Regulation & Quality Improvement Authority

RQIA Governance Review of the Northern Ireland Breast Screening Programme

March 2006

Quality Improvement Review 2/06

Contents

Foreword

The Genesis of the Report

The Quality Improvement and Regulation Order [2003] Northern Ireland places responsibility upon the Regulation and Quality Improvement Authority to carry out functions to support improvement in the quality and the Regulation of services.
The functions of carrying out investigations into, conducting reviews of and making reports on, the management, provision or quality of the health and personal social services, for which statutory bodies have responsibility, are undertaken with the general duty of encouraging improvement in the quality of services.

The Incident Reported

This Report sets out the findings and recommendations for improvement following a serious adverse incident notification. The adverse incident was notified in the Breast Screening Service where it was noticed that the protocols for diagnosis of potential Breast Cancers, in some women, were not undertaken in accordance with recognised standards. The adverse effect of the serious clinical incident was minimised by the actions of staff who, having recognised failings in the standards of service, notified their concerns in accordance with good clinical practice and sound clinical governance. It is this standard of good governance and clinical practice which characterises health services, which the public has a right to expect, which must be encouraged and which must help to give confidence in screening services to the wider public.

Public Awareness

Breast Screening is crucial to improving the health outcome and well being of women. The media interest which surrounds the publication of this report should take the opportunity to encourage women to use the Breast Screening Service and to read this report to restore public confidence in the standards of the service where the recommendations for improvements in the service and its Quality Assurance systems will be monitored by Regulation and Quality Improvement Authority.

The Women Affected

The women who were recalled for further assessment at Breast Screening following the notification of the adverse incident have suffered serious and varying degrees of anxiety and distress. The service has offered a sincere apology and an acknowledgement of the difficulties experienced by the women and their families.
For those women whose recall revealed a diagnosis of cancer there is the additional fear of whether or not the delay in diagnosis has had a significant

clinical effect. Our thoughts are with those women and their families who are now on a path of care and treatment for the Breast Cancer and who can expect the best standards of care for the optimum outcome for their health and well being. Those affected may take some small consolation from the recommendations in this report which will help reduce the risk of such an adverse incident arising again.

Stella Burnside
Chief Executive Regulation and Quality Improvement Authority

Executive Summary

This Regulation and Quality Improvement Authority report follows a request from the Department of Health, Social Services and Public Safety, to undertake a Clinical and Social Care Governance review of the Northern Ireland Breast Screening Programme.

The review was prompted by concerns raised by clinical staff in the Antrim Area Hospital about the clinical judgement of a single consultant radiologist. These concerns were the subject of a serious adverse incident report to the DHSSPS.

The report follows a clinical review of the Breast Imaging work of the identified consultant, led by Dr Robin Wilson Consultant Radiologist, Nottingham Breast Institute.

The terms of reference for the report are as follows:

1. To investigate the circumstances that contributed to the need to reassess 44 patients at Antrim Area Hospital, following referral from the Breast Screening Programme.

2. To determine whether clinical guidelines for Breast Screening Assessment are in place and being applied in Northern Ireland.

3. To determine whether the Quality Assurance Guidelines for Breast Screening radiology are in place and being followed in Northern Ireland.

4. To investigate any other governance issues pertaining to this matter.

The RQIA agreed a methodology for the investigation and identified an independent, expert review panel.

Background

The report examines the circumstances and key events that led to the recall of 44 women at Antrim Area Hospital, following referral from the Breast Screening Programme, over the period January 2004 to October 2005. The Northern Ireland Breast Screening Service was set up in 1988 at the same time as the National Health Service Breast Screening Programme, with screening/assessment services provided in 4 static breast units supported by 3 associated mobile screening units. The service is supported and monitored by a Regional Advisory Group that was set up within the National Health Service Breast Screening Programme Guidelines. These guidelines not only determine

advisory structures but also set out best practice guidelines on all aspects of the provision of breast screening services.

One of the static screening units is at Antrim Area Hospital which is part of the United Hospitals Trust. This unit provides breast screening, assessment and breast symptomatic services for patients in the Northern Health and Social Services Board.

The consultant whose work is at the centre of this review was employed as a general radiologist doing a small number of breast radiology sessions in Altnagelvin Hospitals Trust since 1995. The consultant was recruited to Antrim Area Hospital from July 2003 as part of a team of 3 radiologists, all of whom were undertaking sessions in the breast unit. From December 2003 he worked as the sole breast radiologist in Antrim Area Hospital within a multi-disciplinary team.

Although this review deals with the incident notified to the DHSSPS on 7th November 2005, it was necessary for the panel to review a related incident in March 2004. In March 2004 film reading radiographers raised concerns about the clinical judgement of the identified consultant in relation to the management of 5 women recalled for breast screening assessment. The concerns centre on a three month period from January 2004 when the identified consultant had been working as the sole breast radiologist. There were no concerns expressed about his work prior to January 2004 when he had worked in the Breast Unit with an experienced consultant breast radiologist.

In order to identify the lessons that must be learned from this critical incident and to make recommendations for the wider health and social services in Northern Ireland, this review has identified four important parameters throughout the period January 2004 to October 2005 into which causes for concern can be grouped.

1. How workforce issues impacted on the service.
2. How the identified consultant radiologist's competency and clinical performance were managed in the Trusts in which he worked.
3. How the selection and recruitment process for medical consultants impacted on the circumstances leading to this incident.
4. How the use of clinical and QA guidelines influenced the quality and provision of breast screening services.

The findings of the review team illustrate that within each of these parameters there were opportunities for senior medical and management staff to take actions that could have led to a different outcome. A number of concerns are raised from which lessons must be learned so that the risk of recurrence is minimised.

Workforce issues and their impact on the service

A chronic shortage of radiology and non radiology film readers contributed to the circumstances which led to the identified consultant working in a degree of isolation, without peer support, at Antrim Area Hospital from January 2004 to October 2004 except for a short period of time in April – June 2004. These workforce problems had been highlighted in numerous letters and meetings in relation to radiologist and radiography workforce in the Northern Ireland Breast Screening Programme. Reports into other breast screening services across the United Kingdom show similar workforce shortages in radiology and radiography. There would appear to have been little progress made to resolve these issues. Antrim Area Hospital undertook proactive steps to recruit a radiologist for the breast screening unit which extended beyond Northern Ireland, with no success. It is also clear that substantial investment had been made by DHSSPS to increase the numbers of staff working within radiological services, however this did not specifically focus on the workforce issues in the breast screening services despite the ongoing concerns raised through the Regional Advisory group, the Northern Health and Social Services Board or Antrim Area Hospital. The Northern Ireland Breast Screening Programme remains understaffed in the key areas of film reading, assessment and symptomatic breast radiology. The review panel feel that the workforce issues outlined appear to have had an influence on the circumstances leading to the incident under review.

Management of competency issues (i)

March 2004 - November 2004

During this period, issues were raised about the clinical competence of the identified consultant. Formal procedures had been considered by Antrim Area Hospital, however they stated that they felt this was not the appropriate vehicle to address the concerns raised at this time and subsequently favoured a more supportive approach to the consultant. This supportive approach involved considerable management of the issues by the Regional QA Director who did not in fact have any line management responsibility for the identified consultant. Senior Managers at Antrim Area Hospital stated that this approach was taken to protect the working relationships within the breast unit team and sustain the service, which was described by the Trust as being under threat. However, at no time did anyone from the Trust senior management team or the regional QA Director discuss the concerns about clinical competence with the identified consultant.

An educational programme was developed by the senior management team in Antrim Area Hospital for the identified consultant, which included visits to a training centre in Glasgow, supervision at screening sessions at the Eastern Health and Social Services Board screening centre and supervision for a 3 month period at clinics in the breast screening unit in Antrim Area Hospital. However, a formal assessment of the consultant's competence was not carried

out at any time during this programme. This appeared to run contrary to the plans that had been agreed by the senior management team in Antrim Area Hospital. A planned attendance at the international training day, did not take place until June 2005 which was 7 months after the identified consultant left his post in Antrim Area Hospital.

The review panel is in agreement with the Wilson Report which highlights that the periods of retraining and supervision provided in 2004 *"appear not to have prevented this radiologist from providing substandard care".* The review panel suggest that the efficacy of the training programme had not been formally assessed. This could have been carried out by an exclusive audit of the identified consultant's own work. The audit of the cases seen between April to June 2004 included work which had been supervised by the regional QA Director and another experienced breast radiologist. No further audit of the consultant's own work was carried out from July to October 2004, a time when the identified consultant worked as the sole radiologist in Antrim Area Hospital. The reason cited for this was because the consultant had been appointed to another job in the Belfast City Hospital. It is the opinion of the review panel that the QA Director's advice to Antrim Area Hospital may have been flawed. The chief Executive of the Antrim Area Hospital stated that he placed considerable weight on the advice of the regional QA Director.

There is little evidence that the concerns about the identified consultant's laissez faire approach, was being managed by Antrim Area Hospital throughout this period. It would also appear that the way in which this was managed by the Trust was to state that they reduced the workload of the consultant at clinics to match the work rate of the identified consultant rather than the requirements of the service. It would also appear that the Clinical Director abdicated his line management responsibilities in relation to the identified consultant's competence and attitudinal failings. The review panel also conclude that he failed to support the identified consultant in managing his workload.

These actions led the review team to conclude that throughout this time there was no focused management or leadership from the Clinical Director of Radiology who made an assumption that the regional QA Director was dealing with the competency issues. This lack of focused management or leadership provides a key indicator of the future performance of the identified consultant. The review panel are concerned that management at the most senior level within Antrim Area Hospital failed to recognise the significant risks being taken in continuing to provide breast screening services where there was an element of doubt about the competence of a consultant radiologist. In the management of the incident in March 2004 they failed to:

- Be explicit with the consultant about the nature of the issues raised about his clinical judgement.

- Follow good governance principles for dealing with failing competence and performance.
- Implement the agreed action plan in relation to the management of the identified consultant.

Management of competency issues (ii)

November 2004-October 2005

In October 2005 clinical staff again raised concerns about the clinical competence of the identified consultant. On this occasion the review panel can conclude that the action taken by the Trust and Northern Health and Social Services Board on 7th November 2005 was appropriate and in accordance with NHS Breast Screening Programme Guidelines for Managing Incidents in the Breast Screening Programme. In addition to these actions the United Hospitals Trust also notified the DHSSPS of the incident through the Serious Adverse Incident Procedure.

It was notable that in addressing the issues highlighted under this adverse incident the Trusts, Boards and Regional Advisory Group in co-operation with the DHSSPS acted swiftly to review the cases under the management of the identified consultant. The speed of this review was unprecedented and should be commended as a model of good practice for similar incidents in the future. The review panel agrees with the comments on "lessons learned" from using this methodology. How patients are informed without causing anxiety must be noted for future reviews and investigations.

The review panel note that despite concerns expressed by DHSSPS about the payment to the identified consultant for his locum work, which considerably exceeded the sessions worked, the Trust continued with this payment. This was despite the fact that the Trust stated that they continued to reduce clinic throughput to match the work rate of the consultant and not the requirements of the service. It would also appear that in directly approaching the identified consultant about undertaking this locum work, at an enhanced pay rate, management at Antrim Area Hospital failed to be open and transparent in offering locum work to other consultants who may have been interested in providing locum cover.

The Review Panel acknowledge that the principle reason for the incidents was that the identified consultant did not fulfil his professional responsibilities in a manner which the Trust had a right to expect from an accredited radiologist. However, the availability of expert advice on which the Trust placed considerable weight, from the regional QA director did not replace the singular accountability of the employing authority.

The Recruitment and Selection Process

The review panel accepts that there is a fine balance between disclosing knowledge of a candidate at interview and the impact on the reputation of the employing body, however, this should in no way negate the view that the welfare and safety of patients is paramount. Belfast City Hospital senior management staff stated that they would expect any interview panel member to disclose information about a candidate's professional competence and that this information may influence the outcome of the interview. Although there appears to have been no formal mechanism for the transfer of such information to other organisations, it is notable that in the revised procedures for handling concerns about doctors and dentists HSS(TC8) 6/2005 (new procedures which were introduced in June 2005) there is specific guidance on sharing information with other organisations to promote patient safety. The Neale Enquiry (2004) states that all previous contacts between applicant and interviewers should be disclosed and recorded.

The review panel are concerned at the inconsistent approach taken by the interview panel at the time of the appointment of the identified consultant to the Belfast City Hospital. The ratings awarded to the candidate appeared to be inconsistent with the comments made by panel members. Concerns also arise from the number of panel members who made changes to the ratings given to the candidate. In at least one example these changes brought the candidate's scoring up to the minimum level required for appointment.

The job specification and the interview transcripts highlight the need for increased focus on non-clinical competencies for consultant posts. The job description for the post advertised shows little emphasis on the concepts of leadership, communication and team working which are increasingly important attributes in modern medical practice.

