Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Breast Screening Programme
Barnsley Hospital NHS Foundation Trust

17 October 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 Barnsley Breast Screening Programme (BSP) held on 17 October 2019.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in breast screening. This is to make sure that all eligible people have access to consistently 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, commissioner and external organisations
- information collected during pre-review visits
- information shared with the North regional SQAS as part of the visit process

Local screening service

The Barnsley Breast Screening Service (BBSS) functions in the geographic area of the NHS Barnsley Clinical Commissioning Group. It has an eligible screening population (ages 47 to 73) of around 45,000 people.

The current[1] screening cohort for women aged 50 to 70 years is 35,679 invited to screening over a 3-year period. The numbers of women in the age extension trial (women aged 47 to 49 and 71 to 73) are 5,758 and 4,434, respectively.

One assessment clinic is run per week and there are no mobile screening units. The area covered includes areas of high deprivation and small numbers of ethnic minority populations. For more information please refer to the programme management and governance section of this report.

The service offers all aspects of high-risk screening.

[1] Source: NHS Digital 2019

Findings

Immediate concerns

The QA visit team identified 2 immediate concerns. A letter was sent to the chief executive on 18 October 2019, asking that the following items were addressed within 7 days:

- critical lack of resilience in staffing
- the requirement to use 2 separate picture archiving and communications systems (PACS)

A response was received and actions have been taken to partially mitigate the immediate risks within the programme. Follow up of the completion of these actions should be included within the QA visit action plan (see recommendations 10,11,12,17,19 and 24).

High priority

The QA visit team identified 10 high priority findings as summarised below:

- no protected time for DoBS to complete the duties and responsibilities for the role
- lack of staff training in reporting incidents and monitoring of incidents on Datix
- many standard operating procedures (SOPs) are not in line with national guidance
- shortfall in radiography, radiology, pathology staff; and potentially administration staff
- sustainability of the service due to the absence of key staff
- no business continuity plan for breast screening, which should include PACS migration to new PACS system, IT disaster recovery, succession planning, staff cover arrangements and process for equipment replacement
- PACS system does not permit simultaneous viewing of current and previous images
- MRI scans are not double reported
- bespoke in-house training for the assistant practitioners requires confirmation of accreditation by the Society of Radiographers
- a breast care nurse is not present in each assessment clinic

Shared learning

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

- consistent engagement in the QA process
- staff demonstrate dedication to the service and the team, with a clear patient focus
- the medical physics department provides a monthly round-up of routine quality assurance
- patient dose audit takes place on an annual basis, which exceeds the NHSBSP recommended frequency of 3 yearly audit
- comprehensive monitoring of high-risk women requiring MRI
- development of in-house training for assistant practitioners
- good scope of practice documentation for advanced practitioners and assistant practitioners
- comprehensive supporting documentation for the Eklund technique
- pathology department has regular audit of practice and good internal quality control
- Barnsley Prevention and Early Diagnosis Steering Group has a comprehensive action plan and mechanisms in place to monitor the effectiveness of engagement work

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1901	The director of breast screening (DoBS) 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
CBA1902	Commissioner and provider to ensure that the appropriate governance mechanisms are in place across the whole of the programme in relation to sub-contracts	(1)	6 months	Standard	Confirmation of process
CBA1903	Ensure the job plan for the DoBS offers protected time to complete the duties and responsibilities for the role	(2)	3 months	High	Trust-approved job description
CBA1904	Complete a training needs assessment and training programme for both programme managers and administration staff on all relevant data entry/administrative processes to include; • Using BSIS • BS Select • Clinical data inputting • Registration of high-risk women	(2)	6 months	Standard	Training plan and training log

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	• Ceasing women under the Mental Capacity Act and bilateral mastectomy				
CBA1905	Review the local incident management process and supporting trust policies, to ensure • consistency with national guidance and timely reporting of incidents • all staff are trained in completing a screening incident assessment form	(3)	3 months	High	1. Local incident management policy 2. A one-off Datix report showing 6 months of submissions (Datix period 1 November 2019 to 30 April 2020) 3. Training log
CBA1906	Review and update quality management system (QMS) to include all standard operating procedures (SOPs), work instructions and version control of each document. Ensure this is included in the annual QMS audit	(4)	3 months	High	Updated QMS approved by the management meeting with an annual audit schedule
CBA1907	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
CBA1908	Progress completion of the recommendations made during the right results walkthrough of 31 July 2019	(4)	6 months	Standard	Action log

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1909	Produce an annual report 2018/2019 and present this to the relevant trust and programme boards	(1)	6 months	Standard	1. Annual report 2. Minutes of meetings where report was presented

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1910	Review current staffing levels, workload and skill mix. Create and implement a succession plan to ensure current and future capacity meets demand for all disciplines. To include • a skill mix review to address the vulnerability of the advanced practice, training and mammography leadership within the service • 0.91 WTE shortfall of radiographers • appropriate programme manager supervision of clinical areas • support for all management responsibilities • review of administrative staffing structure • WTE shortfall of consultant radiologists and 2 unfilled pathology consultant posts • support to the QA radiographer • review of WTE to take on stereotactic biopsy • protected time to carry out training • timely recording of interval cancers on NBSS	(1), (4), (5), (14), (15)	3 months	High	1. A detailed workforce and implementation plan, identifying staff requirements for all disciplines 2. Action plan to address the shortfall 3. Training plan for newly appointed backfill for programme manager (clinical areas) 4. Identified support for all management responsibilities 5. Administrative staffing review 6. Action plan to address the shortfall 7. Identified support 8. Action plan to ensure sustainability 9. Training log 10. Action plan to address the backlog

WTE, or whole-time equivalent, is a unit that shows the workload of an employed person in a way that makes workloads comparable in various contexts.

