Public Health
England

Screening Quality Assurance visit report

NHS Breast Screening Programme
North London Breast Screening Service

20 March 2019

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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 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.

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Contents

About Public Health England 2

About PHE screening 2

Scope of this report 4

Executive summary 5

Table of consolidated recommendations 8

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 London Breast Screening Administration Hub
Invitation and information	Yes	Functions are shared with the London Breast Screening 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 findings signs of the disease at an early stage.

The findings in this report relate to the quality assurance visit of the North London Breast Screening Service (NLBSS) held on 20 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
- evidence submitted by the provider(s), commissioners
- information collected during pre-review visits to 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 NLBSS is based in Deansbrook House at Edgware Community hospital, which forms part of the Royal Free London NHS Foundation Trust.

The NLBSS serves an estimated total eligible population of 227,042 women, aged 50-70 (NHS Digital; November 2018 population estimates). 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 64,770 women.

The NLBSS covers 6 Clinical Commissioning Groups (CCGs) of North London and West Hertfordshire:

- NHS Barnet
- NHS Enfield
- NHS Haringey

- NHS Brent
- NHS Harrow
- NHS West Hertfordshire

The catchment population of North London Breast Screening Service (NLBSS) is ethnically diverse and growing. There is wide spread health inequality and large populations live in deprivation. A significant proportion of people belong to the Black and Minority Ethnic (BAME) groups with differing health needs and health risks. High rates of mental illness exist amongst both adults and children and significant fraction of population do not have English as their first language.

The service undertakes digital mammography and provides screening at 3 static sites: The service has 5 mobile screening units. Assessment clinics are held at Deansbrook House. Screen-detected cases are mostly treated at one of the following hospitals: Barnet hospital, Chase Farm hospital, North Middlesex University hospital (NMH), Whittington hospital (WH), Northwick Park hospital (NPH), St. Albans hospital and Royal Free London hospital(RFH).

During 2015-2016, 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 breast screening services, including NLBSS. Prior to this, each breast screening service in London provided an end-to-end pathway which included the administrative functions now provided centrally by the Administration Hub (Hub). Since the last visit on 10th June 2014, NLBSS personnel have experienced sizable changes and have overcome many challenges. This includes the procurement of NLBSS and the Hub in 2015/16 and mobilisation of the administrative function for all London breast screening services. In April 2016, NLBSS was the first of the 3 services to transfer the administration tasks to the centralised Hub call/recall model which was a new way of working. The call recall function for NLBSS started in July 2016. Royal Free London NHS Foundation Trust also bid for Central and East London Breast Screening Service (CELBSS) and won the contract in 2017 which placed additional pressure on existing NLBSS staffing resources particularly senior management, administrative and clerical as well as radiography staff. In addition, the team actively managed the national breast screening incident and the impact of a new national cohort identification system - Breast Screening Select (BS-Select).

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High Priority

The visiting team identified 5 high priority findings:

- Complex management structure with overlapping roles and responsibility across the 3 commissioned screening services: North London Breast Screening Service (NLBSS), Central & East London Breast Screening Service (CELBSS) and the London Breast Screening Administrative Hub (Hub)
- The move from the current premises will require strategic planning by senior management
- Lack of focused and equitable support from NLBSS senior management to staff
- An annual report produced and shared with the Trust
- Staffing not fully established across screening pathway

Shared learning

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

- Staff are flexible and resilient to meet service requirements including staff shortages
- Good access to trust's senior level management
- Surgical presence at screening MDT
- Communication form used for telephone communication between client and Breast Care Nurses (BCNs)
- Daily 'huddle' between Whittington hospital (WH) consultants' pathologists and biomedical scientist staff to prioritise specimens for MDT
- System of internal audits within radiology

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.

Screening Quality Assurance Service (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.

Table of consolidated recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Commissioners to review and update Terms of Reference (TOR) and risk register for the Pan-London breast screening programme board	Service Specification No. 24 (and local variations)	3 months	S	Confirmation of updated documents in place
2	Produce an annual report for the service and present it at chief executive level board	Service Specification No. 24 (and local variations)	12 months	S	Confirmation that annual report is produced and shared with a chief executive board level group
3	Ensure there is a named programme manager and a deputy programme manager in place for the service in line with national guidance	Service Specification No. 24 (and local variations)	3 months	H	Confirmation of appointment and updated accountability and governance structure
4	Undertake an audit of incidents logged on the trust Datix to identify if any should be reported by service to Screening Quality Assurance Service (SQAS)	Service Specification No. 24 (and local variations)	3 months	S	Outcome of audit and submission of SIAF as required
5	Make sure that passwords for the encrypted memory sticks are being	Right results walkthrough	1 month	S	Confirmation that the service is compliant with the organisation’s

