

**TRUST BOARD**

<b>Date of Meeting:</b> 11/01/2011		<b>Enclosure:</b> Enc 10
		<b>Agenda Item No:</b> 10.2
<b>Title of Report:</b> Breast Screening Incident – Update Report		
<b>Aims:</b>  This report provides the Trust Board with an update on progress with the implementation of the recommendations outlined in the Breast Screening Incident Report, published by NHS Cumbria in November 2010.		
<b>Summary:</b>  In June 2010, the Breast Screening Programme, provided by the Trust was suspended by the Director of Public Health following concerns raised by an interim Quality Assurance visit. A full investigation was then launched by NHS Cumbria and the Trust. The final report into this investigation was published in November 2010.  The Trust and NHS Cumbria have been working on implementing the recommendations outlined in this report during the last two months.		
<b>Specific implications for consideration (Financial/Workforce/Risk/Legal/Race Equality etc):</b>		
<b>Financial</b>	The additional support being provided by Newcastle Upon Tyne NHS Foundation Trust has resulted in significant additional costs being incurred during 2010/11 and the withdrawal of the contract income by the PCT associated with this service.	
<b>Workforce/E&amp;D</b>	No specific implications	
<b>Other</b>	To ensure the Trust and NHS Cumbria fully implement the recommendations outlined in the Breast Screening Incident Report	
<b>Recommendations:</b> That the Trust Board:  a) NOTES this report and; b) APPROVES the terms of reference to review clinical governance across the Trust, attached at Appendix 3 of the report.		
<b>Document previously approved by:</b> Not applicable. Report directly to the Trust Board.		
<b>Prepared by:</b>  Ramona Duguid Company Secretary		<b>Presented by:</b>  Kevin Clarkson, Chief Operating Officer/Deputy Chief Executive

Helen Kelly Head of Governance and Quality	
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**TRUST BOARD  
BREAST SCREENING INCIDENT –  
UPDATE REPORT  
JANUARY 2011**

## **1. INTRODUCTION**

In June 2010, NHS Cumbria suspended the Breast Screening Service whilst work was carried out to make improvements and to strengthen the service in order to ensure that the highest standards of patient care were being provided. This decision was taken following an interim visit by a radiologist from the regional Quality Assurance Team due to a small number of issues that required further investigation. This included some early indications that some women may not have received some additional tests.

The Trust and the PCT commissioned an independent review of 1,537 women who had attended for assessment during the current screening round.

The final report (attached at Appendix 1) into the review was published by NHS Cumbria in November 2010.

This report updates the Trust Board on progress with implementation of the recommendations. In addition it also updates Board members on the additional review of 1000 cases, for assurance purposes, which was requested by the multi-agency team.

## **2. BREAST SCREENING INCIDENT REPORT**

The final report into the Breast Screening Service confirmed that a review of breast imaging carried out in the Trust identified 16 cases of breast cancer from the 1,537 cases reviewed.

The final report outlined six recommendations for implementation by NHS Cumbria and the Trust:

- **Recommendation 1:** A safe and effective breast screening programme should be re-established in North Cumbria as soon as practicable. In re-establishing this programme, a larger screening programme which demonstrates centre-of-excellence qualities should

be commissioned to provide screening and assessment services locally.

- **Recommendation 2:** The new service should include plans for catch up so that women whose screens have been delayed are seen as soon as possible.
- **Recommendation 3:** The new screening programme should reflect national plans for digital mammography and age expansion.
- **Recommendation 4:** Screening, diagnosis and treatment services should continue to be delivered locally within North Cumbria.
- **Recommendation 5:** A review of clinical governance procedures should be carried out by North Cumbria University Hospitals NHS Trust in other services provided by the hospitals Trust to ensure proper processes are in place. The results of this review should be presented to the NCUHT and NHS Cumbria Trust Boards.
- **Recommendation 6:** No North Cumbria University Hospitals NHS Trust consultant radiologists involved in this incident should be involved in breast imaging until they have completed additional training delivered by a recognised NHS Breast Screening Programme.

The Trust and NHS Cumbria have been working together to implement the above recommendations and an updated action plan is attached to this report (Appendix 2).

### **3. ADDITIONAL REVIEW OF CASES**

During the investigation of the Breast Screening Incident, it was agreed by the multi-agency team that a further review of cases should be undertaken to provide further assurance on whether basic mammographic interpretation at North Cumbria University Hospitals NHS Trust was being performed to an acceptable standard.

A random sample of 1,000 patient records of women who had undergone routine three-yearly or annual mammograms was undertaken by two independent radiologists.

This sample review has now been completed and it has been confirmed that these other parts of the North Cumbria University Hospitals Trust programme were working properly.

The findings from this review have been fully endorsed by both the North West Breast Screening Quality Assurance team and the chair of the National Breast Screening Quality Assurance Coordinating Committee for Radiology.

### **4. NEXT STEPS**

The Trust is continuing to support NHS Cumbria in their role of commissioning a long term solution for the screening service as well as working closely with Newcastle Upon Tyne NHS Foundation Trust on the re-commencement of the screening programme, which commenced during the first week of January 2011.

The Trust Board will continue to be updated as necessary regarding progress with implementing these recommendations.

## **5. RECOMMENDATION**

That the Trust Board:

- c) NOTES this report and;
- d) APPROVES the terms of reference to review clinical governance across the Trust, attached at Appendix 3 of the report.

**Kevin Clarkson**  
**CHIEF OPERATING OFFICER/DEPUTY CHIEF EXECUTIVE**

*Supporting Appendices to this report:*

*Appendix 1 – Breast Screening Incident Report November 2010*

*Appendix 2 – Action Plan on Breast Screening Incident Recommendations*

*Appendix 3 – Terms of reference for Recommendation 5b)*