The review panel considered that the reference provided by the Clinical Director of Radiology in Antrim Area Hospital (dated 31st July 2004), in respect of the identified consultant may have been misleading given the ongoing professional competency issues. In 2001 the General Medical Council issued specific guidance on providing a reference. It stated that *"you must provide only honest and justifiable comments when giving references for or writing reports about colleagues. When providing references you must include all relevant information which has any bearing on your colleague's competence, performance and conduct".*

It is concerning that the Clinical Director of Radiology in Antrim Area Hospital reported that although he provided a reference within the time frames outlined he felt that the reference provided was accurate. He stated that the responsibility for informing the panel of the ongoing competency issues of the identified consultant was with the QA Director who had provided support and advice during the re-

training programme. This QA Director was also a member of the interview panel. The review panel are concerned that the view of Clinical Director for Radiology in Antrim Area Hospital appears to abdicate his professional and managerial responsibilities. He provided a reference for a consultant whom he knew to be the subject of an ongoing investigation and assessment about his clinical work. It would appear to reflect the approach of senior management staff at the Trust that responsibility lay with the regional QA Director, whose role should have been primarily advisory. It continues to highlight the need for clarity of roles and responsibilities in the accountability and employment structures for the Northern Ireland Breast Screening Programme.

The HPSS procedure for the appointment of medical staff does not make provision for any current, previous, pending inquiry or investigation about their professional competence. The review panel recommend that application forms should contain a declaration (that all information is correct to the best of the applicant's knowledge and belief and any matter, professional or personal unresolved or pending that might undermine the applicant's standing, or cause embarrassment to the NHS, should be declared) by a confidential side letter to the chairman of the interview panel.

Clinical and QA Guidelines

All Boards and Trusts involved in this review indicated in their submissions that National Clinical and QA standards were in use within the services that they provided. It would appear that Antrim Area Hospital did not rigorously adhere to a number of these guidelines. These included:

- British Association of Surgical Oncologists Guidelines for the management of symptomatic breast disease
- NHS Breast Screening Programme Guidelines for Breast Screening Assessment and,
- Managing incidents in the Breast Screening Programme (March 2004)

Not only was it clear that the identified consultant appeared not to follow guidelines rigorously; it appeared that there was no mechanism within the Trust to ensure that these guidelines were adhered to. For example no action was taken by the Trust to ensure that there was a radiologist at the multi-disciplinary meeting.

It would also appear that to a large extent the Annual Statistical Reports compiled by the Regional QA Director would focus more on the overall performance of the service rather than its quality assurance.

The review panel were concerned that the QA audit visit undertaken in October 2003 and published in August 2004 used the Scottish Board Standards. The Northern Ireland programme works to the NHS Breast Screening Programme standards. It is notable that the chairperson of the Regional Advisory Group has

stated that the next QA visit scheduled for 2006 will be undertaken by the Nottingham Training Centre which will assess the Northern Ireland Breast Screening Programme against the NHS Breast Screening Programme standards. Given that this QA visit concentrates on the performance of the service the review panel are of the view that the Northern Ireland Breast Screening Programme should also take account of the Quality Standards for Health and Social Care published by the DHSSPS.

Recommendations

Workforce issues and their impact on the service

1. **DHSSPS, Boards, Trusts and Northern Ireland Medical and Dental Training Agency should actively promote post graduate radiology trainees to choose breast radiology as a sub-speciality. The DHSSPS should target a number of Specialist Registrar posts in radiology for the breast radiology sub-speciality in addition to those planned for other radiology practice or sub-speciality interest. This recommendation should also be applied in other vulnerable medical specialities.**

2. **DHSSPS, Boards and Trusts should actively promote the various models of service provision through a range of skill mix options as outlined by NHS Breast Screening Programme, the UK Department of Health and The Society of Radiographers. Skill mix options for the Northern Ireland Breast Screening Programme should be reflected in the Northern Ireland Workforce Development Strategy developed by the DHSSPS.**

3. **The viability and sustainability of the Breast Screening Programme in an area where there are on-going staff shortages, must be considered by DHSSPS, HSS Boards and Trusts within an agreed action plan based on the assessed risks and good governance.**

4. **Plans to further extend the upper eligible age range of routine invitation to Northern Ireland Breast Screening Programme to women aged 65-70 years, should be suspended until workforce issues have been satisfactorily resolved within the service to provide such capacity.**

Management of competency issues (i) March 2004 - November 2004

5. **The Northern Ireland Breast Screening Programme should clarify with Trusts and Boards the role and accountability of the Regional QA Director and make explicit the responsibilities in the management of failing competence and underperformance of staff.**

6. **All Trusts should ensure that concerns about failing competence and/or performance of medical consultants should be dealt with under the recognised framework - Maintaining High Professional Standards in the Modern HPSS (November 2005) HSS(TC8) 6/2005.**

7. **Governance processes should be in place to ensure that when failing competence and medical underperformance is assessed, action**

plans are developed with agreed timescales for implementation. Implementation should be subject to review and monitoring by Trusts with appropriate use of the National Clinical Assessment service.

8. **The DHSSPS should further review and issue definitive guidance on the payment of incentives to consultant medical staff, ensuring that those staff are able to meet in full the requirements of their substantive contract and agreed work plan.**

9. **The DHSSPS should issue revised guidance on the recruitment and selection of locum consultant staff in Trusts/Boards.**

10. **All Trusts should ensure that annual consultant appraisals are implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months). RQIA will undertake an improvement review of consultant appraisal and the role of Clinical Directors in managing medical performance across all Trusts in 2006/2007.**

<u>Management of competency issues (ii) November 2004-October 2005</u>

11. **The results of the Wilson Report and the findings of this review identify grave concerns in professional competence which should be notified to the General Medical Council if this has not already been done. RQIA will review the governance processes within Belfast City Hospital as applied to this issue.**

12. **The RQIA will conduct a further detailed governance review of medical management and leadership in United Hospitals Trust (with particular emphasis on clinical directors) using HPSS Clinical and Social Care Governance Standards.**

<u>The Recruitment and Selection Process</u>

13. **Trusts and employers must ensure that disclosure of information as part of the selection and recruitment processes for all grades of medical staff are in accordance with relevant legislation, good practice guidelines and professional regulatory requirements. The RQIA will require Antrim Area Hospital to demonstrate that due process is followed in the review of the matter of the reference provided, regarding the identified consultant's application to Belfast City Hospital.**

14. **Trusts must take appropriate steps to ensure that interview panel members have up to date knowledge and skills in selection and recruitment processes.**

15. **Medical staff must adhere to General Medical Council Guidelines when providing references or reports about medical colleagues.**

16. **All documentation relating to selection and recruitment of medical staff should be reviewed to ensure that there is provision to question applicants about any professional or personal, unresolved or pending issue that might undermine the applicant's standing, or cause embarrassment to the NHS. An arrangement should be incorporated for a confidential declaration to be received by the interview panel chair.**

17. **Medical Managers and Human Resource departments should ensure that all job specifications for consultant medical staff and Clinical Directors clearly outline all relevant competency domains relating to the role. These should include clear descriptions of competency in leadership, communication and team working as relevant to the post.**

<u>Clinical and QA Guidelines</u>

18. **Any future QA visits to breast screening units must be based on the NHS Breast Screening Programme guidelines and standards. These visits should also take account of the DHSSPS Quality Standards for Health and social care.**

19. **The recommendations of Northern Ireland Breast Screening Programme QA visits and all other quality reviews of the Northern Ireland Breast Screening Programme must be acted upon. It is the responsibility of the QA Director and QA Coordinator to ensure that these action plans are implemented within the agreed time frames through 6 monthly visits to breast screening units.**

20. **Whilst valuing the contributions of the entire multi-disciplinary team, all units should ensure that the screening assessment multi-disciplinary team meeting cannot take place without the attendance of the breast radiologist, breast surgeon/clinician and pathologist and that symptomatic multi-disciplinary team meetings cannot take place without the above clinicians and an oncologist.**

1 Introduction

1.1 On the 21st November 2005 the Regulation and Quality Improvement Authority (RQIA) was asked by the Department of Health, Social Services and Public Safety (DHSSPS) to carry out a Clinical and Social Care Governance review of issues arising from the Northern Ireland Breast Screening Programme **(Appendix 1)**. This review was prompted by concerns raised by clinical staff in Antrim Area Hospital about the clinical judgement and decision making of a particular consultant radiologist. These concerns were viewed by senior hospital staff and medical staff at the Northern Health and Social Services Board as serious adverse incidents and were reported to the DHSSPS under the serious incident reporting procedure. The findings of the RQIA governance review presented in this report are independent of the Wilson Report[1] - an extended clinical review of breast imagining work by the identified consultant.

1.2 The RQIA operates within the legislation of the Quality Improvement and Regulation Order (Northern Ireland) 2003[2]. It is an independent, non-departmental public body that has the responsibility for monitoring, inspecting and reviewing standards for health and social care across all sectors and keeping the DHSSPS informed of those standards. This Order places a statutory duty of quality upon Health and Personal Social Services (HPSS) organisations, determines the development of standards for care and for clinical and social care governance and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

1.3 Clinical and social care governance is described as a framework within which HPSS organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment.

1.4 The events which are the subject of this review have been examined within the context of clinical and social care governance, the legislation as outlined above and within the terms of reference as determined by the DHSSPS. This report makes recommendations for learning and improvement in the Breast Screening Programme and the wider HPSS in Northern Ireland.

[1] Wilson (2006) Report on a Review of Breast Imaging at Altnagelvin Hospital, Belfast City Hospital and Antrim Area Hospital, September 2002 – November 2005

[2] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

2 Background

2.1 The concerns raised by clinical staff working in the breast screening unit in Antrim Area Hospital in early October 2005 resulted in the issuing of a critical incident report on the 18th October 2005. This led to a decision on the 31st October 2005 to initiate a review of breast screening assessment cases that had been carried out in that unit by an individual consultant radiologist. The review identified cases of cancer that would have been overlooked had other clinical staff not intervened at that time to ensure that correct procedures were undertaken. This prompted a further review of the breast imaging work of the identified consultant radiologist, led by Dr R Wilson on the 15th November 2005. A total of 519 breast screening assessment cases that were seen at Antrim Area Hospital between July 2004 and November 2005 were reviewed.

2.2 The identified consultant who was under investigation in the Wilson Report had carried out breast imaging and general radiology services in three acute hospitals in Northern Ireland since September 2002. These hospitals are sited in three different HPSS Board areas, as outlined in **Table 1**.

Hospital	**HPSS Board**	**Time in substantive consultant post**	**Time in locum post**	
Altnagelvin Hospital	WHSSB	Jan 1995 – July 2003		
Antrim Area Hospital	NHSSB	Aug 2003 – Oct 2004	Sept 2002– July 2003	Dec 2004 – Oct 2005
Belfast City Hospital	EHSSB	Nov 2004 to date		

Table 1: Employment by Hospitals across HPSS Board Areas

2.3 The findings of the Wilson Report identified serious failure in standards of clinical medical practice in breast screening assessment. The Wilson Report states that *"of the 519 breast screening assessment cases reviewed on 15th November 2005 there were 39 cases recommended for urgent reassessment because of concerns that appropriate investigations had not been carried out"*. These 39 cases were in addition to the 5 cases identified on 31st October 2005 in an audit carried out by the regional QA Director when concerns were initially highlighted. Therefore a total of 44 cases were recalled to Antrim Area Hospital.

2.4 The Wilson Report states that:

In the extended review carried out in the Wilson Report, *"77 of the 963 assessment cases were reviewed and identified as requiring*

reassessment (Belfast City Hospital 19; Antrim Area Hospital: 58). Eight women have been diagnosed to have breast cancer as a result of the screening assessment review and all have received initial treatment (Belfast City Hospital 1; Antrim Area Hospital 7). Two women declined reassessment and one woman declined to have a breast biopsy."

2.5 Wilson Reports that: *Three hundred and fifty five of the 6640 symptomatic patients reviewed were identified as requiring re-assessment (Belfast City Hospital 104; Antrim Area Hospital 251). Six of these have been diagnosed to have breast cancer and are being treated (Belfast city Hospital 1; Antrim Area Hospital 5).*

2.6 The decision to undertake an "extended" review of the consultant's breast imaging work in the three hospitals involved was made at a meeting with representatives from the hospitals, HPSS Boards and DHSSPS on the 19th November 2005. The identified consultant radiologist was suspended from clinical practice pending Belfast City Hospital disciplinary procedures which would be determined by the outcome of the Wilson Report.

2.7 Further to the Wilson Report the DHSSPS Minister, Shaun Woodward requested that an independent governance investigation be undertaken by RQIA into the circumstances that resulted in 44 patients being recalled for further breast cancer assessment.

2.8 The terms of reference for this investigation were set out by the DHSSPS as follows:

1. To investigate the circumstances that contributed to the need to reassess 44 patients at Antrim Area Hospital, following referral from the Breast Screening Programme.

2. To determine whether clinical guidelines for Breast Screening Assessment are in place and being applied in Northern Ireland.

3. To determine whether the Quality Assurance Guidelines for Breast Screening radiology are in place and being followed in Northern Ireland.

4. To investigate any other governance issues pertaining to this matter.

2.9 The RQIA acknowledge that as a result of the incident there is a requirement to ensure that public confidence is restored in the Breast Screening Programme. This report will include recommendations and

follow-up monitoring on the actions of Boards and Trusts in respect of these recommendations.

3 The Review

3.1 The RQIA agreed with the DHSSPS to undertake the review as a matter of urgency and provide a report to the DHSSPS by the end of March 2006. Details of the timescales for each aspect of the review process are shown in **Appendix 2**.

3.2 The RQIA agreed a methodology for the investigation and identified an independent, expert review panel.

3.3 A review panel was formed with membership that included service user representation and NHS staff with expertise in the areas of breast screening radiology, breast screening quality assurance, public health and human resources management **(Appendix 3)**.

3.4 A meeting was held on 1st December 2005 with the relevant organisations to provide details of the review methodology and timescales.

