons meet the caseload requirements of the programme	NHSBSP 20	3 months and 12 months	Standard	Action plan to ensure all surgeons meet the requirements at 3 months and audit data demonstrating attainment at 12 months
42	Ensure accurate recording of surgical data	NHSBSP 20	3 months	Standard	Confirmation of plan in place

I = Immediate
H= High
S = Standard

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 following the issuing of the final report. 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.