Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Cornwall

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, 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.

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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 Cornwall screening service held on 25 April 2018.

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-visits to review pathology reports and slides, radiology and surgical performance, and attendance at a multidisciplinary team meeting
- information shared with SQAS South as part of the visit process

Local screening service

The Royal Cornwall Hospitals NHS Trust is commissioned to deliver the NHS Breast Screening Programme to the eligible women in the Kernow clinical commissioning group (CCG) registered population in Cornwall.

The Cornwall breast screening service has an eligible screening population of approximately 66,000 in the 50 to 70 age group and screens an additional 19,200 women age 47 to 49 and 71 to 73 as part of the national randomised age extension trial.

The service is located at The Mermaid Centre, The Royal Cornwall Hospital, Truro, and is part of the Royal Cornwall Hospitals NHS Trust. The Mermaid Centre provides a combined screening and symptomatic service for the Cornwall population. Screening is also carried out on 2 mobile vans covering a large rural area.

All screening assessment clinics take place at The Mermaid Centre. Pathology services are provided at the Royal Cornwall Hospital and surgery is undertaken at St Michael's Hospital in Hayle.

High risk screening is performed at The Mermaid Centre and MRI (magnetic resonance imaging) scans are performed on site at the Royal Cornwall Hospital.

Findings

The QA visit team found that this is an effective and safe service. The service meets most national standards and is performing well.

Uptake for 2016 to 2017 was 74.5% which is above the minimum standard of more than 70%.

The immediate and high priority findings, and areas for shared learning, are summarised below.

Immediate concerns

The QA visit team identified one immediate concern. A letter was sent to the chief executive on 26 April 2018 requesting that the following recommendation be addressed within 7 days:

- outstanding documentation for ultrasound and workstation testing to be provided immediately

A response was received within 7 days which provided the QA visit team with the information required and this issue is no longer an immediate concern.

High priority

The QA visit team identified several high priority findings summarised below:

- having only one phone line to the breast screening office causes inconvenience to women trying to book/change appointments
- problems with the siting of mobile vans
- current radiography staffing levels do not meet national guidelines
- issues with the accuracy and timeliness of medical physics reports
- the transfer of patient notes to mobile vans is not sufficiently secure
- the local policy for technical recall/repeat is not in line with new national guidance
- local criteria for allowing a repeat examination is inflexible
- the current set up of core biopsy and assessment clinics do not enable same day stereotactic biopsies
- a second assessor is not consistently used for assessment cases and this is particularly important for women discharged to routine recall
- not all women are met by a nurse at the start of an assessment clinic

Shared learning

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

- a good relationship between the service and the community learning disability team which has improved access to screening
- duty of candour has been introduced and is working well
- MRI biopsy service introduced which supports services across Devon and Cornwall
- multi-disciplinary team meeting for high risk women that includes a geneticist, a psychiatrist and a psychologist
- borderline lesions are discussed by 2 pathologists before reporting
- learning from a surgical incident has improved governance
- time to treatment has been 100% for the past 12 months
- successful recruitment into research trials and a dedicated research team
- MDT working commended in a report from the Royal College of Surgeons

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Annual report to SQAS on completion	Service Specification 24	3 months	Standard	Annual report
2	Coordinate a long term strategy with the local authority public health team regarding siting of mobile vans	Service Specification 24	3 months	High	Confirmation that strategy has been agreed
3	Write work instructions for reporting screening incidents	NHSBSP Managing safety incidents in NHS screening programmes	3 months	Standard	Copy of work instruction
4	Provide a flow chart showing risk and incident escalation and governance routes to SQAS	NHSBSP Managing safety incidents in NHS screening programmes	3 months	Standard	Copy of flow chart

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Provide an update on the implementation of the trust governance improvement arrangements	Service Specification 24	6 months	Standard	Update
6	Formally evaluate, on a quarterly basis, the results from the client satisfaction surveys carried out on the mobile units	Service Specification 24	3 months	Standard	Evaluation results
7	Carry out an assessment clinic client satisfaction survey	NHSBSP publication no 29	12 months	Standard	Survey results
8	Ensure women contacting the office by phone are dealt with in a timely manner to maximise accessibility of the service	Service Specification 24	3 months	High	Confirmation of process put in place to improve telephone access
9	Ensure any updates to the programme and national specialty guidance are discussed in the radiography team meetings	Service Specification 24 NHSBSP Guidance for breast screening mammographers	1 month	High	Confirmation that updates are included as an agenda item

