Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Breast Screening Programme Dorset

13 November 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 finding signs of the disease at an early stage.

The findings in this report relate to the quality assurance visit of the Dorset breast screening service held on 13 November 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 Public Health England (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-visits to review pathology reports and slides, radiology and surgical performance and attendance at multidisciplinary team meetings
- information shared with the south regional SQAS as part of the visit process

Local screening service

The Dorset breast screening service operates from Poole Hospital. The screening unit is located on the ground floor, with the Ladybird Breast Unit (symptomatic service) directly on the floor above. The radiography team works across both the screening and the symptomatic service.

NHS England South West and East (Wessex) commissions the breast screening service from Poole Hospital NHS Foundation Trust (PHFT) for the population of Dorset.

The Dorset service provides screening for eligible women living within the Dorset Clinical Commissioning Group (CCG) area. The service is part of the national randomised age extension trial which means it offers screening to women aged 47 to 49 years and women aged 71 to 73 years, in addition to those aged 50 to 70 years. The eligible population is 112,643 (50 to 70 years), 15,792 (47 to 49 years) and 17,527 (71 to 73 years).

Dorset breast screening service operates an on-site screening service within Poole Hospital, as well as 3 mobile units covering the local population in the surrounding area. All screening assessment clinics take place at Poole Hospital. Breast core biopsies and vacuum assisted biopsy (VAB) specimens are performed at the breast screening service and reported by pathologists at the histopathology departments at Poole Hospital and The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) in Bournemouth.

Surgery is either carried out at PHFT, RBCH or Dorset County Hospital NHS Foundation Trust (DCHFT) in Dorchester, depending on patient postcode or preference. Each of these 3 hospitals has its own cellular pathology department for the reporting of breast pathology resection specimens.

The Dorset service provides screening for women at high risk of breast cancer. Magnetic Resonance Imaging (MRI) scans are performed at Poole Hospital. Women requiring MRI guided biopsies are referred to Northwick Park Hospital, London.

Findings

The Dorset breast screening service meets or exceeds most key performance indicators. There is a very good small cancer detection rate. Clinical and professional standards are generally high which is reflected in several areas including the quality of images. Skill mix has been adopted in the radiography team which allows for career progression and service developments.

The service has made progress in many areas since the last QA visit in May 2016. However, at the time of the current visit in November 2019, some recommendations had not been implemented. The service is experiencing radiology staffing shortages. There are also staffing shortages and workforce pressures within the histopathology team at Poole Hospital. There have been changes in the leadership of the programme with a new director of screening, who had been in post for 18 months, recently stepping down from the role. Since the visit an interim director has been appointed.

Immediate concerns

There were no immediate concerns identified at this visit.

High priority

The QA visit team identified several high-priority findings, summarised as:

- several retirements and resignations in the radiology team are a risk to the service's ability to meet breast screening targets
- disabled women have their initial mammography and any follow up tests at the same time rather than through 2 separate appointments, and this is not in line with national guidance
- the number of women who are recalled for further tests after their first mammogram is higher than in other units despite efforts by the service to reduce this rate
- some local practices for the assessment clinic process are not in line with national guidance
- the breast screening service and the Public Health Commissioning Team do not have full oversight of activity and risks for screening patients at RBCH in Bournemouth and at DCHFT in Dorchester
- issues were raised during the visit about the breast pathology service, including:
  - there is a shortage of breast pathologists in the region, and the pathology department at Poole Hospital has been affected by this
  - the pressures within the 3 pathology departments mean that there is often no time for discussion of complex cases and this can lead to errors in reporting
  - there is limited integration of procedures and practice between the 3 pathology departments
  - not all breast screening pathologists meet the requirement to report a minimum of 50 primary cancer specimens per year
  - there is no digital specimen x-ray cabinet for viewing breast screening specimens in the Poole and Bournemouth pathology departments
- radiologists and pathologists do not have sufficient time to prepare cases for discussion at multi-disciplinary team (MDT) meetings
- there is no formal process for informing the director of breast screening of changes in diagnosis for screening patients, and amendments to pathology reports are not always acted upon
- oncologists do not routinely participate in MDTs at Dorset County Hospital and this inhibits a full discussion of cases

Shared learning

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

- a dedicated clinical trainer for the radiography team
- good support from the breast care nurses for women who are recalled for further investigations
- pro-active recruitment of patients into clinical trials