3.5 The review panel's findings and recommendations are informed by all documentary evidence that was collected and analysed from relevant stakeholders using a governance pro-forma based on the terms of reference. Follow-up interviews were conducted with relevant HPSS and DHSSPS staff to complete the investigation **(Appendix 4)**.

3.6 Draft copies of the review panel's findings and recommendations were forwarded to the organisations reviewed for comment on factual accuracy.

4 Context

4.1 The Northern Ireland Breast Screening Programme

Breast cancer is the most common form of cancer in women, both in Northern Ireland and the developed world. Screening for breast cancer by mammography has been shown to reduce the death rate from breast cancer by up to one-third among women aged 50-69 years through early diagnosis.

The Northern Ireland Breast Screening Programme was set up in 1988. It provides screening/assessment services in 4 static area screening units and is supported by 3 associated mobile screening units.

The aim of the Northern Ireland Breast Screening Programme is to invite all eligible women aged 50-64 years to attend a free breast screening appointment once every 3 years. Approximately 42,021 women across Northern Ireland are invited for breast screening each year. The annual "Analysis of Statistical and QA information"[3] reports show that over the past five years an average number of 72% of those who were invited to attend accepted the invitation. Women over 64 years are also encouraged to self-refer to this screening programme. The DHSSPS Priorities for Action 2003/04[4] recommended that the Northern Ireland Breast Screening Programme should extend the upper eligible age range of routine invitation to include women aged 65 - 70 by March 2006.

4.2 **The Screening Process**

The first stage of the screening is mammography (a low radiation x-ray of the breasts) which although not a definite, diagnostic test in itself is the most reliable way of detecting early breast cancer. It allows a radiologist or film reader to identify whether a woman's mammogram is satisfactory or requiring further assessment. If a mammogram result is satisfactory, the woman is returned to the routine recall system and will be invited for another screening test 3 years later. Where there is a question over whether the x-ray film is normal the woman will be recalled for assessment. Assessment may involve procedures beyond those undertaken at the first appointment including further x-rays and/or clinical examination, ultrasound, removal of a small amount of tissue or cells from the breast by the processes known as core biopsy or fine needle aspiration. A definitive diagnosis should be achieved in the minimum number of assessment visits wherever possible and women should not have to make more than two visits for interventional procedures. The Northern Ireland Breast Screening Programme currently detects

[3] Analysis of Statistical and QA information reports (2000-2005)
[4] DHSSPS (2003) Priorities for Action 2003 - 2004

approximately 5.6 invasive breast cancers and around 1.7 non-invasive cancers per 1000 screens in Northern Ireland.

It is now widely accepted that the multi-disciplinary team forms the basis for best practice in the management of breast disease[5]. These constituent members of the breast team are generally divided into two separate but interdependent groups:

- The Diagnostic Team (Breast Assessment)
- The Cancer Treatment team

The role of the breast clinic is both to diagnose and treat breast cancer and to treat and reassure patients with benign breast disorders. The key component members of the breast assessment multi-disciplinary team are:

- Breast Specialist Clinician (normally a consultant surgeon with an interest in breast disease)
- Associate specialists, breast clinicians, staff grade surgeons and specialist registrar trainees
- Specialist radiologist
- Specialist radiographer
- Pathologist (and laboratory support staff)
- Breast care nurse
- Clinic staff
- Administrative staff

The cancer treatment team may include members of the diagnostic team as well as a number of other clinicians specifically involved in the treatment of cancer.

These structures not only bring a range of specialist knowledge and skills together in determining the diagnosis and management of breast disease but also put in place a system of governance by ensuring checks and balances through an ability of the team to debate and challenge aspects of patient management.

4.3 Accountability structures

The Northern Ireland Breast Screening Programme is commissioned by the four HPSS Boards. Screening services are provided and managed by the HPSS. Screening unit staff are accountable through the Area Clinical Director- Breast Screening Unit to the HPSS Trust management which in turn is directly accountable to DHSSPS.

[5] Journal of cancer Surgery (2005) Guidelines for the management of symptomatic breast disease. The Association of Breast Surgery at BASO – Royal College of surgeons of England

4.4 **The Regional Advisory Group**

The NHS Breast Screening Programme guidelines place a requirement to have a regional Advisory Group for breast screening in Northern Ireland. The main remit of the group is:

- To advise the DHSSPS on the development and delivery of the Breast Screening Programme in Northern Ireland.
- To monitor performance against national quality standards.
- To advise on both the quality assurance programme and quality issues.
- To co-ordinate regional activities within the Breast Screening Programme.

4.5 **Key roles identified within the structures are as follows:**

Director of Quality Assurance for Breast Screening:

The post-holder is a consultant radiologist. The role of this post is to take the lead in the development of the Regional Quality Assurance Programme for Northern Ireland and give advice to all relevant agencies Boards, Trusts and DHSSPS concerning the provision of a high quality and effective screening programme. This post is based at the Quality Assurance Reference Centre [6].

Regional Quality Assurance Coordinator:

The post-holder is a consultant in public heath medicine. In conjunction with QA Directors (mammography and cervical screening) has responsibility for ensuring the provision of a high quality and effective screening programme throughout Northern Ireland. This post is based at the Quality Assurance Reference Centre.

The advisory structure for breast screening programmes as shown at **Appendix 5** outlines the lines of responsibility for the commissioning, delivery of the breast screening programme. The employer accountability structure is shown in **Appendix 6**.

4.6 **Clinical and QA Guidelines**

The Northern Ireland Breast Screening Programme takes its clinical standards and QA guidance from the NHS Breast Screening Programme publishes a range of guidelines for specific professions working within the service as well as guidelines for issues such as QA visits, breast cancer screening assessment and the management of incidents in the NHS Breast Screening Programme. The symptomatic service is also expected to adhere to the British Association of Surgical Oncologists standards for the management of symptomatic breast disease. It is

[6] NIBSP (2001) NIBSP – Advisory and Organisational Structures

recommended that screening, assessment and symptomatic services are provided if possible in one location.

5 Key Findings

This section of the report examines the circumstances and key events that led to the recall of 44 women at Antrim Area Hospital, (following referral from the Breast Screening Programme), over the period January 2004 to October 2005. This section will also consider the use of Clinical and Quality Assurance guidelines within the Northern Ireland Breast Screening Programme as set out within the DHSSPS terms of reference. The findings are based on the written and verbal submissions from organisations and key personnel involved in the incident and its management. These circumstances are discussed within four key parameters:

1. How workforce issues impacted on the service.
2. How the identified consultant radiologist's competency and clinical performance was managed in the Trusts in which he worked.
3. How the selection and recruitment process for medical consultants impacted on the circumstances leading to this incident.
4. How the use of clinical and QA guidelines influenced the quality and provision of breast screening services.

5.1 Workforce issues and their impact on the service

5.1.1 The review panel noted that from September 2000, The Northern Ireland Regional Advisory Group, the Northern Health and Social Services Board and Antrim Area Hospital identified difficulties in maintaining the breast screening, assessment and symptomatic breast services because of workforce shortages in radiology and radiography which had an adverse effect on radiological services in general. These concerns were particularly acute in the Northern Board's Breast Screening Programme where a "single handed", senior breast radiologist had worked in the breast screening unit in Antrim Area Hospital for long periods between 2000 and 2003. As a result of these workforce concerns, the Northern Health and Social Services Board submitted frequent and ongoing communication with the DHSSPS through a number of routes, including the Chief Medical Officer's office, the Workforce Development Unit and the Permanent Secretary's office.

5.1.2 Examination of the "Analysis of Statistical and QA information"[7] for this period shows that the Breast Screening Programme in the Northern Health and Social Services Board was performing well and no concerns had been raised about the outcomes for women in the breast screening programme. It is noted that although the term "single handed" radiologist is used in describing the way in which the Northern Board's breast screening programme operated at this time, radiology work within the programme was complemented by the skills of a full multidisciplinary clinical team. It was the collective effort of this team that maintained the quality and performance of the breast screening service.

5.1.3 Prior to 2003 the identified consultant radiologist was working in the Altnagelvin Hospitals Trust in 2000/2003 as part of a larger radiology team undertaking intermittent sessions in breast screening and assessment. The identified consultant stated that at this time he carried out breast radiology sessions approximately once every five weeks. There were no concerns expressed about his work during that time in the Altnagelvin Hospitals Trust. The Wilson Report indicates that there were no cases in which the identified consultant radiologist was involved in the Altnagelvin Hospitals Trust that raised concern. During this time in acknowledgement of the workforce shortages in Antrim Area Hospital, the identified consultant radiologist was released from Altnagelvin Hospitals Trust to provide support in the Antrim Area Hospital breast unit. During this period he worked in partnership with the senior breast radiologist and the multi-disciplinary breast team. No identifiable concerns had been raised at that time about the identified consultant's clinical work.

[7] NIBSP Statistical Profile (2003 – 2004)

5.1.4 In July 2003 the identified consultant was recruited to Antrim Area Hospital to a permanent post of consultant in general radiology with a special interest in breast imaging, to work within a team of 2 consultant radiologists undertaking breast work, one of whom was the Clinical Director of Radiology. When the Clinical Director left the post in Antrim Area Hospital, another consultant who has been undertaking a small number of breast screening sessions took over the post of Clinical Director (January 2004) and dropped his breast radiology sessions by agreement of the Trust. The identified consultant was then required to work as the sole breast radiologist in the Breast Screening Programme and symptomatic service in Antrim Area Hospital.

5.1.5 To offset the continuing shortfall in the breast screening and assessment workforce it is commendable that Antrim Area Hospital developed the roles of two radiographers as film readers in 2003. Film reading radiographers help in the task of reading mammograms when the films are also read by a consultant radiologist. This "double reading" is considered best practice and is undertaken by the majority of units in the UK. However, the task of directing and interpreting additional mammograms taken during the assessment process is usually the responsibility of a consultant radiologist.

5.1.6 Senior staff in Northern Health and Social Services Board and Antrim Area Hospital continued to focus predominantly on the issue of radiologists as a workforce problem and, as a result the service was continuously described as being "under threat". Actions taken by the Trust in relation to the recruitment of radiologists are commended even though unsuccessful in filling the vacant post. Antrim Area Hospital undertook an overseas recruitment effort to recruit a radiologist in to the vacant breast radiology post with no success. The radiologist workforce issue was also emphasised in the annual reports compiled by the QA Director for Breast screening on behalf of the Regional Advisory Group.

5.1.7 Information provided by DHSSPS to the review panel shows that significant focus was placed on workforce issues for radiological services, with increases in investment in the numbers of radiology specialist registrars, consultant radiologists and radiography staff. These increases are outlined in **Tables 2 and 3**:

	1999	2000	2001	2002	2003	2004	2005
Number of specialist registrars	20	22	28	31	33	34	35
Number of consultants	64	61	65	66	74	75	82
Vacant consultant posts	3	12	10	12	10	12	15

Table 2: Radiology Medical Staffing from 1999 – 2005 Whole Time Equivalents

5.1.8 **Table 2** shows:

- Specialist registrar numbers have increased by 75% (20-35).
- Total number of consultants in post have increased by 28% (64-82).
- Total Number of consultant posts have increased by 45% (67-97).

5.1.9 All of the increases noted above are increases in staffing across the wide range of radiology sub specialties and should be seen in the context of ongoing developments and expansion in the field of radiology. The DHSSPS indicate that there was a perception that the high vacancy rate of consultant posts meant that specialist registrars could choose from the full range of specialties in radiology in the knowledge that vacancies were available. It is noted that breast radiology is not popular despite advice that career opportunities in this sub-specialty would be available. Although there has been a healthy increase in the uptake of training in radiology, it may be another four years before the present overall demand for consultant radiologists is met.

5.1.10 **Table 3** shows the number of radiographers employed in the HPSS from 1999-2005 as reported by DHSSPS. These numbers include those working in both diagnostic and therapeutic radiography.

Year	**Headcount**	**WTE**
1999	480	405.6
2000	484	413.6
2001	496	432.9
2002	519	451.2
2003	558	488.5
2004	590	510.8
2005	617	543.1

Table 3: Number of radiographers employed in the HPSS (1999 – 2005)

5.1.11 **Table 3** also shows that the number of whole time equivalent (WTE) radiographers has increased by 35% between 1999 and 2005. It was suggested by DHSSPS in the submission to RQIA review that this increase in the number of radiographers in post was a direct result of

implementation of DHSSPS initiatives following a series of workforce reviews. It should be noted that a large proportion of the additional radiographers have been deployed in other developing areas of radiography, without specific targeting of the breast screening service.

5.1.12 The DHSSPS reported that it has produced promotional information on careers within the Health and Social Care Team. The material contains details on posts, skills, requirements, training, how to apply, professional qualifications, career pathways and further information reference points. It would appear that this has not had an impact on the specific workforce issues within the breast screening programme.

5.1.13 In the DHSSPS Priorities for Action (2003/04) there was a strategic intention to extend the upper eligible age range of routine invitation to Northern Ireland Breast Screening Programme to include women aged 65-70 years by March 2006. This has not been achieved but remains a strategic objective, when workforce issues in the Northern Ireland Breast Screening Programme have resolved. The Department's emphasis is currently on maintaining the quality of the services provided.