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	maintained in line with Trust information governance guidelines.				Information Governance policies
6	Implement handover process for high risk clients who have had MRI imaging that need to be booked for assessment.	Right results walkthrough	3 months	S	Confirmation that the process is in place
7	NLBSS and the Hub to work together to monitor the number of clients being turned away due to ID issues and escalate this issue to QA	Service Specification No. 24 (and local variations)	6 months	S	A log of the number of clients being turned away due to ID issues.

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8	Backfill to the 0.4WTE breast care nursing establishment in North London Breast Screening Service was lost to Central and East London Breast Screening service	Service Specification No. 24 (and local variations)	6 months	H	Confirmation of the backfill for the position
9	Develop a business continuity plan of the move from the current premises	Service Specification No. 24 (and local variations)	6 months	H	Confirmation of business continuity plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Ensure that there is a firm plan for replacing mammography X-ray equipment over or approaching the end of its working life with consultation from medical physics and trust oversight	HSE Guidance Note PM77 (3rd Edition): Equipment used in connection with medical exposure	6 months	S	A copy of the Trust's equipment replacement plan for the ageing Hologic Selenia units
11	Risk assesses the ageing mammography X-ray equipment and get confirmation from MIS or Hologic that they can source parts easily	HSE Guidance Note PM77 (3rd Edition): Equipment used in connection with medical exposure.	3 months	S	Written confirmation that MIS or Hologic can provide X-ray tubes and digital detectors during the term of the current service contract.
12	Risk assess the ageing US machines to determine whether newer technology may improve assessment work up and allow for more US guided biopsies	Guidance notes for the acquisition and testing of ultrasound scanners for use in the NHS Breast Screening Programme 2011 (NHSBSP Publication No. 70)	6 months	S	Review of performance compared with modern US technology
13	Evaluate the current method of environmental dose monitoring at the Edgware site	Work with ionizing radiation: Approved Code of Practice and guidance: HSE document L121 second edition. Published 2018	6 months	S	A written description of the method for performing environmental dose monitoring in the breast unit.

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Review networking connection to the Forest Road Health Centre site to allow direct transfer of images to base and obviate the risks associated with Dimex transportation	The commissioning and routine testing of full field digital mammography systems 2009 (NHSBSP Report 0604, version 3)	6 months	S	Outcome of review to include a cost benefit analysis
15	Review the list of duty holders in the IR(ME)R 2017 Employer's procedures to determine whether the radiographers have a role as IRMER referrer	The Ionizing Radiation (Medical Exposure) Regulations 2017 (SI 1322)	6 months	S	Written confirmation that this has been considered and details of the outcome
16	Collate a 'log of PACS issues' and ensure they are on the risk register and an action plan is in place	Service Specification No. 24 (and local variations)	6 months	H	Confirmation of action plan
17	Work with MIS to resolve orphan images on the PACS system	Service Specification No. 24 (and local variations)	3 months	H	Confirmation of outcome with MIS
18	Risk assess all manual PACS processes to include 'how to deal with wrong markers'	Service Specification No. 24 (and local variations)	3 months	H	Outcome of risk assessment
19	Resolve the 'no work list issue' at the Whittington hospital site	Service Specification No. 24 (and local variations)	3 months	H	Confirmation of resolution

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Review process for entering Loris trial clients onto National Breast Screening System (NBSS)	Service Specification No. 24 (and local variations)	6 months	S	Confirmation of review and agreed actions
21	Complete the NBSS and BS-Select system audit to ensure that both systems match	Service Specification No. 24 (and local variations)	3 months	S	Outcome of audit
22	Review manual demographic entry for MRI to ensure that client details match examination	Service Specification No. 24 (and local variations)	6 months	S	Confirmation of review and agreed actions

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	Review SMART clinic template and booking with the hub to maximize the smooth throughput of clients. a. Consider including a mammographer in the planning meeting. b. Review the practice of booking 200 clients and associated risks.	PHE, 2018. NHS Breast Screening Programme Good practice guidance for ergonomics in breast screening mammography. London, PHE.	3 months	H	Review and agreed actions completed