- evidence of good pathology audits at Dorchester and Poole despite the lack of a suitable IT system for data collection
- high immediate reconstruction rates for women who have had a mastectomy
- the introduction of magnetic tracers for patients needing sentinel lymph nodes identification at Dorset County Hospital which avoids the need for radioisotopes

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 and PHFT to put in place appropriate governance, supported by relevant written agreements, so that there is full oversight of activity, performance and risks for screening patients at RBCH and at DCHFT	NHS England agreement of commissioning intentions; National service specification no. 24 2019/20	6 months	High	Confirmation of arrangements; signed written agreements between the 3 trusts (PHFT, RBCH and DCHFT)
2	Commissioners to update terms of reference (TOR) for programme board meetings including leadership arrangements; and ensure that inequalities, audits, and patient feedback are included as standard agenda items	NHS England agreement of commissioning intentions; National service specification no. 24 2019/20	6 months	Standard	Revised terms of reference and standardised agenda
3	Commissioners to support the service to develop a prioritised, evidence-based inequalities action plan, links with CCGs and other stakeholders, and actively monitor this through the programme board	NHS England agreement of commissioning intentions; National service specification no. 24 2019/20	12 months	Standard	Inequalities action plan; minutes of the programme board where the inequalities plan is approved

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Finalise the appointment of the director of breast screening (DoBS) with job description and time allocation agreed in accordance with guidelines	National service specification no. 24 2019/20; Breast screening: best practice guidance on leading a breast screening service 2018	3 months	High	Confirmation of appointment of DoBS; copy of job description and evidence of adequate time allocation
5	Plan for the appointment of a deputy director to provide increased resilience	National service specification no. 24 2019/20; Breast screening: best practice guidance on leading a breast screening service 2018	12 months	Standard	Job description and job plan for new deputy director; confirmation that appointment made
6	Conduct a review of managerial and administrative roles within the programme, with engagement from the wider screening team, and consider the appointment of a dedicated screening programme manager	Breast screening: best practice guidance on leading a breast screening service 2018	6 months	Standard	Outcome of review
7	Implement regular administration team meetings and agree actions to check and update the quality management system (QMS)	Quality assurance guidelines for administrative and clerical staff November 2000	3 months	Standard	Meeting minutes showing evidence of discussion of QMS processes
8	Formalise incident reporting and escalation processes between the 3 hospital trusts across the patient pathway	National service specification no. 24 2019/20	3 months	Standard	Agreed process

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9	Ensure radiography staffing levels are in line with national guidance	Guidance for breast screening mammographers December 2017	12 months	Standard	Written confirmation that required numbers of staff are in post
10	Recruit into current radiology vacancies and plan for impending retirements of consultant radiologists	National service specification no. 24 2019/20	12 months	High	Radiology recruitment action plan with updates on progress provided quarterly
11	Establish a clear line of professional accountability within PHFT for the breast care nurses and ensure there is clinical supervision	Clinical nurse specialists in breast screening January 2019	3 months	Standard	Written confirmation of reporting arrangements
12	Ensure there is appropriate office space for the administration and nursing teams, separate to a clinic recovery room, and provide a counselling room for nursing staff	National service specification no. 24 2019/20	6 Months	Standard	Written confirmation that space has been provided
13	Ensure medical physics staffing levels comply with national guidance	Breast screening: guidelines for medical physics services September 2019	12 months	Standard	Review of staffing levels, and action plan
14	Undertake an audit of Ionising Radiation (Medical Exposure) Regulations IRMER compliance for the most recent year with the support of the Medical Physics Expert	Breast screening: guidelines for medical physics services September 2019	6 months	Standard	Audit report
15	Update medical physics service level agreement (SLA) between the breast screening service and the medical physics department at Poole hospital, in line with current guidance	Breast screening: guidelines for medical physics services September 2019	3 months	Standard	Updated SLA