5.1.14 **Review panel Analysis**

It would appear that although workforce problems have been highlighted in numerous letters and meetings in relation to radiologist and radiography workforce in the Northern Ireland Breast Screening Programme, there has been little progress in relation to these issues. It is also clear that substantial investment had been made by DHSSPS to increase the numbers of staff working within radiological services. However, despite these measures the Northern Ireland Breast Screening Programme remains understaffed in the key areas of film reading, assessment and symptomatic breast radiology. It should be noted that these shortages are reflected in radiology and radiography posts across breast screening services in the United Kingdom.

5.1.15 This shortage of radiological readers contributed to the circumstances which led to the identified consultant working without peer, consultant support, whilst in Antrim Area Hospital (January 2004 to November 2004 apart from a short period of time in April – June 2004).

5.1.16 Recommendations

5.1.17 DHSSPS, Boards Trusts and Northern Ireland Medical and Dental Training Agency should actively promote post graduate radiology trainees to choose breast radiology as a sub-speciality. The DHSSPS should target a number of specialist registrar posts in radiology for the breast radiology sub-speciality in addition to those planned for other radiology or sub-speciality interest. This recommendation should also be applied in other vulnerable medical specialities.

5.1.18 DHSSPS, Boards and Trusts should actively promote the various models of service provision through a range of skill mix options as outlined by NHS Breast Screening Programme, the UK Department of Health and The Society of Radiographers Royal College of Radiologists. Skill mix options for the Northern Ireland Breast Screening Programme should be reflected in the Northern Ireland Workforce Development Strategy developed by the DHSSPS.

5.1.19 The viability and sustainability of the Breast Screening Programme in an area where there are on-going staff shortages, must be considered by DHSSPS, HSS Boards and Trusts within an agreed action plan based on the assessed risks and good governance.

5.1.20 Plans to further extend the upper eligible age range of routine invitation to Northern Ireland Breast Screening Programme to women aged 65-70 years, should be suspended until workforce issues have been satisfactorily resolved within the service to provide such capacity.

5.2 Management of competency issues (i) March 2004–November 2004

5.2.1 The review panel examined the events and actions taken by senior managers and medical staff in Antrim Area Hospital when professional staff raised concerns about an identified consultant's clinical management of patients in the Breast Screening Unit. The subsequent action taken by Antrim Area Hospital, Northern Health and Social Services Board and the Regional QA Director to remedy this aspect of the breast screening services in that hospital is discussed.

5.2.2 In early March 2004 staff in the Antrim Area Hospital Breast Screening unit, raised concerns with the Clinical Director for Radiology about the competency of the identified consultant. The concerns centred on the consultant's procedural and clinical management decisions regarding 5 patients. Concerns were also raised about the increase in the number of patients waiting for breast screening assessment.

5.2.3 On 9th March 2004 professional staff also reported the concerns about the clinical management of the 5 cases to the Regional QA Director who subsequently undertook a review of the cases. It was identified that there were problems with the clinical management of these patients (the management of 2 cases within this patient group gave particular concern). The Regional QA Director contacted the appropriate Consultant in Public Health Medicine in the Northern Health and Social Services Board, as commissioner, to express concerns regarding the clinical management of patients and the growing backlog of assessment cases in the breast screening unit in Antrim Area Hospital.

5.2.4 In verbal evidence to the review panel, professional staff stated that they had raised concerns with the Clinical Director for Radiology about the identified consultant's pattern of late arrival for clinics and dilatory approach to his work, which affected the efficiency of screening assessment and symptomatic clinics. There is no evidence that management action was taken at that time to deal with these issues. Although the Trust senior management assert that these concerns were addressed at the time, in his verbal submission to the Review Panel the Clinical Director for Radiology stated that he did not remember these concerns being relayed to him.

5.2.5 On 18th March 2004 a meeting was held with the Regional QA Director, Consultant in Public Health Medicine and the Clinical Director of Radiology, Antrim Area Hospital to discuss the concerns raised. The Regional QA Director reported that the 5 cases were now being properly managed. The following action was agreed:

- The Breast screening programme in Antrim Area Hospital would be suspended.
- The Breast Surgeon for the Trust agreed to reduce clinic lists to a maximum of 20-25 patients per clinic session.
- The breast screening assessment clinic would continue in order to clear the backlog of patients waiting for assessment.
- The Regional QA Director and another breast radiologist would be in attendance with the identified consultant at assessment clinics.
- The Regional QA Director would, in close liaison with the identified consultant, undertake a retrospective audit of cases assessed by the identified radiologist (100 cases from the previous January 2004 – March 2004). This would be seen as part of a proposed re training programme.
- The identified Consultant radiologist would:
  - Continue to attend assessment clinics along with the regional QA Director.
  - Undertake further training in the UK and overseas (Tabar course).

The Regional QA Director agreed that he would confirm these arrangements with the identified consultant in writing. This was carried out and noted in the Trusts written submission to the review.

5.2.6 In their submission to the review panel the senior management team in Antrim Area Hospital stated that the issues raised initially were seen to be of a general management nature. However this view changed when the Regional QA Director presented the findings of the review of 5 cases that had been managed by the identified consultant over the previous three month period. It was then realised by Trust senior managers and medical staff that there were also concerns related to the clinical judgement of the consultant.

5.2.7 The written and verbal evidence submitted by Antrim Area Hospital suggests that, in the first instance, the Trust considered dealing with this issue in accordance with Circular HSS(TC8)15/91[8]. Under that procedure it is indicated that clinical staff should provide written statements of any concerns. The Trust also planned to involve their legal advisor. However in light of advice from the Regional QA Director to provide the identified consultant with support, training and guidance a decision was made not to continue with this formal procedure. Therefore written statements from clinical staff were not requested. It was agreed that the concerns about clinical judgement would not be directly relayed to him. In his verbal submission, the Trust's Chief Executive stated that the issue was dealt with under "normal management processes". It is also notable that the Trust did not instigate the NHS Breast Screening

[8] HSS(TC8)15/91 Disciplinary Procedures for Hospital and Community Medical and Dental Staff

Programme Guidelines for the Management of Incidents within the breast screening programme which the review panel conclude would have been indicated at this time.

5.2.8 The review panel considers that given the nature of the concerns being raised, the supportive approach taken by the Trust may have been appropriate. However the panel are of the view that the principles outlined in circular HSS(TC8) 15/91 (the HPSS procedure in place at that time for dealing with issues of consultant competence and performance) would have guided the Trust to ensure that a more structured approach to the management of the issues was undertaken and ensured completion of the agreed action plan.

The review panel noted that the approach suggested by the regional QA Director to deal with these competency issues was taken on the basis of additional support, training and guidance. However the explicit decision not to tell the identified consultant about the nature of the concerns was not in accordance with the general principles of the circular:

"A practitioner should immediately be made fully aware in writing of any adverse report giving rise to the question of disciplinary action and should be given every opportunity to answer it"

In his verbal submission to the review panel the identified consultant indicated that he was not aware of the nature of the concerns. The perception was that the concerns were related to the use of diagnostic protocols and the increasing waiting lists in the Breast Screening Unit.

5.2.9 Between 19th and 30th March 2004 a series of meetings took place with the Chief Executive Antrim Area Hospital, the Regional QA Director, the Clinical Director for Radiology in Antrim Area Hospital, the Consultant in Public Health Medicine (NHSSB Area Breast Screening Co-ordinator), Northern Health and Social Services Board and the Director of Public Health, Northern Health and Social Services Board to discuss:

1. The re-training programme to be undertaken by the identified consultant radiologist.
2. The results of the Regional QA Director's review of cases seen at the assessment clinic.

These discussions led to an agreement that:

- Additional training needs would be discussed with the identified consultant (by the regional QA Director and the Clinical Director Radiology).

- Agreement would be obtained with the identified consultant to attend regular breast screening assessment training at Eastern Health and Social Service Board under the supervision of the Regional QA Director of Breast Radiology on a weekly basis.
- Regular meetings would be held with the identified consultant, the Clinical Director for Radiology and radiography staff to address specific concerns that arise.
- The identified consultant would be offered the opportunity to drop further general radiology sessions in order to facilitate the reporting of breast screening cases.
- It was agreed that the Regional QA Director would arrange a competency assessment of the identified consultant, which would include a report on his competency from the establishment in Glasgow where he was to undertake further training and supervision of the identified consultant's work at the assessment clinic (as outlined in correspondence from the Director of Public Health NHSSB who attended the management meetings).
- The issue would be kept under review.

5.2.10 In their analysis of the evidence presented, the review panel concluded that it would appear that substantive, direct management and communication with the identified consultant had fallen to the Regional QA Director whose main role at this time was advisory. He had no line management responsibility for the radiologist concerned. The agreed Trust action plan that had an emphasis on improving breast screening services in the hospital was relayed to the identified consultant by the Regional QA Director.

5.2.11 In correspondence with the trainer in the Glasgow Centre where the identified consultant undertook a week long visit it was stated that a competency assessment would not be undertaken, because the identified consultant radiologist was not aware that he was being assessed or that his competence was in question. The review panel were unclear as to the nature of this retraining programme and its utility. It did not include an independent competency assessment as had been previously agreed at management meetings. The identified consultant's attendance at the Tabar course did not take place until June 2005 - seven months after he had resigned from his post in Antrim Area Hospital.

In evidence to the review panel the identified consultant stated that the learning outcomes from the visits to Glasgow were more focused on the management of clinics and not clinical skills and knowledge.

5.2.12 A meeting was held on the 19th April 2004 with Antrim Area Hospital managers and Northern Health and Social Services Board

commissioners to review progress made in dealing with the concerns about the breast screening service in Antrim Area Hospital. Notes of the meetings confirmed that:

1. Senior members of Trust staff were aware that a competency assessment would not be provided by the Glasgow hospital where the identified consultant had been sent as an observer.

2. The Regional QA Director stated that he "could not say that the identified consultant was not clinically sound". The evidence as to how this conclusion was made appears to be based on the audit of the 100 cases reviewed in the period January 2004 – March 2004 and the regional QA Director's experience of working with the identified consultant at assessment clinics.

3. The review of cases undertaken by Regional QA Director and identified consultant found that 3 cases, from the 100 reviewed, needed further review, 1 of which there were particular concerns about.

5.2.13 Written and verbal submissions from the Trust stated that at this time further audits of the identified consultant's work would be undertaken in 3 and 6 months time. Arrangements would also be made to establish the numbers of patients going through assessment clinics and the number of films to be read by identified consultant.

5.2.14 The Chief Executive recorded that there would be a "*conscious and collective decision not to tell Dr X about the concerns raised regarding his clinical judgement".* This decision was based on maintaining good relationships within the local Breast Screening Unit and the assessment by the regional QA Director that he "could not say that the identified consultant was not clinically sound ". This decision appears to run contrary to the principles in the guidance in dealing with perceived failing competence HSS(TC8) 15/91. Trust management stated that this decision was also taken in order to ensure the maintenance of the service in the absence of another breast radiologist in the Trust.

5.2.15 The Trust stated that they continued to reduce and control the number of cases going through primary screening and assessment in order to suit the work rate of the identified consultant radiologist. There was no detail available on how this was planned.

In verbal submissions to the review panel the identified consultant stated that his perception was that clinic numbers continued to rise. In evidence to the Review Panel it would appear that clinic numbers were reduced to the levels agreed in the action plan.

5.2.16 In their verbal submission to the review panel, senior Trust staff from Antrim Area Hospital also acknowledged that despite the concerns regarding the identified consultant's clinical practice, no appraisal had been undertaken with him throughout his period of employment in Antrim Area Hospital. The introduction of the consultant contract was cited as a reason for the delay in consultant appraisals being undertaken within the Trust. Consultant appraisals commenced in the Trust in December 2004. It is noted that Trusts had been asked to ensure that consultant appraisals commenced following the issue of HSS Circular HSS(TC8)11/01 in May 2001. It was also noted that an assumption had been made that an appraisal had been undertaken before the identified consultant radiologist had left his previous position in Altnagelvin Trust. It was subsequently confirmed by Altnagelvin Trust that an appraisal had not been undertaken.

5.2.17 The review panel examined what happened after the action plan for improvement had been implemented in the Antrim Area Hospital and the circumstances leading up to the incident recorded in October 2005.

5.2.18 On 18th August 2004 the Regional QA Director confirmed that further audits of the identified consultant's assessment work had been carried out between April 2004 to June 2004. Of the 59 assessment cases seen, 9 proved malignant and had been assessed satisfactorily by the identified consultant. The Regional QA Director recommended early re-screening of 4 cases, all of which were noted to be benign on re-screen. It was noted that QA Director had no concerns about the identified consultant's clinical management. However, during this period the identified consultant had been assisted at the clinics by either the QA Director or another experienced breast radiologist. The audit was therefore not entirely of the identified own work.

5.2.19 It was noted at this stage that there were no unacceptable waiting lists in the breast screening assessment clinic and that all patients were being seen within 2 weeks.

5.2.20 In August 2004 the identified consultant radiologist was recruited by Belfast City Hospital as consultant radiologist with an interest in breast and cross sectional radiology. He was the sole applicant for the position. He was successful in the appointment, completed a period of notice in Antrim Area Hospital and took up the position of consultant radiologist in Belfast City Hospital in November 2004. At this point there was no substantive consultant radiologist in breast screening in Antrim Area Hospital.

5.2.21 The panel noted that as a result of the identified consultant's decision to leave Antrim Area Hospital from August 2004 to November 2004 the QA Director and Trust did not continue with the audit for the months July – October 2004 as previously agreed (during this period the Identified consultant was the sole radiologist working in breast screening assessment and symptomatic work in Antrim Area Hospital).