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1911	Develop and implement a service business continuity plan to include all disciplines delivering breast screening, to include: • mitigating risk to service delivery during the PACS migration • IT disaster recovery (including National Breast Screening System (NBSS)) • succession planning • staff cover arrangements • process for equipment replacement	(1), (15)	3 months	High	1. Business continuity plan with agreed implementation plan 2. Service delivery improvement plan
CBA1912	Ensure the equipment, accommodation / premises in use throughout the service meets the specification, guidance and needs of service users	(1)	9 months	Standard	Risk assessment done and action in place; to action plan closed
CBA1913	Review, monitor and ensure that symptomatic services do not compromise screening service delivery	(5), (6)	3 months	Standard	1. Minutes of programme board discussion and assurance provided 2. Detailed workforce plan, identifying staff requirements for symptomatic and screening service delivery

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1914	Produce written protocols for • returning equipment to clinical use and the required QC checks • inputting histology of interval cancer cases.	(7), (2)	6 months	Standard	Protocols
CBA1915	IRMER procedures should be adapted to reflect practice in NHSBSP accurately	(8)	3 months	Standard	Updated procedure
CBA1916	Review User QC processes to • produce a written protocol for testing of the stereotactic kit • ensure the roles and accountabilities of the QA radiographer are set out in writing. • establish communication between the QA radiographer and the MR Superintendent, with QC records shared	(9), (5)	6 months	Standard	1. Protocol 2. Trust approved job description 3. Protocol
CBA1917	Review PACS processes: • complete a risk assessment of the current PACS system and imaging viewing • develop and implement a risk-assessed action plan for the transition to the new PACS system	(10), (15)	3 months	High	1. Risk assessments and action plans done and action in place; to action plan closed. 2. Time lined action plan in place; to action plan closed.

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1918	Review administration processes to ensure • meetings have a set agenda. • complaints and non-conformance are discussed at staff meetings.	(1)	6 months	Standard	1. Agenda 2. Minutes
CBA1919	Review radiology processes to ensure • MRI scans are double reported	(10)	3 months	High	Confirmation of compliance

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1920	The commissioners and stakeholders should develop an action plan to improve uptake	(11), (12)	6 months	Standard	1. Action plan 2. Health promotion strategy

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1921	Review radiography processes to ensure: • regular reviews of individual image quality**;** with feedback and identification of educational and development needs provided to the individual to promote learning. • individuals perform a personal audit of a minimum of 20 sets of imaging every 2 months. • monitor repeat rates over a rolling 3-month period for individual mammographers. Feedback, training and development to be provided to individuals with a high repeat rate and documented with associated actions plans when necessary.	(5)	6 months	Standard	1. Protocol 2. Protocol with confirmation of compliance 3. Charts of repeat rates for individual mammographers over 3-month periods 4. Evidence of feedback, training and development provided, if applicable
CBA1922	Confirm that the bespoke in-house training for the assistant practitioners will be accredited by the Society of Radiographers	(5)	3 months	High	Confirmation from the Society of Radiographers

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1923	Review radiology processes to ensure • regular reviews of individual film reading to prevent outliers • cases with calcification are managed according to national guidelines • B3 lesions are managed in line with national guidance. • review of cases that are discharged from assessment clinic without biopsy.	(10)	6 months	Standard	1. Action plan 2. Protocols and confirmation of compliance

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1924	Ensure service routinely meets date of first offered assessment (DOFOA) and date of assessment (DOA) key performance indicators	(1)	3 months	Standard	Action plan

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1925	A breast care nurse (BCN) must be present in each assessment clinic	(11)	3 months	High	Audit of compliance
CBA1926	Ensure implementation of tomosynthesis	(1)	9 months	Standard	Action in place; to action plan closed
CBA1927	Review false negatives	(10)	9 months	Standard	Protocol and audit of compliance

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1928	Ensure screening cases can be differentiated from non-screening cases	(14)	9 months	Standard	Audit period 1 November 2019 to 30 April 2020
CBA1929	Audit breast core biopsy results with particular attention to B1 cases.	(14)	9 months	Standard	Audit period 1 November 2019 to 30 April 2020
CBA1930	Audit ER positive tumours to check ER positive rates	(14)	9 months	Standard	Audit period 1 November 2019 to 30 April 2020
CBA1931	Review pathology processes to ensure • number of cancer resections reported by each consultant is monitored • pathologists attend at least 1 regional QA meeting each year • the cut-up protocol for sentinel lymph nodes adheres to NHSBSP guidelines	(14)	9 months	Standard	1. Action plan 2. Attendance record 3. Confirmation of compliance

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1932	Access to a psychologist should be available, if required	(11)	6 months	Standard	Confirmation of compliance
CBA1933	Review MDT meeting processes to ensure attendees sign in	(1)	6 months	Standard	MDT sign in sheets for period 1 November 2019 to 30 April 2020

No.	Recommendation	Reference	Timescale	Priority	Evidence required
CBA1934	Surgeons and pathologist to audit accuracy of the 2018 to 2019 data inputted into the ABS database, performed by the office admin team	(1)	6 months	Standard	Outcome of audit

Next steps

The screening service provider is responsible for developing an action plan with the commissioners to complete the recommendations of 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. Following this, SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline further actions, if needed.