Public Health England

NHS

Screening Quality Assurance visit report

NHS Breast Screening Programme
Jarvis Breast Screening Service

12 October 2017

Public Health England leads the NHS Screening Programmes

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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 better 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. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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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 (QA) visit to Jarvis Breast Screening Centre held on 12 October 2017.

Purpose and approach to quality assurance (QA)

Quality assurance 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 of data collected by the NHS screening programmes
- evidence submitted by the provider(s) and commissioner
- information collected during pre-visits to review pathology reports and slides, attend multidisciplinary team meetings, and peer review for radiology/surgical performance
- information shared with the South regional SQAS as part of the visit process

Description of local screening service

The Jarvis breast screening service has an eligible population of 176,559 women aged 50 to 70 and 231,116 aged 47 to 73. The main service is located at the Jarvis centre. It operates a static screening service as well as having 5 mobile units covering the defined population.

Since April 2017, the screening programme is provided by InHealth, an independent sector provider, commissioned by NHS England South (South East). The geographic area is covered by East Surrey, Surrey Downs, North West Surrey, Guildford and Waverley, North East Hampshire and Farnham, Surrey Health Clinical Commissioning Groups (CCG).

All screening assessment clinics take place at the Jarvis. Pathology for screening assessment biopsy samples is carried out at the Royal Surrey County Hospital with pathology for surgical samples undertaken here and in 5 additional NHS hospitals (East Surrey Hospital, Ashford and St Peter’s Hospital, Frimley Park Hospital, Royal Marsden Hospital and Kingston Hospital).

Screening patients are referred to 6 NHS trusts (Royal Marsden/Kingston/Surrey and Sussex/Royal Surrey County/Ashford and St Peter's and Frimley Park) for surgical and oncological treatment.

High risk screening, MRI (Magnetic Resonance Imaging) scans are performed off site by Alliance Medical. MRI guided biopsies are referred to North West London Breast Screening Service.

Findings

The Jarvis delivers a good service despite challenges with the recent move to a new provider and a high vacancy rate in radiography and office staff. Uptake for 2016-17 is 68.6% which is below 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 an immediate concern around breast pathology services.

All pathology consultants reporting breast screening biopsies and resections are required to participate in the national breast screening external quality assurance scheme. However, not all pathologists fulfil these NHSBSP requirements.

A letter was sent to the Chief Executive of Royal Surrey County Hospital on 16 October 2017. The letter requested confirmation within 7 days that all reporting pathologists had registered with the EQA scheme and an action plan was in place to address the remaining issues. The letter stated that should it not be possible to resolve these issues, individual pathologists not fulfilling the NHSBSP requirements should cease reporting on breast screening specimens.

Confirmation was received on 17 November 2017 that these issues have been addressed.

High priority

The QA visit team identified 5 high priority findings as summarised below:

The service has no multidisciplinary team (MDT) meeting at the Jarvis centre, and not all biopsy cases have been discussed at MDT. This poses a risk to screening patients. High risk screening MRI waiting time standards are not always met. The unit outsources high risk MRI to 3T mobile MRI magnet in the grounds of the Royal Surrey University

hospital. This provider refuses to scan women who have MRI compatible coils in situ after a breast biopsy. These patients are then sent to a site further away for a scan on a 1.5T MRI. This delays the pathway and gives a poorer and inequitable service to some women.

There are no formalised agreements (MOUs) between the Jarvis and the referral units in 6 acute trusts. Having such agreements will reduce risk for screening patients along the pathway.

For the eligible screening population of 231,116 (aged 47-73), the NHSBSP recommended radiography staffing level for a population of this size is around 30 whole time equivalent (wte). There are currently 15.9 wte in post accounting for a significant shortfall of mammography staffing levels.

The daily reporting workstation test has not been performed since April 2017. The unit needs to ensure reporting monitors are checked daily.

Shared learning

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

- Jarvis has a good reputation as a training centre delivering high quality training services
- the centre has a website that allows women to change appointments
- there are good health promotion activities particularly within prisons and community settings
- intraoperative sentinel node analysis is offered to patients at RSCH, ASPH and Frimley Park hospitals

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Formalise reporting arrangement for the Director of Screening and identify a deputy	Service Specification No. 24	3 months	S	Arrangements formally documented
2	Screening patients are referred to 6 NHS trusts for treatment. Formalise agreements with the 6 acute trusts to reduce risk for screening patients along the pathway	Service Specification No. 24	3 months	H	Signed agreements in place and a copy sent to SQAS
3	Update job descriptions for clinical director, programme manager and superintendent radiographer	Service Specification No. 24	3 months	S	Updated job descriptions
4	Agree the process for compiling and presenting an annual report to the executive team	Service Specification No. 24	3 months	S	Confirmation of the process to SQAS and copy of the annual report that was presented to the board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
5	Ensure adequate A&C staffing levels for the population served as part of the staffing review. Enable a good skill mix and cross cover to ensure resilience and stability	QA guidelines for A&C publication No. 47	6 months	S	Copy of the staffing review report and future succession plan
6	Develop a succession plan to fill staff vacancies and recruitment including training	NHSBSP	1 month	H	Copy of the succession plan
7	Recruit to radiography vacancies, and ensure radiography staffing establishment meet the NHSBSP recommended levels	NHSBSP radiography guidelines	3 months	H	Copy of the succession plan
8	Ensure the lead superintendent radiographer has direct access to appropriate clinical leadership and supervision	NHSBSP radiography guidelines	3 months	S	Written confirmation to SQAS in the form of a formally agreed staffing reporting structure
9	Review current breast care nurse qualifications against guidelines and ensure attendance to relevant courses	NHSBSP No. 29	6 months	S	Written confirmation to SQAS