5.2.22 When the consultant left employment at Antrim Area Hospital, a decision was made that the Clinical Director for Radiology would ask the identified consultant, in agreement with BCH Medical Director to work as a locum each Wednesday in Antrim Area Hospital to the following timetable:

1. Manage a symptomatic clinic in the morning.
2. Take part in a multidisciplinary team meeting at lunchtime.
3. Manage an assessment clinic in the afternoon.

The identified consultant's stated to the panel that he felt that he was being pressurised into undertaking the locum position by the Chief Executive and Clinical Director of Radiology in Antrim Area Hospital in order that the service could be maintained. The Chief Executive of the Trust strongly refutes that the consultant was pressurised into undertaking the locum work. However significant financial incentives were discussed between the two parties as outlined below. The Medical Director and Directory of Human Resources in the Belfast City Hospital stated that they were not part of these negotiations on pay; they did confirm that they facilitated the locum arrangement.

5.2.23 The review panel were informed by the Belfast City Hospital Medical Director and Director of Human Resources that the arrangement to facilitate the identified consultant to work in Antrim Area Hospital each Wednesday was external to his substantive contract in Belfast City Hospital. They stated that the arrangement was facilitated by enabling the identified consultant to displace his 2.5 Supporting Professional Activity sessions out of hours. It was stated that that these supporting professional activity sessions were not monitored by Belfast City Hospital as this was a temporary arrangement and was expected to finish in August 2005. During this time the identified consultant was not involved in teaching, audit or research in Belfast City Hospital except for the routine involvement in QA audit in Northern Ireland Breast Screening Programme as stated in his job plan.

5.2.24 Senior managers in Antrim Area Hospital confirmed to the review panel that the identified consultant had been paid the equivalent of 5 programmed activities for the work undertaken on Wednesdays (whereas the work he undertook was the equivalent to 2 programmed

activities). It was confirmed that this arrangement had been the subject of correspondence with DHSSPS (Director of Human Resources). However, discussions with the Director of Human Resources at the DHSSPS confirm that he had communicated his dissatisfaction with this arrangement as it contravened the balance between maintaining services and financial equity, relating to remuneration of those staff delivering the service. In this instance it would appear that in directly approaching the identified consultant about undertaking this locum work, at the rate of pay outlined, management at Antrim Area Hospital failed to be open and transparent in offering this locum work to other consultants who may have been interested in providing locum cover.

5.2.25 It was further noted that, during this period, Antrim Area Hospital maintained the throughput of the Wednesday symptomatic and assessment clinics at a level comparable with the identified consultant's previous work rate. No arrangements were made to carry out audit on the identified consultant's work in Antrim Area Hospital in this locum capacity. Professional staff within the breast unit reported that the previous concerns regarding his dilatory approach to his work and late arrivals for clinics continued. In his further verbal submission to the review panel the Clinical Director of Radiology advised the panel that the multi-disciplinary team meeting had never been rearranged for Wednesdays, the only time when a consultant radiologist could have been available for the multi-disciplinary team. This was confirmed by the identified consultant in his submission to the panel.

5.2.26 **Review panel analysis**

How the concerns raised were managed during the period January 2004 to November 2004 appear to have been key indicators as to the future performance of the identified consultant. It is noted in the minutes of a management meeting held in Antrim Area Hospital on 24th October 2005 that the QA Director had stated that the identified consultant tended *"to hide behind the decisions of others in the team. Within the Belfast City Hospital he was within a protected environment and seldom making individual decisions whereas in Antrim he was working on his own".*

5.2.27 The review panel suggest that during this period, issues raised about clinical competence should have been managed within a more formal framework. Although the HSS (TC8) 15/91 a disciplinary procedure for dealing with consultant medical staff had been considered and then dismissed by Antrim Area Hospital in favour of a more supportive approach the panel conclude that the principles within this procedure would have provided a more systematic framework in which to deal with the issues and monitor the outcomes of the agreed action plan. Senior Managers at Antrim Area Hospital stated that this approach was taken to protect the working relationships within the breast unit team and sustain the service, which was described by Antrim Area Hospital as under threat. However, at no time did anyone from the Trust senior management team or the regional QA Director discuss the concerns about clinical competence with the identified consultant. It would appear that there was no focused management or leadership given to the situation from the Clinical Director of Radiology. The Chief Executive of Antrim Area Hospital stated that the regional QA Director was dealing with the competency issues, although he had no line management responsibility.

5.2.28 The educational and management plan which was developed by the senior management team in Antrim Area Hospital in consultation with the QA Director included visits to a training centre in Glasgow, supervision at screening sessions at the Eastern Health and Social Services Board screening centre and supervision for a 3 month period at clinics in the breast screening unit in Antrim Area Hospital. However no formal assessment of the individual's competence was performed at any time during this programme. The trainer in the Glasgow centre confirmed that the identified consultant had attended as an observer. This appeared to run contrary to the plans that had been agreed by the senior management team in Antrim Area Hospital. The planned attendance at the international training day, did not take place until June 2005 – 7 months after the identified consultant left his post in Antrim Area Hospital.

5.2.29 The Wilson Report highlights that the periods of retraining and supervision provided in 2004 *"appear not to have prevented this radiologist from providing substandard care".* The review panel suggest that the efficacy of the training programme was never formally assessed through an exclusive audit of the identified consultant's own work as the audit of the work carried out of the cases seen between April to June 2004 was an audit of work that had included clinical management of patients by the regional QA Director and another experienced breast radiologist. No further audit of the consultant's own work was carried out from July to October 2004, a time when the identified consultant worked as the sole radiologist in Antrim Area Hospital. The reason cited for this was because the consultant had been appointed to another job in the Belfast City Hospital. The advice to Antrim Area Hospital from the regional QA Director, as outlined by the Chief Executive of the Trust, on the competence of the identified consultant would appear to be based on flawed analysis as the basis of this advice was the outcome of an audit that was not an exclusive audit of the consultant's own work. The Chief Executive of the Antrim Area Hospital stated that he placed significant weight on the advice given by the regional QA Director. The availability of expert advice on which the Trust placed considerable weight, from the regional QA director did not replace the singular accountability of the employing authority.

5.2.30 There is little evidence that the concerns about the identified consultant's dilatory approach, was being managed by Antrim Area Hospital throughout this period. Although the Trust assert that these issues were being managed, in his verbal submissions to the review Panel the Clinical Director of Radiology stated that he did not remember these issues being referred to him. It would also appear that the way in which this was managed by the Trust was to say they reduced the workload of the consultant at clinics to match his work rate rather than the requirements of the service. It would appear that the Clinical Director for Radiology did not fulfil his line management responsibilities in relation to the identified consultant's competence and attitudinal failings, nor did he appear to support the identified consultant in managing his workload.

5.2.31 The review panel accept that senior management in Antrim Area Hospital placed significant weight on the advice of the regional QA Director, however the panel are concerned that management at the most senior level within Antrim Area Hospital failed to recognise the significance of the risks involved in continuing to provide the breast screening programme in the knowledge that the competence and attitude of the identified consultant was under question and had not been subject to the agreed programme of audit as outlined in their action plans formulated at a series of meetings. In their management of the incident in March 2004 they failed to:

- Be explicit with the consultant about the nature of the issues raised about his clinical judgement.
- Follow good governance principles for dealing with failing competence and performance.
- Implement in full the agreed action plan in relation to the management of the identified consultant in that they did not:

    - Complete a full assessment of the identified consultant's competence.
    - Complete an audit of the identified consultant's work at 3 months which was of the consultant's own work.
    - Complete a further audit of the identified consultant's work at 6 months following the March 2004 concerns.

5.2.32 Recommendations

5.2.33 The Northern Ireland Breast Screening Programme should clarify with Trusts and Boards the role and accountability of the Regional QA Director and make explicit the responsibilities in the management of failing competence and underperformance of staff.

5.2.34 All Trusts should ensure that concerns about failing competence and/or performance of medical consultants should be dealt with under the recognised framework - Maintaining High Professional Standards in the Modern HPSS (November 2005) HSS(TC8) 6/2005.

5.2.35 Governance processes should be in place to ensure that when failing competence and medical underperformance is assessed, action plans are developed with agreed timescales for implementation. Implementation should be subject to review and monitoring with appropriate use of the National Clinical assessment service.

5.2.36 The DHSSPS should further review and issue definitive guidance on the payment of incentives to consultant medical staff, ensuring that those staff are able to meet in full the requirements of their substantive contract and agreed work plan.

5.2.37 The DHSSPS should issue revised guidance on the recruitment and selection of locum consultant staff in Trusts / Boards.

5.2.38 All Trusts should ensure that annual consultant appraisals are implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months). RQIA will undertake an improvement review of consultant appraisal and the role of Clinical Directors in managing medical performance across all Trusts in 2006/2007.

5.3 Management of competency issues (ii) November 2004–October 2005

5.3.1 In this section the review panel examined the events leading to the recall of women to the Breast Screening Programme in November 2005. During this time the identified consultant had been working in his substantive post in Belfast City Hospital and on one day per week in Antrim Area Hospital.

5.3.2 On the 4th October 2005 the Breast Screening programme in Antrim Area Hospital was suspended due to high numbers of cases awaiting assessment.

5.3.3 On 24th October 2005 a meeting was held to discuss the concerns raised by a breast clinician and superintendent radiographers in Antrim Area Hospital about the identified consultant radiologist's decision-making skills. A meeting was held with the Chief Executive and the Clinical Director of radiology, Antrim Area Hospital, Director and Consultant in Public Health, Northern Health and Social Services Board, Regional QA Director for Breast Screening to agree action regarding these concerns. The Regional QA Director made the following points:

- *"The identified consultant radiologist's assessment work had been audited for a three month period following further training and no great concerns had been found.*
- *The identified consultant radiologist had attended a Tabar course in June 2005.*
- *The identified consultant radiologist had been working for the past 11 months in the Belfast City Hospital and no complaint had been made about his work by any other health professional during that period.*
- *The QA Director was not aware that multidisciplinary meetings scheduled for Wednesday lunchtime had not been moved from Mondays to facilitate the surgeons but preventing the identified consultant radiologist's attendance"*.

5.3.4 The Regional QA Director met with the professional staff who had raised the concerns and the identified consultant on 31st October 2005, at which the 'difficulties' were presented. The identified consultant stated that he was under tremendous pressure. The symptomatic clinic was larger than agreed and often he was required to carry out 'localisations' in the middle of the clinic. This often overran through lunchtime and assessment patients were arriving before symptomatic patients had left.

5.3.5 Further to this meeting the Trust and Northern Health and Social Services Board agreed the following action on 7th November 2005:

- Review all assessment cases from August 2004
- Review the identified consultant radiologist's symptomatic work
- Extend the suspension of the breast screening programme unit until the end of January 2006
- Explain actions in letters to GP's
- Convene an incident team under NHS Breast Screening Programme Guidance
- Press release
- Regional Advisory Group Chairperson to be notified
- The Clinical Director of Radiology to advise the identified consultant radiologist that his locum support position would be terminated from 16th November 2005
- Consider the implications for Belfast City Hospital (current employer)

5.3.6 **Review panel analysis**

It was felt by the review panel that the action taken by the Trust and Northern Health and Social Services Board on 7th November 2005 was appropriate and in accordance with NHS Breast Screening Programme Guidelines for Managing Incidents in the Breast Screening Programme[9]. In addition to these actions the United Hospitals Trust also notified the DHSSPS of the incident through the Serious Adverse Incident Procedure (**Appendix 7**).

5.3.7 It was notable that in addressing the issues highlighted under this adverse incident the Trusts, Boards and Regional Advisory group in co-operation with DHSSPS acted swiftly to review the cases under the management of the identified consultant. The comments on "lessons learned" from using this methodology in relation to informing patients that may have caused undue anxiety should be noted for future reviews and investigations.

5.3.8 It is highlighted in the Wilson Report that there was clear evidence of substandard care which led to significant and avoidable delays in the diagnosis of breast cancer. It stated that there was *"evidence of substandard radiological skills in the interpretation of breast radiology and failure to follow expected diagnostic protocols".* The review panel conclude the consultant's clinical decision making did not change from the incidents in 2004, despite the actions taken by Antrim Area Hospital and the Regional QA Director, or from his working experiences in Belfast City Hospital.

5.3.9 The Review Panel acknowledge that the principle reason for the incidents was that the identified consultant did not fulfil his professional responsibilities in a manner which the Trust had a right to expect from an accredited radiologist. However, the availability of expert advice on which the Trust placed considerable weight, from the regional QA director did not replace the singular accountability of the employing authority.

[9] NHSBSP (January 2004) Guideline for Managing Incidents in the Breast Screening Programme

5.3.10 Recommendations

5.3.11 The results of the Wilson Report and the findings of this review identify grave concerns in professional competence which should be notified to the General Medical Council if this has not already been done. The RQIA will review the governance processes within Belfast City Hospital Trust as applied to this issue.

5.3.12 The RQIA will conduct a further detailed governance review of medical management and leadership in United Hospitals Trust (with particular emphasis on clinical directors) using HPSS Clinical and Social Care Governance Standards.

5.4 The Recruitment and Selection Process

5.4.1 In August 2004 the identified consultant radiologist was selected and recruited by Belfast City Hospital as a consultant radiologist with an interest in breast radiology and cross sectional radiology. The identified consultant was the sole candidate for the position.

5.4.2 In their submission the Belfast City Hospital stated that this interview and selection process was carried out in accordance with HPSS guidance on the recruitment and selection of consultant medical staff[10].