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Recruit a further 1 WTE radiographer as per guidance	NHSBSP Guidance for breast screening mammographers	6 months	High	Confirmation
11	Any outstanding equipment survey reports should be generated and issued to the unit	SLA NHSBSP Publication No. 33	1 month	Immediate	Copy of reports
12	Review the work flow and processes for routine equipment testing to improve the timeliness and accuracy of report generation	SLA NHSBSP Publication No. 33	6 months	High	Copy of workflow and processes
13	Improve the development of templates for equipment testing to include a mechanism for checking the templates on set up and documenting any changes made to the spreadsheet	NHSBSP Publication No. 33	12 months	Standard	Copy of template process

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Revise the stereo testing procedure in line with national guidance	NHSBSP Publication No. 63	3 months	Standard	Revised procedure and a complete set of one months results
15	Create an audit tool to ensure ongoing compliance with BSP QC guidance	NHSBSP 0702	12 months	Standard	Copy of audit tool
16	Implement a secure system for transfer of notes to the mobile vans	NHSBSP Guidance for breast screening mammographers	1 month	High	Confirmation of system

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Ensure the technical recall/technical repeat (TR/TP) local policy is in line with new guidance	NHSBSP Guidance on collecting, monitoring and reporting technical recall and repeat examinations	3 months	High	Revised policy

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Ensure the local policy for repeat images is in line with new guidance	NHSBSP Guidance for breast screening mammographers	3 months	High	Revised policy
19	Review radiology staffing levels and recruit to fill any shortages highlighted in the recent internal staffing review	NHSBSP publication No 52 Service Specification 24	12 months	Standard	Confirmation of review and recruitment
20	Reorganise stereo core biopsy and assessment clinics to enable same day stereo core biopsy	NHSBSP publication No 49	6 months	High	Assessment clinic protocol
21	Audit MRI reporting numbers in order to achieve the standard of 100 reads per radiologist	NHSBSP publication No 68	12 months	Standard	Results of audit
22	Audit false negative assessment cases and submit the appropriate false negative assessment forms to SQAS in a timely manner	NHSBSP Reporting, classification and monitoring of interval cancers and cancers following previous assessment, August 2017	6 months	Standard	Results of audit

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	Ensure the local protocol for interval cancer review reflects national guidance	NHSBSP Reporting, classification and monitoring of interval cancers and cancers following previous assessment, August 2017	1 month	High	Protocol for interval cancer review

Diagnosis

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Ensure surgical and pathological data is entered correctly and in a timely manner onto the National Breast Screening System (NBSS)	Service Specification 24	6 months	Standard	Confirmation of completed training
25	Ensure all women are met by a clinical nurse specialist at the start of assessment clinic to enable a holistic assessment to be made	QA guidelines for Clinical Nurse Specialists, 2012	6 months	High	Assessment clinic protocol

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Ensure there is a consistent second assessor for all assessment cases	NHSBSP publication 49	3 months	High	Assessment clinic protocol
27	Review estrogen receptor (ER) immunohistochemistry protocol and prospectively audit ER positivity rate	Public Health England. Breast Screening Pathology Data: England. Performance for the period 1 April 2013-31 March 2016	12 months	Standard	Results of audit
28	Redistribute breast work to ensure all pathologists meet the minimum caseload standard	Quality Assurance Guidelines for Breast Pathology Services Second edition 2011	6 months	Standard	Written confirmation

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Produce plan for the continuing professional development (CPD) of pathologists who have not met minimum CPD requirements in the last 3 years	Quality Assurance Guidelines for Breast Pathology Services Second edition 2011	3 months	Standard	Copy of plan

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
30	Restructure the multi-disciplinary team meeting (MDT) into defined sections to enable the oncologists to plan their attendance	NHSBSP No. 20	3 months	Standard	Confirmation of new MDT arrangements

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/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.