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Confirm that there is a funded plan for replacement of X-ray equipment used in the static unit at Poole Hospital	National service specification no. 24 2019/20	3 months	Standard	Equipment replacement plan
17	Develop a process for assurance that equipment used in localisations at other hospitals meets national standards for breast screening	Breast screening: guidelines for medical physics services September 2019	3 months	Standard	Assurance that equipment used for screened women complies with national standards
18	Improve the process for actioning medical physics report recommendations	Guidance notes for the acquisition and testing of ultrasound scanners for use in the NHS breast screening programme April 2011	3 months	Standard	Physics report and action log of closure of recommendations
19	Update the medical physics survey protocol to ensure data is entered directly on to spreadsheets during surveys	Breast screening: guidelines for medical physics services September 2019	12 months	Standard	Copy of updated protocol /spreadsheet
20	Update the ultrasound protocol to ensure reference is made to NHS breast screening guidance detailing the acquisition and testing of ultrasound scanners	Guidance notes for the acquisition and testing of ultrasound scanners for use in the NHS breast screening programme April 2011	6 months	Standard	Updated protocol/spreadsheet
21	Ensure the local QA radiographer has sufficient protected time to fulfil her role	Guidance for breast screening mammographers December 2017	6 months	Standard	Rota showing QA radiographer's time for duties; records demonstrating actions in response to physics reports and data

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Change the procedure for testing the stereotactic biopsy unit to ensure the full range of needles are tested and any unused needles are removed from the dropdown menu	Guidance for breast screening mammographers December 2017	3 months	Standard	Revised protocol and copy of results covering 2 months
23	Introduce weekly quality control checks on the MRI equipment used for high risk women to ensure compliance with national guidelines	Technical guidelines for magnetic resonance imaging (MRI) for the surveillance of women at higher risk of developing breast cancer 2012	6 months	Standard	Documented protocol and a sample of results
24	Improve the storage capacity and functionality of the Patient Archiving and Communication System (PACS) at Poole Hospital to support the workflow during assessment clinics and to improve the viewing of images at multi-disciplinary meetings (MDTs)	National service specification no. 24 2019/20; Guidelines and standards for implementation of new PACS/RIS solutions in the UK	3 months	Standard	Agreed business case; written evidence of improvement

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Ensure guidance is followed on screening round length, and that PHE advice on screening large practices is followed	Achieving and maintaining the 36 month round length October 2019	3 months	High	Evidence that round plan is regularly checked and appropriately adjusted to accommodate large practices

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Maintain weekly checks of the reports on the national breast screening system (NBSS) and action required reports (including SRE and SPMR) on a regular basis	National service specification no. 24 2019/20	3 months	Standard	Confirmation and update of protocol
27	Conduct an audit to provide confirmation that the service is compliant with the requirement that all Magnetic Resonance (MR) readers reports 100 MRs each year	Technical guidelines for magnetic resonance imaging (MRI) for the surveillance of women at higher risk of developing breast cancer 2012	6 months	Standard	Audit results with confirmation that 100 reads are achieved by all readers

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28	Put in place a plan to support screening women with learning disabilities, using good practice guidance and leaflets from the national team and other services	Supporting women with learning disabilities to access breast screening November 2018	3 months	Standard	Written confirmation

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Cease routinely inviting disabled women for first stage screening in assessment clinics	Clinical guidance for breast cancer screening assessment November 2016	3 months	High	Written confirmation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
30	Ensure the clinical trainer has dedicated sessional time for carrying out the image assessment audit	Guidance for breast screening mammographers December 2017	3 months	Standard	Written confirmation
31	Establish mechanisms to decrease the service's prevalent recall rate and consider the introduction of consensus meetings	National service specification no. 24 2019/20; Consolidated programme standards 2017	6 months	High	Sustained improvement in the recall rate minuted at programme board meetings
32	Make sure that all film readers access the breast screening information system (BSIS) for performance and education purposes, and review their performance with the director of breast screening	Quality assurance guidelines for breast cancer screening radiology March 2011	12 months	Standard	Confirmation of access to BSIS; confirmation from director of breast screening that BSIS information is reviewed with film readers
33	Improve the false negative assessment and interval cancer process by: • conducting reviews as a group • checking that the guidance for interval cancers is applied in the classification of cases	Reporting, classification and monitoring of interval cancers and cancers following previous assessment August 2017	3 months	Standard	Amended protocol for interval cancer reviews

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
34	Responsible Assessor to maintain their clinical skills by performing both clinical examinations and ultrasounds during the assessment clinic	Clinical guidance for breast cancer screening assessment November 2016	3 months	High	Assessment clinic protocol