5.4.3 It is notable that for all medical consultant posts leadership, communication and team working competencies are assessed at interview. It is notable that in both job specifications for the posts that the identified consultant was successful in obtaining there is no specific emphasis on these skills.

5.4.4 On examination of the selection and recruitment information that was submitted by Belfast City Hospital in relation to the identified consultant radiologist it was noted that the interview panel consisted of seven members. Five of the panel members were radiologists including the Regional QA Director for Breast Screening, in his capacity as lead Radiologist for Breast Screening Programme in Belfast City Hospital. He had previously been involved in managing the incidents that occurred between January and April 2004.

5.4.5 It was noted that that 4 interview panel members had altered their ratings on the interview score sheets. One such alteration to the scoring brought the candidate up to the level required for appointment. It was less clear in the other instances what impact the score changes had on the outcome of the interview. These changes were discussed with the Belfast City Hospital Director of Human Resources who stated that he regarded alterations in ratings on scoring sheets as normal practice during the course of an interview.

5.4.6 In his written submission to the review panel, Belfast City Hospital Chief Executive, stated that the external assessor at the interview advised the panel without reservation that the candidate was suitable for appointment. He also stated that each of the five radiologists on the panel regarded the candidate as suitable for appointment, including the Regional QA Director for Breast Screening.

5.4.7 When questioned about his participation in this interview panel the regional QA Director stated that he did not wish to inform the panel about the previous concerns about the identified consultant. He felt that

[10] DHSSPS (1996) Appointment of Consultant's Regulations (Northern Ireland) 1996

these concerns had now been resolved and that this information could have unduly interfered with the recruitment and selection process. He added that in his assessment of the consultant in April 2004 that he had no concerns about his clinical judgement. The review team noted that the interview for this post was held on 3rd August 2004. The regional QA Director's second audit visit to Antrim Area Hospital to assess the identified consultant's clinical management of patients was held on the 17th August 2004.

5.4.8 Belfast City Hospital senior management staff in their verbal evidence to the review panel suggested that there was a duty for any panel member who has information about a candidate's competency to inform the panel. In his written submission to the review panel the Belfast City Hospital Chief Executive stated that *"At no time was there any suggestion that the candidate had been subject to a previous investigation into the quality of his performance".*

5.4.9 The review panel noted that the Clinical Director of Radiology in Antrim Area Hospital who had been involved in the management of the incidents in January 2004–April 2004 provided a reference for the identified consultant dated 31st July 2004 which stated that *"Dr X's work has been more than satisfactory. Dr X's work is of good quality. His decision making skills are good and he works well as a team member. His time keeping has been satisfactory".* The second audit of the identified consultant's work did not take place until the 17th August 2004.

5.4.10 At no point in the application or interview process for medical consultant positions are questions posed to candidates whether they are currently or have previously been subject of any inquiry or investigation about their professional competence.

5.4.11 **Review panel analysis**

5.4.12 Disclosure of information

Belfast City Hospital senior management staff stated that in a fair and open recruitment process they would expect any panel member to disclose information about a candidate's professional competence and that this information may influence the outcome of the interview. Although there appears to have been no formal mechanism for the transfer of such information to other organisations, it is notable that in the revised procedures for handling concerns about doctors and dentists HSS(TC8) 6/2005 there is specific guidance on sharing information with other organisations to promote patient safety. However the use of such information is only relevant in disciplinary actions against doctors. It is also noted that The QA Director continues to assert that in his opinion he had no concerns about the clinical judgement of the identified consultant. He had not completed the second audit of the consultant's work at this time. The Neale enquiry[11], although not directly related to this review noted a recommendation that all previous contacts between applicant and interviewers should be disclosed and recorded.

5.4.13 Making alterations to ratings on interview scoring sheets

The review panel accepts the statement made by Belfast City Hospital Director of Human Resources that it is not unusual for ratings to be changed on score sheets; however, it did appear to be unusual for 4 of the 7 interview panel members to alter score sheets. It was also noted that in some instances comments did not match high scores awarded. Examples are shown in **Table 4**:

[11] DOH (2004) Committee of Enquiry – To investigate how the NHS handled allegations about the performance and conduct of Richard Neale

Personnel Specification Criteria	Marks Available	Marks Awarded	Comments
Experience in Management	10	7	Adequate
Reasoning / Judgement	10	7	Adequate
Communication skills Oral and written	5	2	Barely satisfactory
Capacity to undertake Teaching / research	15	7	Limited
Leadership ability / Team building	10	6	Participate in breast Team but not a leader
Experience in Management	10	5	Very limited
Leadership ability / Team building	10	6	Team player (rugby) rather than leader

Table 4: Example of interview scores awarded and comments

5.4.14 It was noted by the review panel that 3 out of 7 interview panel members awarded the candidate a score of 60 which was the minimum score for appointment.

The job specification and the interview transcripts highlight the need for increased focus on non-clinical competencies for consultant posts. There appears to be poor focus on the concepts of leadership, communication and team working.

Reference from previous employer

5.4.15 The review panel considered that the reference provided by the Clinical Director of Radiology in Antrim Area Hospital (dated 31st July 2004), in respect of the identified consultant may have been misleading given the ongoing professional competency issues. Comparisons can be drawn from the Neale Enquiry (2004) in which it was noted that: *"employing authorities/ medical colleagues should not give a reference that is capable of misleading by omission*". In 2001 the General Medical Council issued specific guidance on providing a reference. It stated that *"you must provide only honest and justifiable comments when giving references for or writing reports about colleagues. When providing references you must include all relevant information which has any bearing on your colleague's competence, performance and conduct"*[12]. It is also notable that the Neale enquiry made a recommendation that *"the panel chairman should be responsible for ensuring that referees are*

[12] GMC (2001) Good Medical Practice

contacted by telephone and that the content of the reference should be confirmed at or around the time of appointment".

5.4.16 On further verbal submissions to the review panel the Clinical Director of Radiology in Antrim Area Hospital repeated that although he provided a reference within the time frames outlined he felt that the reference provided was accurate. He stated that the responsibility for informing the panel of the ongoing competency issues of the identified consultant was that of the QA Director, who was a member of the interview panel. The review panel are concerned that his view appears to negate his responsibility in the provision of a reference that fails to indicate that the identified consultant was subject to ongoing investigation and assessment over concerns about his clinical work. It would appear to reflect the approach within the Trust that responsibility lay with the regional QA Director, whose role should have been primarily advisory. It continues to highlight the need for clarity of roles and responsibilities in the accountability and employment structures for the Northern Ireland Breast Screening Programme.

5.4.17 The Medical Director and the Director of Human Resources in Belfast City Hospital pointed out that the HPSS procedure for the appointment of medical staff does not make provision for any current or previous or pending inquiry or investigation about their professional competence is compared with the findings of the Neale enquiry in which it was noted that *"The application form should contain a declaration that all information is correct to the best of the applicant's knowledge and belief and any matter, professional or personal unresolved or pending that might undermine the applicant's standing, or cause embarrassment to the NHS, should be declared by a confidential side letter to the chairman. The penalty for failure to disclose such information should be summary dismissal".*

5.4.18 Recommendations

5.4.19 Trusts and employers must ensure that disclosure of information as part of the selection and recruitment processes for all grades of medical staff are in accordance with relevant legislation, good practice guidelines and professional regulatory requirements. The RQIA will require Antrim Area Hospital to demonstrate that due process is followed in the review of the matter of the reference provided, regarding the identified consultant's application to Belfast City Hospital.

5.4.20 Trusts must take appropriate steps to ensure that interview panel members have up to date knowledge and skills in selection and recruitment processes.

5.4.21 Medical staff must adhere to General Medical Council Guidelines when providing references or reports about medical colleagues.

5.4.22 All documentation relating to selection and recruitment of medical staff should be reviewed to ensure that there is provision to question applicants about any professional or personal, unresolved or pending issue that might undermine the applicant's standing, or cause embarrassment to the NHS. An arrangement should be incorporated for a confidential declaration to be received by the interview panel chair.

5.4.23 Medical Managers and Human Resource departments should ensure that all job specifications for consultant medical staff and Clinical Directors clearly outline all relevant competency domains relating to the role. These may include clear descriptions of competency in leadership, communication and team working as relevant to the post.

5.5 Clinical and QA Guidelines

5.5.1 The review panel examined the written submissions from the organisations in relation to current use of NHS Breast Screening Programme clinical and quality assurance guidelines and standards in the Northern Ireland Breast Screening Programme. These responses indicated that as far as organisationally and managerially appropriate these guidelines are implemented and adhered to. These guidelines are disseminated to Trusts through the Regional Advisory Group, professional specific groups and via the Quality Assurance Reference Centre. They are also available on the cancer screening website www.cancerscreening.nhs.uk.

Within the Trusts the guidelines are communicated to staff in a range of ways:

- As part of induction training for medical staff (Altnagelvin Hospitals Trust)
- Through breast screening quality assurance groups (Belfast City Hospital and Antrim Area Hospital)
- As part of continuous professional development programmes for clinical staff (Antrim Area Hospital)
- As part of an operational manual system in the Breast Screening Unit (Antrim Area Hospital)
- At weekly multidisciplinary team meetings (Antrim Area Hospital)

However closer examination showed that a number of the guidelines were not being applied rigorously in Antrim Area Hospital. These are discussed in detail in the Wilson Report.

5.5.2 Mammographic Screening Film Reading

The NHS Breast Screening Programme guidelines requires film readers to read a minimum of 5000 screening mammograms per year, to be involved in the assessment of screen detected abnormalities, to attend multidisciplinary clinical management meetings and to participate in an approved radiology performance QA scheme for mammography. It would appear that whilst working as a consultant in Antrim Area Hospital the identified consultant read 5433 which would have appeared to have achieved this standard. In the Wilson Report the increase in recall rates reflected the Antrim Area Hospital reliance on locum radiologists in 2004/05 to double read the screening mammograms but who did not have subsequent responsibility for the assessment of cases recalled. The NHS Breast Screening Programme guidelines recommend that those involved in the screening are directly involved with the assessment at the same site. The increase in recall from screening caused a further increase in the numbers needing assessment. This would appear to have further compounded the problems with waiting lists at assessment

clinics. These problems were reported by Antrim Area Hospital, Northern Health and Social Services Board and the identified consultant.

5.5.3 Multi-disciplinary Team (MDT) Working

It is now widely accepted that the multi-disciplinary team forms the basis for best practice in the management of breast disease. This is reflected in the guidelines issued by both the NHS Breast Screening Programme and the British Association of Surgical Oncologists group. The Wilson Report highlighted the importance of multi-disciplinary team working for effective delivery of breast diagnosis and stated the *"the failure to review results and decide patient management with a radiologist present was a contributory factor in the substandard care of several of the breast screening assessment cases at Antrim Area Hospital".* In their verbal and written submission to the review panel it is clear that senior management in the Trust were aware that the multi-disciplinary team meeting had never been rearranged to the only day that the identified consultant was available to attend as this did not suit the surgeons involved. This resulted in a prolonged period in which no consultant radiologist opinion was available at these meetings and therefore they fell short of the requirements of the guidelines that the Trust stated they were working to.

5.5.4 Double reading

The Wilson Report stated that the method of team working at assessment at the Linenhall Street and the Belfast City Hospital clinics with a minimum of two radiologists appeared to have minimised the opportunity for radiological error in their clinics. The report stated that this process ensured that appropriate management was delivered. It is clear that for long periods of time from 2002 onwards with the exception of the periods July 2003 – December 2003 and April 2004 – June 2004 the breast screening service in the Antrim Area Hospital operated with a sole breast radiologist and two trained screening film readers.

5.5.5 Diagnostic protocols at breast assessment and symptomatic clinics

It was clear that in the submissions to the Review panel and the findings of the Wilson Report that the identified consultant had not been following diagnostic protocols in either the breast screening assessment or symptomatic clinics whilst working in Antrim Area Hospital. One of the key sets of procedures at assessment is the use of the triple assessment which involves imaging (usually mammogram and ultrasound), clinical examination and needle sampling for cytology or histology. This was highlighted by the professional staff working within the unit both in the 2004 and 2005 incidents.

5.5.6 Equipment

The NHS Breast Screening Programme Guidelines[13] state that mammography equipment should be checked at six monthly intervals to recommended standards. Information provided by all participating Trusts in this review indicates that this standard was being achieved through the provision of support by the Medical Physics Agency. It is noted that in addition to six monthly inspections of equipment with reports, the Medical Physics Agency provides advice to breast screening units on the optimization of the image quality. This includes the purchase of new equipment, the relocation of existing equipment, the need to replace existing equipment and the timing of such replacement.

5.5.7 In the incident report submitted by Antrim Area Hospital to the DHSSPS **(Appendix 7)** on the 18th October 2005 reference was made to the suspension of the breast screening programme due to a "combination of equipment failure and radiological staffing difficulties". It would appear from the verbal submission of the identified consultant and the Wilson Report that the quality of the imaging from the ultrasound equipment in the Antrim Area Hospital breast unit was regarded as "sub-optimal". However, this equipment did meet the recommended standards of the Medical Physics Agency even though the imaging was poor. The identified consultant stated that new ultrasound equipment had been purchased in 2004. This new equipment was shared with the paediatric unit and was unavailable at assessment or symptomatic clinics on Wednesdays. Antrim Area Hospital in their submission state that this equipment was unavailable once a month. It is notable that from the incident in October 2005 the clinical Director of Radiology reported that Antrim Area Hospital have purchased new ultrasound and specimen radiology equipment for the Breast Unit.

