Public Health England

Protecting and improving the nation's health

Quality Assurance Report

Newcastle Breast Screening Programme Observations and recommendations from visit to Newcastle Upon Tyne Hospitals NHS Foundation Trust

10 February 2016

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.

Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

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 four 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.

PHE Screening, Floor 2, Zone B, Skipton House, 80 London Road, London SE1 6LH
www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
Prepared by: Screening Quality Assurance Service (North).
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

Published: November 2018
PHE publications
gateway number: 2018634

PHE supports the UN
Sustainable Development Goals

Executive summary

The findings in this report relate to the quality assurance (QA) review of the Newcastle Breast Screening Programme (BSP) held on 10 February 2016.

Purpose and approach to Quality Assurance

The aim of quality assurance in the NHS Breast Screening Programme (NHSBSP) is to maintain minimum standards and promote continuous improvement in breast screening. This is to ensure that all eligible women have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS) comprising QA staff and a team of professional and clinical advisors (PCAs).

The evidence for this report is derived from the following sources:

- routine monitoring data collected by the NHS Screening Programmes
- data and reports from external organisations as appropriate
- evidence submitted by the provider(s), commissioner and external organisations as appropriate
- information collected during pre-review visits: a selection of evidence completed by the programme covering a number of specialist areas within breast screening
- information shared with the QA team as part of the visit process

Description of Local Screening Programme

The Newcastle Breast Screening Programme has an eligible population of 159,231. This population consists of women aged 47-73, including women in the age extension trial (women aged 47 to 49 and 71 to 73) within the geographic area of the Newcastle Clinical Commissioning Group. For more information please refer to the Programme Management and Governance section of this report, pages 12 to 14.

The programme is provided by The Newcastle upon Tyne Hospitals NHS Foundation Trust. It is commissioned by NHS England (Cumbria and north east).

Key findings

The Immediate and High Priority issues are summarised overleaf as well as areas of good practice.

For a complete list of recommendations, please refer to the related section within this report, or to the list of all recommendations on page 37.

Shared learning

The review team identified several areas of good practice that are worth sharing, including:

- the use of tomosynthesis in assessment of screen-detected abnormalities
- the introduction of iodine seed localisation

Immediate concerns for improvement

The review team identified no immediate concerns.

High priority issues

The review team identified 5 high priority issues, as grouped below.

• performance	pages 14 and 17 for more detail
• communication	pages 13 and 20 for more detail
• staffing	pages 23 and 27 for more detail
• NBSS	page 20 for more details
• sustainability	page 14 for more detail

Key recommendations

A number of recommendations were made related to the high priority issues identified above. These are summarised in the table below:

Priority	Theme	Description of recommendation	Details of recommendation
High	Performance	A recovery plan is required to improve round length	Programme Management and Governance recommendation 2 (page 14)
High	Performance	Timely visits between medical physics and the programme to address equipment QC testing issues	Medical Physics recommendation 1 (Page 17)

High	Communication	Timely notification of screening incidents	Programme Management and Governance recommendation 1 (Page 13)
High	Communication	BSP to inform and send GPs breast screening feedback reports approximately 6 months after screening	Administration recommendation 1 (page 20)
High	Staffing	Review and increase staff levels within radiography and pathology	Radiography recommendation 1 (Page 23) and Pathology recommendation 1 (Page 27)
High	NBSS	Complete an annual reconciliation of high risk screening women held on NBSS with records held by genetics and/or oncology	Administration recommendation 2 (page 20)
High	Sustainability	Business continuity plan to address the planned relocation and staff retirements	Programme Management and Governance recommendation 3 (page 14)

For more information on expected timeframes for completion of recommendations, please see page 37.

5. Next steps

The Newcastle upon Tyne Hospitals NHS Foundation Trust will develop an action plan to ensure completion of recommendations contained within this report.

NHS England North (Cumbria and north east) Screening and Immunisation Team (SIT) will monitor progress against the action plan developed by the provider and seek assurance from the provider that all recommendations are implemented.

