Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Doncaster Hospitals NHS Foundation Trust

5 March 2019

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, research, 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. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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 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
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

Published May 2019
PHE publications
gateway number: GW-608

PHE supports the UN
Sustainable Development Goals

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 (QA) visit to the Doncaster Breast Screening Programme (BSP) held on 5 March 2019.

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 Doncaster BSP
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Doncaster and Bassetlaw Breast Screening Service (DBSS) has an eligible population of approximately 77,300. This population consists of women aged 47 to 73, including women in the age extension trial (women aged 47 to 49 and 71 to 73) within the geographic area of the NHS Doncaster and NHS Bassetlaw Clinical Commissioning Groups. For more information please refer to the programme management and governance section of this report, pages 20 to 22.

The programme is provided by the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust. It is commissioned by NHS England (North) – Yorkshire and the Humber.

Findings

Immediate concerns

The review team identified no immediate concern

High priority

The QA visit team identified 10 high-priority findings, as summarised below.

1. Limited involvement of screening service personnel in the pending relocation of Chequer Road.
2. No director of breast screening job description that reflects the role, responsibilities and job plan.
3. Lack of staff training in reporting incidents and monitoring of incidents on Datix
4. A number of standard operating procedures (SOPs) are not in line with national guidance.
5. No business continuity plan for breast screening, which should include IT disaster recovery, succession planning, staff cover arrangements and process for equipment replacement.
6. Shortfall in administration, radiography, radiology, breast care nursing and pathology staff.
7. Multi-disciplinary team (MDT) display monitor is not fit for purpose.
8. No allocated time for uninterrupted film reading.
9. A breast care nurse is not present in each assessment clinic.
10. False negative assessment process is not within NHSBSP guidelines.

Shared learning

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

- health promotion is undertaken within the family history clinics and with the Moving Forward Programme; a Breast Cancer Care initiative supporting people to live well with and beyond breast cancer
- consistent engagement in the QA process
- willingness to explore new ways of working, as suggested by the QA team
- uptake, coverage and round length are above the national minimum standard

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority*	Evidence required
CDO1901	Involve key screening service personnel in the pending review of facilities and in the design of new premises	(1)	3 months	High	Confirmation that screening service needs have been assessed and implemented in the estates and facilities plans
CDO1902	The director of breast screening should present this QA visit report and key risk issues at a trust board meeting	(1)	6 months	Standard	Trust board meeting minutes and action log feedback receipt
CDO1903	Develop a job description for the director of breast screening (DoBS) that reflects the duties, responsibilities and job plan for the role	(2)	3 months	High	Trust approved job description
CDO1904	Keep a record of discussion, escalation and outcome by formalizing management meetings between the DoBS and senior management within the trust DoBS, programme manager and screening office manager	(1)	6 months	Standard	Approved terms of reference

CDO1905	Update local incident policy in line with most recent guidance and make sure all staff are trained in the reporting and monitoring of incidents or potential incidents to SQAS and the Screening and Immunisation Team (SIT)	(3)	3 months	High	1. Approved, updated incident policy 2. Confirmation of incident reporting and monitoring training
CDO1906	Resolve the current issues on the risk register	(1)	6 months	Standard	Action log
CDO1907	Review and update quality management system (QMS) to include all standard operating procedures (SOPs), work instructions and version control of each document. Make sure this is included in the annual QMS audit	(4)	3 months	High	Updated QMS approved by the management meeting with an annual audit schedule
CDO1908	The commissioner should agree with the provider an annual schedule of audits	(1)	6 months	Standard	Confirmation that the methodologies, objectives and reporting mechanisms have been agreed at an MDT meeting and copy of the schedule for the first 12 months
CDO1909	Complete a user survey as per service specification	(1)	12 months	Standard	Results and action plan

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1910	Develop and implement a service business continuity plan to include all disciplines delivering breast screening. Include relocation of the Chequer Road Clinic, IT disaster recovery (including National Breast Screening System (NBSS)), succession planning, staff cover arrangements and process for equipment replacement	(1)	3 months	High	Business continuity plan with agreed implementation plan
CDO1911	Resolve shortfall in administration, radiography, radiology, breast care nursing and pathology	(1)	3 months	High	1. Action plan to address shortfall in staffing approved by the trust board by 31 August 2019 2. Confirmation that mammography staff work at least 2 days weekly
CDO1912	All staff to have an annual appraisal and attend identified training	(1)	6 months	Standard	Appraisal dates and training plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1913	Review medical physics processes to ensure SLA includes all equipment surveyed radiation protection supervisor (RPS) appointed in writing survey reports issued within 1 month as per SLA formal feedback from the screening service to medical physics, when recommendations from physics reports have been actioned medical physics expert (MPE) involvement when procuring new mammography equipment magnetic resonance (MR) breast coil quality control (QC) tests are undertaken at Bassetlaw District General Hospital (BDGH)	(5), (6) and (7)	6 months	Standard	1. Confirmation of revised SLA 2. Confirmation RPS is formally appointed 3. Confirmation of adherence to 1 month timescale 4. Feedback reports 5. Confirmation of involvement of MPE. 6. MR QC testing protocol to be confirmed and results of QC tests
CDO1914	Identify a PACS system to manage existing and future requirements	(1)	6 months	Standard	Implementation plan