5.5.8 QA Visits

The incident being considered in this report occurred after the last QA visit in 2003; however the outcomes of the QA report remain relevant to this review.

5.5.9 The first review of the Northern Ireland Breast Screening Programme was carried out in September 2000 by the Scottish Breast Screening Programme, using standards that were developed for UK-wide Breast Screening Programmes.

5.5.10 A second round of quality assurance reviews of the Northern Ireland Breast Screening Programme was carried out by NHS Quality Improvement Scotland during September and October 2003. The review report which was published in July 2004 set out the performance of both

[13] IPEM Report No. 89 – Recommended standards for the routine Performance Testing of Diagnostic X-ray Imaging Systems

the service as a whole and of each breast screening unit, against the Clinical Standards Board for Scotland document[14]. It is notable that the Northern Ireland Breast Screening Programme was not benchmarked against the standards that each organisation stated it is working to; the NHS Breast Screening Programme standards. The panel would see this process as flawed given the difference in the two sets of standards. In their verbal submission the chairperson and regional QA Director stated that the next QA visit would be carried out by a team from the Nottingham Breast Screening Centre who do work to the NHS Breast Screening Programme standards.

5.5.11 The findings of the 2003 QA visit report described the Northern Ireland Breast Screening Programme as providing a high standard of care. Recommendations that were made:

- There should be wider circulation of the Quality Assurance Reference Centre annual report
- That women who use the service should form a core part of the Regional Advisory Group
- That there should be further development of uni-disciplinary quality assurance meetings
- That service development that makes best use of skills, equipment and other resources. In particular, further opportunities to introduce role extension and skill mix should be explored.

5.5.12 Action taken to address the recommendations in the report included the development of individual action plans for each Breast Screening Unit by the Regional QA Director of the Breast Screening Service, the QA Radiographer and QARC Administrator. Visits were also made to each HSS Board area to meet with Clinical Directors and relevant staff of Breast Screening Units.

5.5.13 An area of concern raised by the NHS Quality Improvement Scotland team was that individual disciplines within the breast screening service did not participate in uni-disciplinary quality assurance peer reviews. The regional response was that each discipline had its own QA meetings and due to the small number of radiologists, peer review was difficult to undertake. It is noted that the QA meetings are used to provide peer support and that individual clinical cases are not reviewed during these meetings. The guidelines for QA Visits state that all disciplines involved in the provision of breast screening services should participate in regular QA activity and that peer review of selected cases should be part of the assessment of professional practice.

5.5.14 <u>Audit</u>

[14] Clinical Standards Board (2002) NHS Quality Improvement Scotland

In addition to the programme for external three yearly QA visits, the Regional QA Director collates monitoring data on the Northern Ireland Breast Screening Programme that is published as an 'Annual Statistical Profile'. This report is forwarded to all stakeholders.

5.5.15 When the breast screening programme was initiated, it was agreed that performance of each breast screening unit would be measured against specific criteria relating to agreed standards. These targets (with a minimum and target level) are set centrally in conjunction with advice from epidemiologists, statisticians and professional experts. By reviewing a Unit's performance on an annual basis, comparison can be made not only with previous years but also with other centres.

5.5.16 In Northern Ireland, the breast screening programme has published statistical figures on an annual basis for a number of years. The most recent available for the review panel relates to the year 2003/4. This document is produced by the Quality Assurance Reference Centre and collated and written by the regional QA Director.

5.5.17 Screening Standards

Twenty one parameters are reported, together with the figures for the previous year, allowing a comparison to be made. Throughout the whole of Northern Ireland, there has been an increase in number of women invited and subsequently the number of women attending for screening. Consequentially, this led to an increased number of cancers detected for the year 2003/4.

5.5.18 Performance in Northern Board (Antrim Area Hospital)

1. Screening Attendance

   In the year 2003/4 there was an increase in the number of women invited, with a consequent increase in the number of women attending for screening (2211).

2. Recall to assessment

   There was an increase in numbers of women recalled to assessment, partly due to increased number of women attending for screening, and partly due to an increase in recall rates (2.3% for first attenders and 0.4% for subsequent attenders). These figures meet the NHS Breast Screening Programme targets. Overall, there was an increase of 158 women being recalled to assessment when compared to the previous year.

3. Benign biopsy rate

   The numbers of women referred for surgical biopsy of a benign abnormality increased slightly from the previous year. However,

this was between the minimum and target level. It should also be noted that these figures are comparable to the other three health boards.

4. Pre-operative diagnosis rate
This remained above the minimum standard, but slightly below the target value. However, the performance had increased when compared to the previous year.

5. Invasive cancer detection rate
The numbers of invasive cancers detected on first screening attendance and subsequent screening attendance had increased when compared to the previous years, and were above the target value. This represents good detection of abnormalities on mammograms combined with good assessment procedures.

The figures were comparable to the other three health boards.

5.5.19 Overall Performance
The Northern Health Board (Antrim Area Hospital), as judged by performance with reference to National QA standards, was comparable to the other three Health Boards within Northern Ireland, and well within acceptable limits.

5.5.20 The Northern Ireland Breast Screening Programme also contributes data to the on-going review of interval cancers and to the British Association of Surgical Oncologists Audit – the results of which are published annually.

5.5.21 It is noted that these audits are not specific to individual clinicians – Trusts reported that all radiologists participate in 'PERFORMS' reviews (annually or at six-monthly intervals). This involves radiologists reading mammograms independently and comparing results to a group of radiologists and to the pathology outcomes for that set of patients. Individual radiologists receive feedback on the outcome of that review. It was reported by Trusts that whilst the results are private, if major concerns were identified these would be fed back to the Regional QA Director. The identified consultant participated in this programme in Antrim Area Hospital. However it would appear that there were no concerns raised about the identified consultant's work through the "PERFORMS" system.

5.5.22 Managing Incidents in the Breast Screening Programme
The NHS Breast Screening Programme Guidelines outline the steps to be taken by managers if there is a failure, by a local Breast Screening Programme to provide breast screening in accordance with clinical and

other nationally agreed standards and if this failure has consequences for the clinical management of women who have been screened. In the incident that occurred in March 2004 these guidelines were not instigated. In the incident that occurred in October 2005 these guidelines were used as the framework for the investigation of the incident.

5.5.23 **Review panel Analysis**

Although all of the Boards and Trusts indicated in their submissions that National Clinical and QA standards were in use within the services that they provided it would appear that a number of these guidelines were not being adhered to rigorously within Antrim Area Hospital. These included:

- British Association of Surgical Oncologists Guidelines for the management for the management of symptomatic breast disease and,
- NHS Breast Screening Programme Guidelines for Breast Screening Assessment
- Managing incidents in the Breast Screening Programme (March 2004)

Not only was it clear that the identified consultant appeared not to follow guidelines; it appeared that there was no mechanism within the Trust to ensure that these guidelines were adhered to. One specific example of this was the Trust's ongoing knowledge that the NHS Breast Screening Programme guidance on multi-disciplinary team meetings was not being adhered to.

5.5.24 It would also appear that to a large extent the Annual Statistical Reports compiled by the Regional QA Director would appear to focus more on the overall performance of the service rather than its quality assurance.

5.5.25 The review panel were concerned that the QA audit visit undertaken in October 2003 and published in August 2004 used the Scottish Board Standards which are different to the NHS Breast Screening Programme standards that the Northern Ireland programme works to. It is notable that the next QA visit scheduled for 2006 will be undertaken by the East Midlands Quality assurance Reference Centre which will assess the Northern Ireland Breast Screening Programme against the Northern Ireland Breast Screening Programme standards. Given that this QA visit concentrates on the performance of the service the review panel are of the view that the Northern Ireland Breast Screening Programme should also take account of the HPSS clinical and social care standards.

5.5.26 Recommendations

5.5.27 Any future QA visits must be based on the NHS Breast Screening Programme guidelines and standards. These visits should also take account of the DHSSPS Quality Standards for Health and Social care.

5.5.28 The recommendations of the QA visits and all other quality reviews of the Northern Ireland Breast Screening Programme must be acted upon. It is the responsibility of the QA Director and QA Coordinator to ensure that these action plans are implemented within the agreed time frames through 6 monthly visits to breast screening units.

5.5.29 Whilst valuing the contributions of the entire multi-disciplinary team, all Units should ensure that the screening assessment multi-disciplinary team meeting cannot take place without the attendance of the breast radiologist, breast surgeon/clinician and pathologist and that a symptomatic multi-disciplinary team cannot take place without the above clinicians and an oncologist.

6 Conclusions and Recommendations

Conclusions

The following recommendations have been made following analysis of the evidence submitted by the DHSSPS, HPSS Boards, Trusts, the Regional Advisory group and key personnel associated with the Northern Ireland Breast Screening Programme. These recommendations are explained in the text of the report and are referenced by the paragraph in the report.

Recommendations

5.1 Workforce issues and their impact on the service

1. **DHSSPS, Boards, Trusts and the Northern Ireland Medical and Dental Training Agency should actively promote post graduate radiology trainees to choose breast radiology as a sub-speciality. The DHSSPS should target a number of specialist registrar posts in radiology for the breast radiology sub-speciality in addition to those already planned for other radiology or sub-speciality interest. This recommendation should also be applied in other vulnerable medical specialities.**

2. **DHSSPS, Boards and Trusts should actively promote the various models of service provision through a range of skill mix options as outlined by NHS Breast Screening Programme, the UK Department of Health and The Society of Radiologists. Skill mix options for the Northern Ireland Breast Screening Programme should be reflected in the Northern Ireland Workforce Development Strategy developed by the DHSSPS.**

3. **The viability and sustainability of the Breast Screening Programme in an area where there are on-going staff shortages, must be considered by DHSSPS, HSS Boards and Trusts within an agreed action plan based on the assessed risks and good governance.**

4. **Plans to further extend the upper eligible age range of routine invitation to Northern Ireland Breast Screening Programme to women aged 65-70 years, should be suspended until workforce issues have been satisfactorily resolved within the service to provide such capacity.**

5.2 Management of competency issues (i) March 2004–November 2004

5. **The Northern Ireland Breast Screening Programme should clarify with Trusts and Boards the role and accountability of the Regional QA Director and make explicit the responsibilities in the management of failing competence and underperformance of staff.**

6. **All Trusts should ensure that concerns about failing competence and/ or performance of medical consultants should be dealt with under the recognised framework - Maintaining High Professional Standards in the Modern HPSS (November 2005) HSS(TC8) 6/2005.**

7. **Governance processes should be in place to ensure that when failing competence and medical underperformance is assessed, action plans are developed with agreed timescales for implementation. Implementation should be subject to review and monitoring with appropriate use of the National Clinical Assessment Service.**

8. **The DHSSPS should further review and issue definitive guidance on the payment of incentives to consultant medical staff, ensuring that those staff are able to meet in full the requirements of their substantive contract and agreed work plan.**

9. **The DHSSPS should issue revised guidance on the recruitment and selection of locum consultant staff in Trusts / Boards.**

10. **All Trusts should ensure that annual consultant appraisals are implemented as a matter of urgency (including appraisal for locum consultant staff employed for more than three months). RQIA will undertake an improvement review of consultant appraisal and the role of Clinical Directors in managing medical performance across all Trusts in 2006/2007.**

5.3 Management of competency issues (ii) November 2004–October 2005

11. **The results of the Wilson Report and the findings of this review identify grave concerns in professional competence which should be notified to the General Medical Council if this has not already been done. RQIA will review the governance processes within Belfast City Hospital as applied to this issue.**

12. **The RQIA will conduct a further detailed governance review of medical management and leadership in United Hospitals Trust (with**

particular emphasis on clinical directors) using HPSS Clinical and Social Care Governance Standards.

5.4 The Recruitment and Selection Process

13. **Trusts and employers must ensure that disclosure of information as part of the selection and recruitment processes for all grades of medical staff are in accordance with relevant legislation, good practice guidelines and professional regulatory requirements. The RQIA will require Antrim Area Hospital to demonstrate that due process is followed in the review of the matter of the reference provided, regarding the identified consultant's application to Belfast City Hospital.**

14. **Trusts must take appropriate steps to ensure that interview panel members have up to date knowledge and skills in selection and recruitment processes.**

15. **Medical staff must adhere to General Medical Council Guidelines when providing references or reports about medical colleagues.**

16. **All documentation relating to selection and recruitment of medical staff should be reviewed to ensure that there is provision to question applicants about any professional or personal, unresolved or pending issue that might undermine the applicant's standing, or cause embarrassment to the NHS. An arrangement should be incorporated for a confidential declaration to be received by the interview panel chair.**

17. **Medical Managers and Human Resource departments should ensure that all job specifications for consultant medical staff and Clinical Directors clearly outline all relevant competency domains relating to the role. These may include clear descriptions of competency in leadership, communication and team working as relevant to the post.**

5.5 Clinical and QA Guidelines

18. **Any future QA visits must be based on the NHS Breast Screening Programme guidelines and standards. These visits should also take account of the DHSSPS Quality Standards for Health and Social Care.**

19. **The recommendations of the QA visits and all other quality reviews of the Northern Ireland Breast Screening Programme must be acted**

upon. It is the responsibility of the QA Director and QA Coordinator to ensure that these action plans are implemented within the agreed time frames through 6 monthly visits to breast screening units.