No.	Recommendation	Reference	Timescale	Priority	Evidence required
35	Formalise the process for obtaining a second opinion in assessment clinics when needed	Clinical guidance for breast cancer screening assessment November 2016	3 months	High	Assessment clinic protocol
36	Bring back women who are given an outcome of early recall after 12 months with bilateral mammograms performed at assessment as per the national guidance	Clinical guidance for breast cancer screening assessment November 2016	3 months	Standard	Copy of current protocol
37	Arrange access for pathologists to a digital Faxitron for specimen and specimen slice x-rays at PHFT and RBCH	National service specification no. 24 2019/20	6 months	High	Approved business cases for digital specimen x-ray cabinets for pathology samples at PHFT and RBCH
38	Ensure that at least one high quality monitor is available in each of the pathology departments at PHFT, RBCH and DCHFT	Guidance on image display equipment for use in breast screening December 2010	6 months	Standard	Confirmation that units have been installed with the minimum spec for diagnostic purposes as per national guidelines (5 megapixel)
39	Agree a protocol which covers input from the 3 pathology departments at PHFT, RBCH and DCHFT to relevant MDTs and which includes informing the director of breast screening of changes in diagnosis	National service specification no. 24 2019/20; The characteristics of an effective multidisciplinary team (MDT) February 2010	3 months	High	Protocol for pathology input to MDTs

No.	Recommendation	Reference	Timescale	Priority	Evidence required
40	Ensure all breast pathologists meet the NHBSP guidelines of reporting 50 primary breast surgery excision specimens per year	Quality assurance guidelines for breast pathology services July 2011	6 months	High	Written confirmation that all pathologists have breast screening activity in their job plans; evidence that required numbers are achieved
41	Commissioners and managers in each trust to review risks in pathology staffing levels at PHFT, RBCH and DCHFT and agree actions to ensure there is sufficient capacity in breast screening pathology reporting	Quality assurance guidelines for breast pathology services July 2011	6 months	High	Confirmation of outcome of review
42	Set up a weekly review/consensus meeting for the breast pathology team in the three departments at PHFT, RBCH and DCHFT to discuss cases of diagnostic uncertainty	National service specification no. 24 2019/20	3 months	High	Confirmation from lead pathologist
43	Introduce a single laboratory information management system (LIMS) system across the 3 pathology departments supported by standardisation of procedures and reporting proformas	National service specification no. 24 2019/20	6 months	High	Confirmation that a single LIMS is in place; confirmation that standardised procedures and proformas are in place
44	Complete the audits for the Association of Breast Surgery (ABS) low outlier for Grade 1 and high outlier for Grade 2 cancers	Surgical guidelines for the management of breast cancer, Association of Breast Surgery at BASO 2009	6 months	Standard	Audit results; evidence of improvement in rate
45	Conduct an audit of B1 and B2 core biopsies to ensure consistency of coding by pathologists	National service specification no. 24 2019/20	6 months	Standard	Audit results; evidence of improvement in consistency of coding

No.	Recommendation	Reference	Timescale	Priority	Evidence required
46	Ensure all breast pathologists at PHFT, RBCH and DCHFT meet the requirement of achieving 8 Continuing Professional Development (CPD) points per year for breast pathology	Quality assurance guidelines for breast pathology services July 2011	3 months	Standard	Written confirmation from lead pathologist
47	Ensure that clinicians act upon amendments to pathology reports	Surgical guidelines for the management of breast cancer, Association of Breast Surgery at BASO 2009	3 months	High	Evidence of communications and improved process; audit at 6 months which demonstrates change in practice

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
48	Adopt the documentation and proforma from national guidance for recording holistic assessments and adapt for local use	Clinical nurse specialists in breast screening January 2019	3 months	Standard	Copy of agreed holistic assessment form
49	Ensure that radiologists and pathologists have time allocation within job plans for preparation of cases for MDTs	The characteristics of an effective MDT February 2010	6 months	High	Confirmation from lead pathologist and lead radiologist that job plans include allocated sessional time for MDT preparation
50	Improve attendance by oncologists in the Dorset County Hospital MDT to facilitate full discussion	The characteristics of an effective MDT February 2010	6 months	High	Confirmation from lead surgeon; copy of attendance records for the MDT

No.	Recommendation	Reference	Timescale	Priority	Evidence required
51	Ensure regular audits take place that check the accuracy of recording of Poole Hospital MDT and Dorset County Hospital MDT decisions on the Somerset Cancer Registry (SCR), and include the process in a SOP	Surgical guidelines for the management of breast cancer, Association of Breast Surgery at BASO 2009	6 months	High	Copy of SOPs, audit schedules, and results for first 2 audits for both MDTs
52	Consider providing a specimen X-ray cabinet in theatre at Poole Hospital to improve the pathway and help with radiography staffing shortages	National service specification no. 24 2019/20	3 months	Standard	Outcome of review

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.