Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

Liverpool, Sefton and Knowsley Breast Screening Service

31 July 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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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 Liverpool, Sefton and Knowsley breast screening service held on 31 July 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 Royal Liverpool and Broadgreen University Hospitals NHS Trust on 18 June to 30 July 2019
- information shared with the North region SQAS as part of the visit process

Local screening service

Liverpool, Sefton and Knowsley breast screening service (LSKBSS) is provided by Royal Liverpool and Broadgreen University NHS Trust (RLBUHT). The total population of the area served is approximately 920,000. There are 125,000 eligible women in the age range of 50 to 70 and 157,000 when the age extended population is included. The screening service covers the geographical areas of Liverpool, Sefton and Knowsley. NHS England North (Cheshire and Merseyside) public health commissioning team commission the service.

LSKBSS is a multi-site service. Screening is provided from Broadgreen Hospital in addition there are 2 mobile vans visiting 12 sites. Assessment clinics are held in the Linda McCartney Centre (LMC) at RLBUHT. The majority of surgery is provided at RLBUHT with a proportion provided at Aintree University Hospital Trust (AUHT). Pathology for all cases is performed by Liverpool Clinical Laboratories based at RLBUHT.

Findings

Immediate concerns

The QA visit team did not identify any immediate concerns.

High priority

The QA visit team identified 7 high priority findings as summarised below:

- mobile units need replacement and the long-term future of mobile sites needs to be secured
- strategic plan required for all aspects of breast screening service in light of merger between RLBUHT and AUHT needs to contain a plan for the integration of the breast screening programme
- text reminders should be implemented to improve uptake
- clinical nurse specialists (CNS) need to be present in assessment clinics
- age ranges on the trust breast screening webpage need correcting
- the director of breast screening (DoBS) job description needs updating to comply with current guidance

Shared learning

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

- a comprehensive health equity audit was undertaken in 2018 which included an excellent literature review and can be used as a foundation to improve uptake and services for women
- use of patient advocacy groups for health promotion activities in areas of low uptake have demonstrated improvements in these areas
- assistant practitioners are accredited with the Society of Radiographers and 2 mammographers have undertaken postgraduate study to become clinical educators
- pathology leads an extensive audit programme incorporating a full audit cycle, re-audits and engagement of trainees

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1901	Director of Breast Screening (DoBS) job description to be updated to reflect latest guidance	1	3 months	High	Updated job description
NLI1902	Appoint a deputy DoBS with a minimum of 0.5 sessions	1	3 months	Standard	Updated job plan
NLI1903	Implement a strategic plan for all aspects of the breast screening service in light of the RLBUHT and AUHT merger (further detail found on page 15)	2	6 months	High	Strategic plan including a risk assessment around the impact to the breast screening service
NLI1904	Produce a detailed annual report and present it to trust board or clinical governance committee	2	6 months	Standard	Annual report and confirmation of presentation to appropriate body
NLI1905	Review staffing in radiology and radiography including succession planning to ensure resilience of service	2	6 months	Standard	Workforce plan and agreed action plan
NLI1906	Service wide audit programme to include full audit cycle	2	6 months	Standard	Audit programme/plan and associated actions
NLI1907	Conduct formal client satisfaction surveys at least annually	2	12 months	Standard	Client satisfaction survey report and agreed action plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1908	Update age ranges on local breast screening webpage	2	3 months	High	Confirmation from DoBS/ screenshot of webpage

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1909	Trust management should support the service in assuring commissioners that mobile sites are secured for future screening	2	6 months	High	Minutes of meetings and outcomes/action plan
NLI1910	Service and medical physics provider should audit QA equipment reports to demonstrate actions are being completed	3, 4	3 months	Standard	Action reports from service and medical physics provider
NLI1911	Implement a detailed project plan for replacement of mobile units and mammography equipment	2	3 months	High	Project plan
NLI1912	Ultrasound QC activity should include;	5	3 months	Standard	SOP of ultrasound QC activities
	- baselines set				Reports from physics provider
	- routine QC data collected				
	-reports from physics provider on collected QC data				
NLI1913	Routine magnetic resonance (MR)breast coil quality control (QC) should include;	6	3 months	Standard	SOP of MR QC activities

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	- baselines set				Reports from physics provider
	- routine QC data collected				
	- reports from physics provider on collected QC data				
NLI1914	Review and update legislative documents and risk assessments to ensure they reference latest radiation legislation	7	3 months	Standard	Confirmation from PM
					Screenshot of document update page in electronic document management system
NLI1915	Maintain evidence of clinical and radiation protection training and competence	8	6 months	Standard	Training schedule and logs
NLI1916	Establish approval process for IRMER procedures and incorporate into trust clinical governance structures	8	6 months	Standard	Updated clinical governance terms of reference and pathway
NLI1917	Update business continuity plan to include a full list of IT systems essential to the service such as the picture archiving and communication system (PACS)	2	3 months	Standard	Business continuity plan

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1918	Perform a risk assessment for invitation letter process	2	3 months	Standard	Risk assessment and approved action plan

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1919	Trust IT department to work with LSKBSS to implement a text reminder service	2	6 months	High	Confirmation from DoBS

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1920	Risk assess use of multiple IT systems in assessment clinics. Trust should determine whether alternative IT solutions can be sought	9	6 months	Standard	Risk assessment and approved action plan Review report with any identified actions
NLI1921	Install additional workstation for use in assessment clinics	2	6 months	Standard	Confirmation from DoBS

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1922	Clinical Nurse Specialist (CNS) needs to be present in all assessment clinics and deliver all aspects of the latest NHSBSP guidance	10	3 months	High	Roster of CNS
NLI1923	Review VAB process for B3 lesions to optimise patient journey and ensure adherence to NHSBSP guidelines	9	6 months	Standard	Report of the review with any identified actions

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1924	Review job description of lead pathologist to ensure adequate time is allocated for completion of roles and responsibilities	2	6 months	Standard	Updated job plan

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
NLI1925	Audit practice for sentinel lymph node biopsy (SLNB) to ensure standardization across surgical sites	9	6 months	Standard	Outcome of review and approved actions
NLI1926	Install higher resolution monitors in surgical unit at RLBUHT	2	6 months	Standard	Confirmation from DoBS
NLI1927	Install specimen cabinet in theatre at AUHT	2	6 months	Standard	Confirmation from lead surgeon AUHT

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.