SQAS (North) will support this process and the ongoing monitoring of progress.

List of all recommendations

Number	Recommendation	Priority	Timescale
Programme management and governance			
1	The programme must comply with incident reporting guidelines. **Standard:** NHSBSP Publication No. 49 **Evidence:** A one-off Datix report showing 6 months of submissions to be sent to SQAS, so that it can be compared to screening incidents declared to ensure no under-reporting of incidents. A copy of the operational group meeting agenda, illustrating that Datix reports are a standing agenda item in operational group meetings	**Requirement to meet defined standard**	31 October 2016
2	In accordance to NHSBSP Good Practice Guide, the programme should ensure there is a recovery plan to improve round length performance and this needs to be shared with the SIT **Standard:** NHSBSP Good Practice Guide No. 10 **Evidence:** A copy of the recovery plan	**Requirement to meet defined standard**	31 May 2016
3	The programme should undertake a business impact assessment and work with the SIT to effectively plan for the relocation to a city centre location and future staff retirements. **Evidence:** Copy of business impact assessment	**Recommendation to achieve a quality service**	31 August 2016
Medical physics			
4	The Medical Physics Service should demonstrate that all required QC visits comply with the frequency and scheduling specified in the SLA. **Standard:** NHSBSP Publication No. 63 **Evidence:** The medical physics service should provide a list of all equipment with: • last test date • test frequency • next test due date(s) (Booked) • report due date	**Requirement to meet defined standard**	31 May 2016

	for the next 12 months with booking to be confirmed by the BSP		
5	The breast screening service should undertake a 12 month prospective audit of medical physics compliance with SLA requirements for the quality assurance testing of all equipment detailed in the SLA. **Standard:** NHSBSP Publication No. 63 **Evidence:** An audit of medical physics QA visits to demonstrate that they have been performed at the required frequency +/- two weeks and reports were issued within one month of the visit date	**Requirement to meet defined standard**	30 April 2017
6	Medical physics, radiographer mammography, MR and Ultrasound QC report should be reviewed by the Superintendent Radiographer on a monthly basis and clearly identify action/s required by the BSP and timescale for task completion indicating subsequent medical physics checks required and provide a quarterly record of this. **Standard:** NHSBSP Publication No. 63 **Evidence:** Quarterly record of medical physics checks and actions required.	**Requirement to meet a defined standard**	31 May 2016
7	The medical physics service should seek confirmation that any actions raised are addressed by the BSP. **Evidence:** Confirmation from the Lead medical physicist that this is happening	**Recommendation to achieve a quality service**	31 August 2016
8	The QC radiographer should sign and date the weekly QC reports from each programme as the data is entered into the QC database. **Evidence:** Confirmation from the Lead QC radiographer that this is happening	**Recommendation to achieve a quality service**	31 August 2016
Administration			
9	GP breast screening feedback reports must be sent to the relevant GP practices approximately 6 months after screening. **Standard:** NHSBSP Publication No. 47 **Evidence:** Email correspondence	**Requirement to meet defined standard**	31 August 2016
10	An annual reconciliation of high risk screening women held on NBSS with records held by genetics and/or oncology referrers.	**Requirement to meet a defined standard**	30 April 2017