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Programme management to ensure a comprehensive health promotion plan in place, and provide appropriate nursing capacity and support to implement it	Service Specification No. 24 (and local variations)	6 months	S	Up to date health promotion reports and confirmation of: • Appropriate nursing capacity • Support to lead Breast Care Nurse and nurses to deliver the plan

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Conduct a workforce review to include the superintendent requirements and have a recruitment plan in place to recruit to the shortfall of staff	PHE, 2017. NHS Breast Screening Programme Guidance for breast screening mammographers. London, PHE	12 months	H	Outcome of review and summary of recruitment plan
26	Review the scope of practice documents for assistant and advanced practice to include the Trust position on vicarious liability	Scope of practice document Trust policies Service Specification No. 24 (and local variations)	3 months	H	Outcome of review

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Arrange for clinical updates and conduct both individual and group Perfect/Good/Moderate/Inadequate (Image Assessment Tool)	PHE, 2017. NHS Breast Screening Programme Guidance for breast screening mammographers. London, PHE.	12 months	S	Confirmation of clinical updates
28	Review trends in medio-lateral obliques and cranio-caudal, and agree training needs	PHE, 2017. NHS Breast Screening Programme Guidance for breast screening mammographers. London, PHE.	12 months	S	Outcome of review and a training schedule in place
29	Put an action plan in place to bring the TR/TP rate back down to below 2%	PHE, 2017. NHS Breast Screening Programme Guidance for breast screening mammographers. London, PHE.	12 months	S	Summary and outcome of action plan
30	Ensure measures are in place so that the team feel valued and supported by the senior management team including adequate staff cover for annual, sick leave so that staff can get their allocated annual leave	Service Specification No. 24 (and local variations)	3 months	H	Summary and outcome of measures put in place

No.	Recommendation	Reference	Timescale	Priority	Evidence required
31	Ensure mobile vans meet infection control requirements	Service Specification No. 24 (and local variations)	3 months	H	Confirmation of requirements met
32	Risk assess toilet facilities at the mobile sites and ensure appropriate access for staff and clients	Service Specification No. 24 (and local variations)	3 months	H	Outcome of assessment and summary of actions agreed
33	Review the radiographer meeting/audit half day agenda to ensure that it is more relevant to mammographers	Service Specification No. 24 (and local variations) PHE, 2017. NHS Breast Screening Programme Guidance for breast screening mammographers. London, PHE.	3 months	S	Agreed actions and relevant minutes
34	Ensure repetitive strain injuries are minimized	PHE, 2018. NHS Breast Screening Programme Good practice guidance for ergonomics in breast screening mammography. London, PHE	12 months	S	Risk assessment and action plan completed
35	Review radiology clinicians' job plans, and ensure that all screening related time is properly recorded	Service Specification No. 24 (and local variations)	12 months	S	Confirmation of the action taken

No.	Recommendation	Reference	Timescale	Priority	Evidence required
36	Allocate adequate film reader and clerical resources to complete the review of interval cancer backlog	Interval cancer guidance 2011	12 months	H	Confirmation of completion of interval cancer review backlog

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
37	Review the breast care nursing staffing capacity to ensure that the full range of clinical commitments are maintained owing to the overall increase of the cohort size and current clinical trials	Service Specification No. 24 (and local variations)	6 months	H	Evidence of nursing staffing review and increase in capacity
38	If participating in the LORIS trial, ensure suitably funded nursing provision to support the recruitment and administration of the trial and avoiding potential conflicts of interest in patient care	Service Specification No. 24 (and local variations)	3 months	H	Confirmation of support in place
39	Review PPV of cancer after recall in prevalent round. Audit outcomes of consensus.	QA Guidelines for breast cancer screening radiology, 2011	6 months	S	Summary of outcome of audit
40	Record second assessor if discussion has taken place	Assessment guidance 2016	3 months	S	Audit of documented discussion and recording second assessor on NBSS to structure
41	Review data entry in NBSS for B3 categories, to ensure	Guidelines for non-operative	12 months	S	Hub audit

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	accurate transcription of the presence of atypia	diagnostic procedures and reporting in breast cancer screening (June 2016)			
42	Review the data entry for the presence of lympho-vascular invasion to ensure information on this prognostic feature is included in National Breast Screening System (NBSS)	Pathology reporting of breast disease in surgical excision specimens incorporating the dataset for histological reporting of breast cancer	12	S	Hub audit
43	Undertake annual audit of receptor status in Royal Free London hospital (RFH) site as per RCPath guidelines.	Pathology reporting of breast disease in surgical excision specimens incorporating the dataset for histological reporting of breast cancer	12 months	S	Audit data
44	Review workload to ensure that pathologists reporting breast pathology at RFH site report sufficient specimens (surgical primary excisions and core biopsy specimens) to maintain expertise, as per UK guidelines.	Quality Assurance Guidelines for Breast Pathology Services Second edition NHSBSP Publication No 2. July 2011.	12 months	S	Workload data by pathologist