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
10	Ensure there is a signed SLA in place with medical physics provider	NHSBSP No. 33	3 months	S	Signed SLA to SQAS
11	Ensure appropriate staff involvement in procurement of new equipment, particularly the Medical Physics experts	NHSBSP No. 33	3 months	S	Written confirmation to SQAS
12	Update documentation to support ionising radiation legislation in line with the new regulations	NHSBSP No. 33	6 months	S	Written confirmation that documentation was updated
13	Appoint to the vacant Radiation Protection Supervisor post	NHSBSP No. 33	3 months	S	Written confirmation to SQAS
14	Test workstation daily as per guidance. The NHSBSP guidance states that reporting workstation tests should be carried out on a daily basis. These tests have not been performed since April 2017 and must be reinstated with immediate effect	NHSBSP No. 33	1 month	H	Written confirmation to SQAS
15	Implement the recommendations from the internal QC audit in September 2017	NHSBSP No. 63	3 months	S	Written confirmation that all recommendations were implemented

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Carry out risk assessment to the delay of integration of breast images in the InHealth PACS		1 month	S	Written confirmation of risk assessment
17	Carry out risk assessment to the automatic closure of jobs in the InHealth PACS		1 month	S	Written confirmation of risk assessment
18	Ensure issues relating to the delay in resolving orphan images, incorrect lateralities, access of previous images for comparative reporting and access of images at assessment are resolved by the local PACS team. The Unit should ring fence dedicated time to the local PACS role		3 months	S	Written confirmation to SQAS

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
19	Run the open episodes SQOE report every 2 weeks to ensure open episodes are closed within time scale	A&C guideline NHSBSP publication No. 47	3 months	S	Detailed SQOE report to SQAS
20	Carry out a randomized audit to clinical data entry to ensure data correctness.	A&C guideline NHSBSP publication No. 47	3 months	S	Detailed audit results to SQAS
21	Achieve the nationally recommended round length plan and ensure service resilience.	NHS BSP Achieving and maintaining the 36 month round length Oct 17 No.2	6 months	S	SQAS receive a detailed screening round length plan
22	Produce a health promotion plan that includes targeting hard to reach groups and deprived areas	Service Specification No. 24	6 months	S	Signed off health promotion plan

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
23	Ensure radiographers have adequate protected time for learning, CPD, participation in audits in line with national guideline	NHSBSP radiography guidelines	6 months	S	Plan on how to meet this requirement
24	Implement the national assessment tool by using the new PGMI template in line with NHSBSP guideline	NHSBSP Publication No. 63	3 months	S	Written confirmation to SQAS
25	Carry out risk assessment to workload, equipment and ergonomic requirements of the mammographic procedures	NHSBSP Publication No. 63	3 months	S	Copy of risk assessment
26	Ensure all film readers achieve a minimum of reading 5000 films per year (including 1500 as first reads)	NHSBSP radiology guideline	6 months	S	Plan on how to meet this requirement
27	All film readers to regularly attend an MDM in line with NHSBSP guideline	NHSBSP radiology guideline	6 months	S	Written confirmation to SQAS

Diagnosis

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
28	Ensure all biopsies are discussed at a screening breast MDM with an appropriate membership	Service Specification No. 24	3 months	H	Written confirmation to SQAS
29	Implement the radiology B3 guidance	NHSBSP assessment guideline	3 months	S	Written confirmation to SQAS
30	Ensure high risk screening MRI waiting time standards are met	Service Specification No. 24	3 months	H	Written confirmation of plans in place to meet the standards
31	Ensure that all patients have good, equitable and timely to external MRI providers	Service Specification No. 24	6 months	S	Written confirmation to SQAS
32	Reduce prevalent recall rate	Service Specification No. 24	6 months	S	Copy of the plans to achieve this recommendation
33	Improve non operative diagnosis rate for ductal carcinoma in situ (DCIS)	Service Specification No. 24	6 months	S	Copy of the plans to achieve this recommendation

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
34	A pathologist should always participate in the MDT process, particularly when diagnostic core biopsies are discussed, as per national standards. All pathologists reporting breast screening cases should regularly participate in the MDT	NHSBSP pathology guideline	3 months	S	Written confirmation
35	Confirm all pathology consultants reporting screening biopsies and/or resections are registered and participate in the national breast screening histopathology EQA scheme	NHSBSP pathology guideline	Immediate	I	Written confirmation
36	Confirm arrangements for all BSP reporting pathologists to undertake adequate CPD	NHSBSP pathology guideline	3 months	H	Written confirmation
37	Confirm all BSP reporting pathologists can meet the standard of reporting 50 primary breast cancer resection specimens per year	NHSBSP pathology guideline	3 months	H	Written confirmation
38	Audit on B2 core biopsies for 2016/2017	NHSBSP pathology guideline	3 months	S	Audit results
39	Ensure HER2 testing on core biopsies routinely for all cancers	NHSBSP pathology guideline	6 months	S	Written confirmation

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
40	Ensure all women are seen by a trained clinical nurse specialist at the start of the assessment process	NHSBSP 29	3 months	S	Copy of SOP
41	Clinical nurse specialist to carry out holistic assessment for all women in line with NHSBSP guidance	NHSBSP 29	3 months	S	Copy of SOP
42	Establish a full functional multidisciplinary team meeting to fulfil the NHSBSP requirement	Service Specification No. 24	3 months	H	Written confirmation of the full MDM meetings and attendance
43	In review of cases from Surrey and Sussex hospital, it was found that the service had a few cases of more than 5 lymph nodes retrieved for node negative invasive cancers. It is recommended to ensure only hot and/or blue lymph nodes are removed	NHSBSP surgical guideline	3 months	S	Revised local protocol

I = Immediate.
H= High.
S = Standard.

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 following the issuing of the final report. 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.