	Standard: NHSBSP Publication No. 47 **Evidence:** Copy of annual reconciliation report and outcome		
Radiography			
11	Review the staffing levels to ensure that there is sufficient capacity to improve the round length to achieve the standard **Standard:** NHSBSP publication No. 63 **Evidence:** Copy of staffing review	**Requirement to meet defined standard**	31 August 2016
12	Introduce peer review of images for all mammographers **Standard:** NHSBSP publication No. 63 **Evidence:** Copy of staff peer review meeting agenda and attendance sheet	**Requirement to meet defined standard**	31 May 2016
13	Arrange update training for all radiographic staff in mammography **Standard:** NHSBSP publication No. 63 **Evidence:** Attendance certificate	**Requirement to meet defined standard**	31 August 2016
14	Implement audit of the more than two view Crystal report **Standard:** NHSBSP publication No. 63 **Evidence:** A copy of the audit report	**Requirement to meet defined standard**	31 August 2016
Radiology			
15	All film readers are expected to participate in audit of their own performance as stated in the QA Radiology guidance. As part of this it is recommended that those film readers with the highest 'missed cancer rates' make particular effort to review the individual cases. Film readers with a miss rate of 2/1000 or higher on a year's FRQA data in particular should undertake this audit **Evidence:** Confirmation of audited work	**Recommendation to achieve a quality service**	31 August 2016
16	In cases where a second needle sample is taken from a lesion with an initial B3 result, the method of data recording should be reviewed. At the visit there was evidence that not all second sample results were recorded on NBSS. **Evidence:** Copy of SOP	**Recommendation to achieve a quality service**	31 August 2016

17	Film readers with recall rates substantially higher than the departmental average will contribute greater numbers of cases needing arbitration. They should be included in as many arbitration meetings as possible in an attempt to modify their recall rates	**Development/ Observation**	
Pathology			
18	The business case for additional reporting PAs in breast pathology should be accelerated and the staffing shortfall addressed to allow all cases to be reported in house. **Standard:** NHSBSP publication No. 2 **Evidence:** Copy of outcome of submission of business case and confirmation of start date of additional staff	**Requirement to meet defined standard**	30 November 2016
Surgery			
19	The programme needs to ensure that there are better acoustics and visibility during the MDT meetings either by relocating or redesigning the current room being used. **Standard:** NHSBSP Publication No. 49 **Evidence**: Written confirmation of relocation or redesign	**Requirement to meet defined standard**	Written plan 31 May 2016, actual delivery 30 November 2016
20	Reconfiguration of the post-operative results clinics should be undertaken to allow more appropriate breast care nurse input to discuss the results with patients. **Evidence:** Confirmation email that nurses complete this task	**Recommendation to achieve a quality service**	Written plan 31 August 2016, actual delivery 31 January 2017
21	Consideration should be given to the incorporation of a ‘tea break’ into the MDT to allow a natural break in the discussions which may improve the time management particularly for pathology and oncology	**Development/ Observation**	
22	Consider giving plastics theatre staff training on the procedures involved with iodine seed localisation surgery to enhance their skills in this procedure	**Development/ Observation**	
Breast care nursing			
23	Staffing review to include formal permanent recognition of temporary overtime hours **Standard**: NHSBSP Publication No. 29 **Evidence:** Written confirmation of adjustment of	**Requirement to meet defined standard**	31 May 2016

	hours		
24	All women should be seen by a nurse at the beginning of clinic. **Standard:** NHSBSP Publication No. 29 **Evidence:** Written confirmation that BCN see women at the beginning of clinic	**Requirement to meet a defined standard**	31 August 2016
25	Staffing review to look at succession planning and extra CNS hours with the aim of reinstating the CNS role at the beginning of clinic. **Evidence:** Copy of reports produced as part of review	**Recommendation to achieve a quality service**	31 August 2016
26	Multidisciplinary team to revisit the use of gowns in assessment	**Development/ Observation**	
27	Audit of patient experience-6 months. (Specific question re gowns/partners in attendance to be included) to highlight any further concerns/ issues	**Development/ Observation**	
28	Provide some dedicated weekly time that the nursing team can meet to discuss caseload and undertake informal clinical supervision.	**Development/ Observation**	
Commissioning and Public Health			
29	The programme should ensure that timescales are added to the process for escalating poor performance, supporting timely intervention. **Evidence required:** Copy of process showing timescales	**Recommendation to achieve a quality service**	31 May 2016
30	The SIT should liaise with the health improvement officer to develop a plan of health promotion activity for 2016/2017 that encompasses evaluation. **Evidence required:** Copy of health promotion plan	**Recommendation to achieve a quality service**	31 May 2016
31	Audits that support quality improvement are developed across a NHS England North (Cumbria and north east) footprint and shared at programme boards	**Development/ Observation**	