20. **Whilst valuing the contributions of the entire multi-disciplinary team, all Units should ensure that the screening assessment multi-disciplinary team meeting cannot take place without the attendance of the breast radiologist, breast surgeon/clinician and pathologist and that a symptomatic multi-disciplinary team cannot take place without the above clinicians and an oncologist.**

7 Acknowledgements

Given the timescales, the volume of documentary and verbal evidence received from relevant organisations, the RQIA would wish to acknowledge all staff in those organisations whose efficient work enabled the compilation of this report within the given timescales.

8 References

1 Wilson (2006) Report on a Review of Breast Imaging at Altnagelvin Hospital, Belfast City Hospital and Antrim Area Hospital, September 2002 – November 2005.

2 Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

3 Analysis of Statistical and QA information reports (2000 - 2005).

4 DHSSPS (2003) Priorities for Action 2003 – 2004

5 Journal of Cancer Surgery (2005) Guidelines for the management of symptomatic breast disease. The Association of Breast Surgery at BASO – Royal College of surgeons of England.

6 NIBSP (2001) NIBSP – Advisory and Organisational Structures

7 NIBSP Statistical Profile (2003 – 2004)

8 HSS(TC8)15/91 Disciplinary Procedures for Hospital and Community Medical and Dental Staff

9 NHSBSP (January 2004) Guidelines for Managing Incidents in the Breast Screening Programme.

10 DHSSPS (1996) Appointment of Consultant's Regulations (Northern Ireland) 1996

11 DOH (2004) Committee of Enquiry – To investigate how the NHS handled allegations about the performance and conduct of Richard Neale

12 GMC (2001) Good Medical Practice

13 IPEM Report No. 89 – Recommended standards for the routine Performance Testing of Diagnostic X-ray Imaging Systems.

14 Clinical Standards Board (2002) NHS Quality Improvement Scotland

9 Appendices

Appendix 1 Terms of reference as outlined by DHSSPS

Appendix 2 Timescales of the review process

Appendix 3 Review panel members

Appendix 4 List of main stakeholders

Appendix 5 Regional Advisory Structure

Appendix 6 Employer Accountability Structure

Appendix 7 Serious Adverse Incident Report

Appendix 1

Appendix 2

Please click on link below & print of page to read

Timelines a4.doc

Appendix 3

The RQIA review panel

- Mr Phelim Quinn, Director of Nursing, RQIA (Chairperson)
- Dr Julie Cooke, Consultant and Clinical Director, Jarvis Breast Screening, Diagnostic and Screening Centre and QA Radiologist for the South East (East) Region
- Mrs Stella Cunningham, Chief Officer Southern Health and Social Services Council
- Mrs Theresa Hughes, Independent Human Resources Consultant
- Dr Julia Verne, Director of South West (England) Public Health Observatory
- Mrs Hilary Brownlee, Project Manager, RQIA
- Miss Carolyn Brown, Review Team Administrator, RQIA

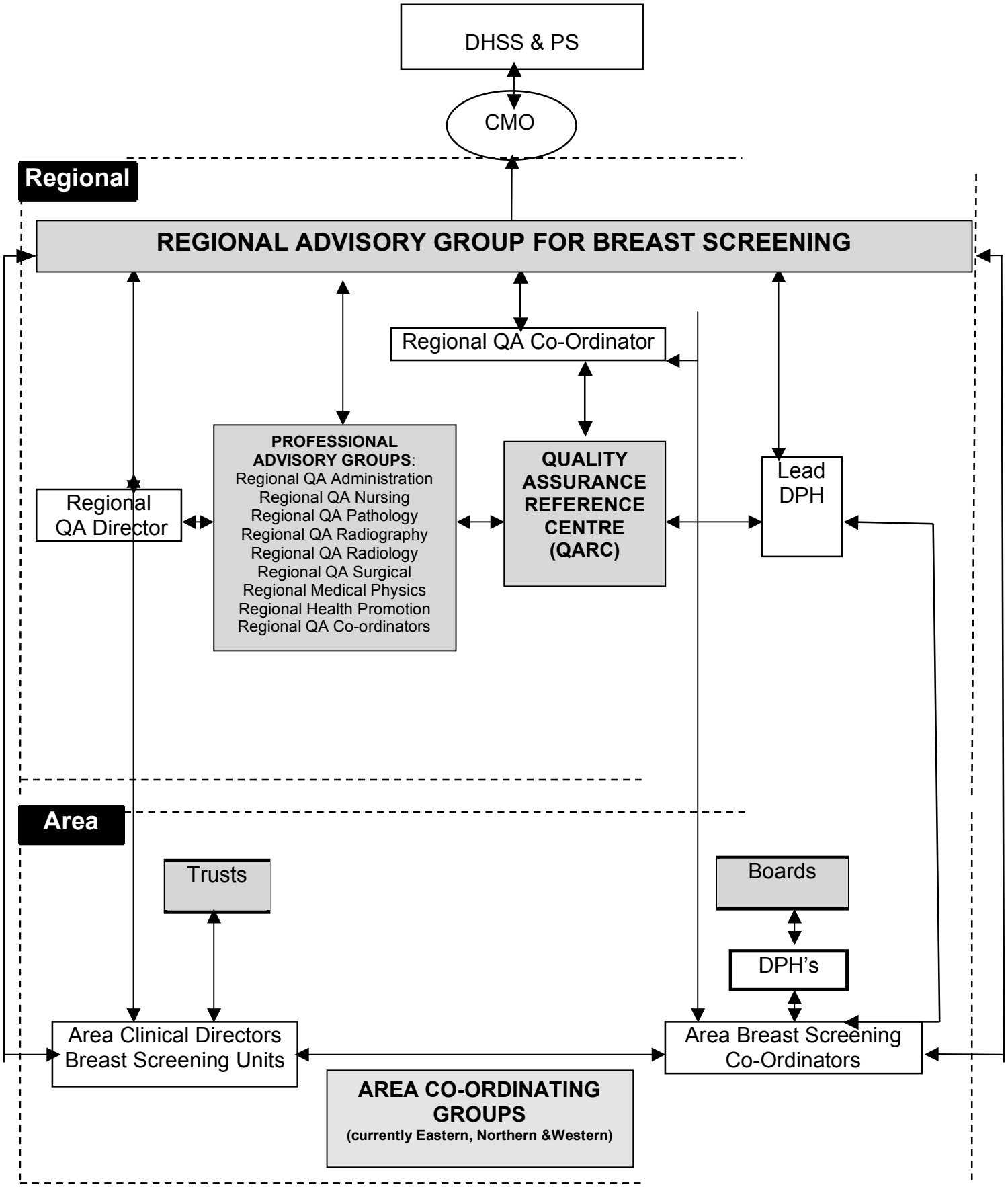
Appendix 4

Organisations and personnel contributing evidence to this review

- DHSSPS
- Breast Screening Programme Regional Advisory Group
- WHSSB
- NHSSB
- EHSSB
- Altnagelvin Trust
- United Hospitals Trust
- Belfast City Hospital Trust
- The Identified Consultant

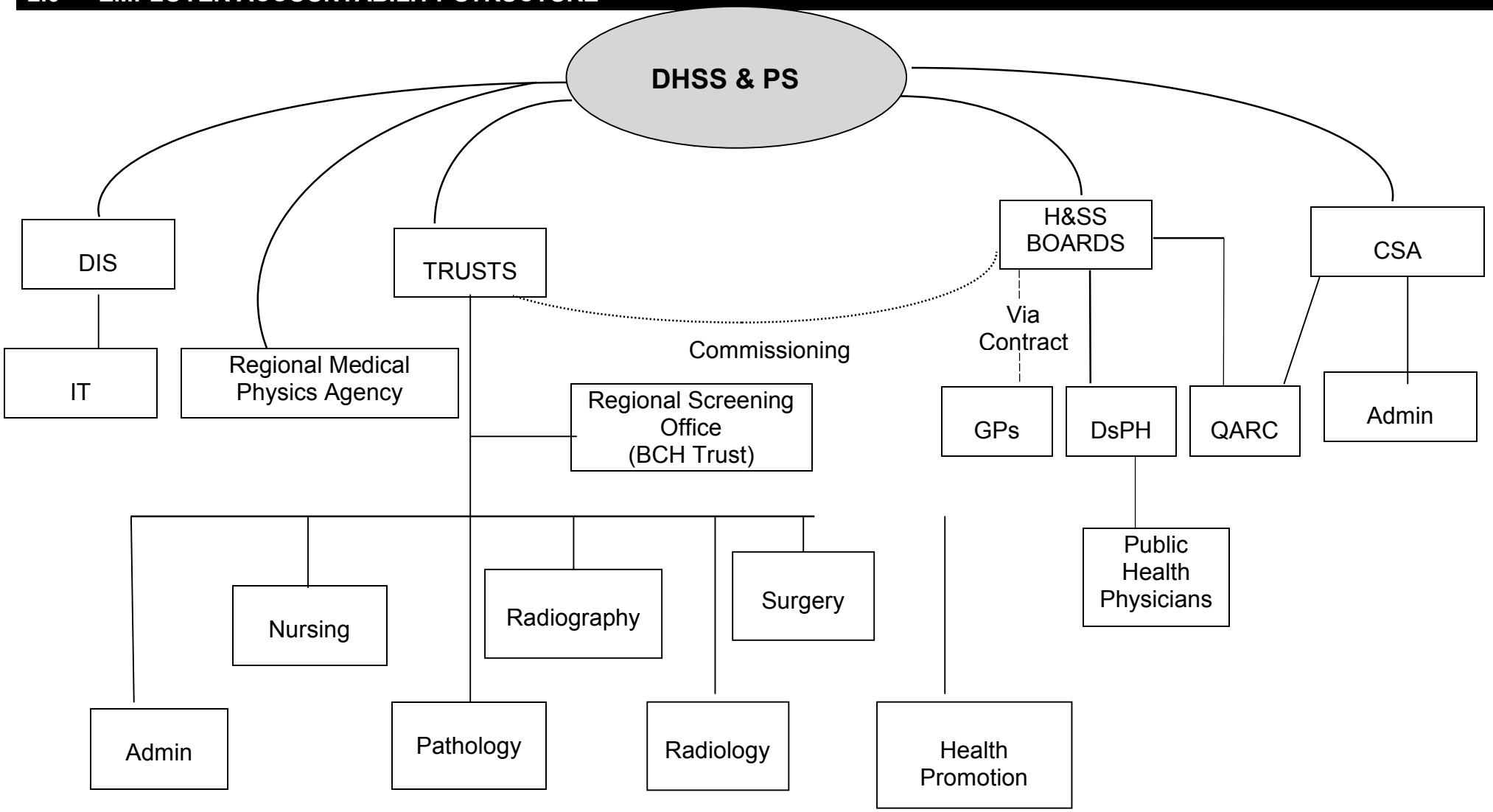
Appendix 5

1.0 ADVISORY STRUCTURE FOR BREAST SCREENING PROGRAMME



Appendix 6

2.0 EMPLOYER ACCOUNTABILITY STRUCTURE



Appendix 7

SERIOUS ADVERSE INCIDENT REPORT
1. Organisation: United Hospitals HSS Trust
2. Brief summary (and date) of incident: Breast programme suspended 4th October 2005 due to a backlog of patients awaiting assessment, due to a combination of equipment failure and radiological staffing difficulties and was due to recommence 25th October 2005. As a result of concerns raised concerning Radiology input to the Breast Screening Service, Antrim Area Hospital, a decision was made to continue the suspension and Chief Executive notified 18th October 2005.
3. Why incident considered serious: "incidents which are likely to be of public concern" (Circular HSS(PPM) 05/05) due to duration of suspension.
4. Action taken: Meeting 24/10/05 Chaired by Trust Chief Executive, including Trust Senior Clinical Staff, NHSSB and Regional Quality Assurance Director for Breast Screening Programme considered concerns and agreed action plan to investigate issues with immediate effect, including the provision of additional Radiological support to the assessment clinic which has now been put in place. Follow-up meeting scheduled for 7th November 2005 at which decision will be made on further action, including whether to reinstate the screening programme.
5. Is any regional action recommended? **Not at this time.**
6. Is an Independent Review being considered? Dr Crothers, Quality Assurance Director for Breast Screening Programme will undertake an audit of assessment cases.
7. Other Organisations informed PSNI **No** Coroner **No** NIHSE **No** **HSS Board** Yes - NHSSB **Other** (please specify) Yes – DHSS&PS, CMO's Office (By NHSSB) 24th October 2005
8. Report submitted by (name and contact details of nominated senior manager or Chief Executive) XXXXXXXXXX, Chief Executive, United Hospitals Trust. Telephone: XXXXXXXXXX

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 8126

10 List of Tables

11 Glossary of Terms and Abbreviations

ANTRIM AREA HOSPITAL:	Antrim Area Hospital, a hospital within the United Hospitals Trust.
Appraisal:	Examination of people or the services they provide in order to judge their professional qualities, success or needs.
Assessment:	The process a woman undergoes following an abnormal mammogram, in order to obtain a definitive diagnosis.
Audit:	systematic review of the procedure used for diagnosis, care, treatment, and rehabilitation, examining how associated resources are used, investigating the effect care has on the outcome and quality of life of the patient, and making changes if necessary.
Call, recall:	The process used to invite people for a screening test.
Fine needle aspiration (FNA):	The withdrawal of fluid, containing calls, from the body by means of suction using a fine needle. The samples obtained are used to provide information on the cells of tumours and cysts.
Multidisciplinary team:	A group of people from different disciplines (healthcare and non-healthcare) who work together to provide care for patients with a particular condition.
Peer review:	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review.