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1915	Review administration processes to ensure • specified batches are double checked • clinic time is protected each month for failsafe clients • data entered on NBSS is double checked	(1)	6 months	Standard	1. Confirmation of double checking. 2. Confirmation of protected clinic time. 3. Confirmation of double checking.
CDO1916	Develop a training plan for all administrative staff on the registration/coordination of high risk women in the screening pathway	(4)	6 months	Standard	Training plan

Invitation, access, and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1917	Put in place a risk management process for printing of letters	(8)	6 months	Standard	Confirmation of process

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1918	Review administration and management processes and facilities to ensure • a map is included with each screening and assessment invitation • screening availability is confirmed with adequate notice to send screening invitation letters at least 3 weeks in advance of the appointment • additional phone lines are available • the screening round plan includes batch end dates and an estimation of how long the batch will take	(1)	6 months	Standard	1. Confirmation that a map is included with appointment invitations. 2. Confirmation that the administration staff have adequate notification of screening availability; and letters are issued at least 3 weeks in advance of the appointment. 3. Confirmation of additional phone lines 4. Confirmation of compliance

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1919	Review monitor and make sure • radiography staff contractual working arrangements do not have a significant impact on update training, CPD opportunities, including MDT attendance • advanced practitioners and assistant practitioners work to a scope of practice • the shortfall of radiographers and support to the symptomatic service is not affecting screening service delivery.	(9)	6 months	Standard	1. 6 month period period of MDT and training attendance logs (1 June 2019 to 30 November 2019). 2. Scope of practice 3. Detailed workforce plan, identifying staff requirements for symptomatic and screening service delivery
CDO1920	Make sure that • film reading facilities are suitable and fit for purpose • adequate time is allocated for uninterrupted film reading • CPD is provided Report to an appropriate trust board meeting	(10)	3 months	High	1. 2 to 3 mega pixel monitor in MDT room 2. Uninterrupted film reading time 3. CPD record 4. Trust board meeting minutes and action log

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1921	Record all interval cancers on the National Breast Screening System (NBSS)	(10)	9 months	Standard	1. Confirmation that process is in place and that there is a timebound plan to record all missing cases. 2. Copy of the protocol and the plan to achieve. 3. Audit of compliance

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1922	Audit date of assessment rates and identify reasons for breaching the key performance indicator	(1)	9 months	Standard	Audit outcome of 6 month period (1 June 2019 to 30 November 2019)

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1923	A breast care nurse (BCN) must be present in each assessment clinic	(11)	3 months	High	Audit of compliance
CDO1924	Ensure the false negative assessment process meets NHSBSP guidelines	(12)	3 months	High	Confirmation of process

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1925	Review pathology processes to ensure: • the development of advanced cut up by biomedical scientists (BMS) is considered/assessed to increase long term sustainability • a laboratory information management system (LIMS) system is used for cross working between trusts • HER2 results are available at the time of MDT discussion slides are reviewed for the MDT	(13)	6 months	Standard	1. Confirmation of process 2. Trust to review and confirm process 3. HER2 results turnaround times (TATs) and availability of HER2 result at MDT over a 3 month period (1 June 2019 to 31 August 2019) 4. Confirmation of compliance

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1926	All BCNs should have clinical supervision sessions	(11)	6 months	Standard	Clinical supervision plan
CDO1927	Access to a psychologist should be available, if required	(11)	6 months	Standard	Confirmation of compliance

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CDO1928	Review MDT meeting processes to ensure • multi-screen projection videoconferencing facilities in Bassetlaw District General Hospital (BDGH). • soundproofing of the MDT (Blythe) room is improved to prevent information governance breaches. • notes are available at the time of MDT discussion, including previous MDT outcome forms	(1)	6 months	Standard	1. Confirmation that all imaging and MDT outcomes can be seen simultaneously. 2. Confirmation of compliance 3. Confirmation of compliance
CDO1929	Audit 2015 to 2016 mastectomy rates for small invasive cancers	(1)	6 months	Standard	Outcome of audit

*** 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 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.