No.	Recommendation	Reference	Timescale	Priority	Evidence required
45	Explore the use of synoptic/proforma reports at all sites, as per UK guidelines to avoid duplication of data entry	Pathology reporting of breast disease in surgical excision specimens incorporating the dataset for histological reporting of breast cancer	6 months	S	Audit of histology reports
46	Ensure all pathologists at each site reach appropriate levels of CPD related to breast and attend a breast course/conference at least once every 3 years	Quality Assurance Guidelines for Breast Pathology Services Second edition NHSBSP Publication No 2. July 2011	12 months	S	Certificates of attendance
47	Review pathway for specimens, from sampling in clinic/theatre, to receipt in the laboratory to reporting, to ensure delays are minimized. This should include ER and HER2 results (to be kept under review when laboratories move site)	Pathology reporting of breast disease in surgical excision specimens incorporating the dataset for histological reporting of breast cancer	6 months with repeat after move of all laboratories to HSL Hub.	S	Audit of turnaround times of reports, including receptor status

No.	Recommendation	Reference	Timescale	Priority	Evidence required
48	Review the accuracy of details of reporting pathologist and the list of reporting pathologist's codes at Royal Free London hospital (RFH) site	Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening (June 2016)	12 months	S	Hub audit
49	Provide appropriate clerical support for breast screening pathology at RFH site for breast screening pathology (as per 2014 QA visit recommendation).	Quality Assurance Guidelines for Breast Pathology Services Second edition	12 months	S	Appointment in place
50	Assess B1 and B2 reporting complies with national guidance for RFH pathologists.	Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening (June 2016)	12 months	S	Pathology audit data

No.	Recommendation	Reference	Timescale	Priority	Evidence required
51	Undertake review of North London Breast Screening Service B3 biopsies, including both radiological and pathological components and pathological-radiological correlation, as well as outcome at RFH site	Guidelines for non-operative diagnostic procedures and reporting in breast cancer screening (June 2016)	6 months	S	Audit of B3 results, incorporating radiological and pathological details
52	Review pathology consultant workforce and ensure appropriate capacity at the Whittington hospital site	Service Specification No. 24 (and local variations)	12 months	High	Appointment of additional Consultant staff
53	Each pathologist at Wittington hospital(WH)site should report 50 surgical primary breast cancer excisions, as per UK guidelines and consider redistribution of workload	Quality Assurance Guidelines for Breast Pathology Services Second edition NHSBSP Publication No 2. July 2011	6 months	S	Workload figure review
54	Facilitate MDT attendance by pathologists at WH	Service Specification No. 24 (and local variations)	6 months	H	MDTM attendance sheets

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
55	Review referral proformas or consider producing a covering letter	Clinical guidance for screening assessment 49 (2016)	6 months	H	Example of revised referral pack for multiple lesion case

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
56	Consider a second screening MDT per week to ensure all women receive biopsy results within 1week	QA Guidelines for breast cancer screening radiology, 2011	12 months	S	Confirmation of 2nd MDT in place
57	Audit axillary operation rates for B5a cases invasive at operation	Quality Assurance guidelines for surgeons in breast cancer screening (2018)	6 months	H	Submission of audit report
58	Audit immediate reconstruction rates for both invasive and non-invasive cases 2017-18	Quality Assurance guidelines for surgeons in breast cancer screening (2018)	3 months	H	Submission of audit report

No.	Recommendation	Reference	Timescale	Priority	Evidence required
59	Ensure pathology videoconferencing or physical attendance available for all MDT	Clinical guidance for screening assessment 49 (2016); Quality Assurance guidelines for surgeons in breast cancer screening (2018)	3 months	H	Confirmation of implementation
60	Facilitate MDT attendance by pathologists at Wittington hospital	Service Specification No. 24 (and local variations)	6 months	H	MDT attendance sheets

I = Immediate
H= High
S = Standard

Next steps

The screening service provider is responsible for developing a plan, in collaboration with the commissioners, to action the recommendations contained in this report.

The London screening quality assurance service (SQAS) will work with commissioners to monitor the progress made in response to the recommendations, for a period of 12 months following issue of the final report. After this, SQAS (London) will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.