Report of the review of symptomatic breast imaging services delivered by County Durham and Darlington NHS Foundation Trust

2 & 3 December 2025

The Royal College of Radiologists

Contents

Table of abbreviations

The report contains a number of abbreviations, acronyms and specific medical terms; for the ease of the reader, these are set out in the table below.

Term	Definition
AVOID	Audit to quantify the volume of disease on axillary ultrasound in the axilla, by assessing the cortical thickness and number of abnormal nodes, to support surgical management of the axilla
BSBR	British Society of Breast Radiology
CD	Clinical Director
CDDFT	County Durham and Darlington NHS Foundation Trust
CPD	Continuing Professional Development
CRIS	Computerised Radiology Information System (RIS software)
CQC	Care Quality Commission
CT	Computed Tomography
DNA	Did Not Attend
EPR	Electronic Patient Record
FFT	Friends and Family Test
GIRFT	Getting It Right First Time
HR	Human Resources
ICB	Integrated Care Board
ICE	Integrated Clinical Environment (electronic requesting system)
IR	Interventional Radiology
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
MDT	Multi-Disciplinary Team
MDTM	Multi-Disciplinary Team Meeting
MES	Managed Equipment Service
MRI	Magnetic Resonance Imaging
NCPES	National Cancer and Patient Experience Survey
NENC	NHS North East and North Cumbria
NHSBSP	NHS Breast Screening Programme
NICE	National Institute for Health and Care Excellence

PACS	Picture Archiving and Communication System: software used in a radiology department to enable storage, retrieval, distribution and display of medical images
PERFORMS	Personal Performance in Mammographic Screening (national self-assessment, training and quality assurance programme)
PET-CT	Positron Emission Tomography-Computed Tomography
PLACE	Patient-Led Assessments of the Care Environment
PTL	Patient Tracking List, which shows the number of patients on the cancer 62-day pathway, who are at risk of breaching the 62-day standards.
QI	Quality Improvement
QSI	Quality Standard for Imaging
RCR	Royal College of Radiologists
RCS	Royal College of Surgeons (England)
REALM	Radiology Events and Learning Meeting
RIS	Radiology Information System: software used in a radiology department to manage and organise medical imaging data
SCOUT	Wire-free radar localisation device
SLA	Service Level Agreement
SOPs	Standard Operating Procedures
SQAS	Screening Quality Assurance Service
VAB	Vacuum Assisted Biopsy
WTE	Whole Time Equivalent

Service review team

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In the event that County Durham and Darlington NHS Foundation Trust decides to publish this report, we request that the personal details of the review team, as set out on this page, are redacted.

Executive summary

Introduction

This report presents the key findings from the Royal College of Radiologists' review of the symptomatic breast imaging service delivered by County Durham and Darlington NHS Foundation Trust (CDDFT), which took place on 2 and 3 December 2025.

The recommendations made by the review team aim to support the Trust to strengthen the quality of symptomatic breast imaging services provided to patients. To that end, this report outlines a series of improvements that can be made to improve the patient experience and the quality of care provided. The summary below initially outlines a series of critical issues that require urgent resolution, together with some further findings that stand to significantly improve the provision of breast radiology services in patients' best interests over the medium to longer term. It should also be noted that, whilst the RCR was commissioned to undertake a review of breast radiology, some of the matters identified have implications for the wider radiology department, which are set out in the summary below.

Further information on the conclusions summarised here can be found in the main body of this report.

Critical issues

The review identified the following critical issues affecting service delivery and patient safety:

1. **Persistent PACS issues**

   Persistent and significant issues with the PACS and related IT infrastructure represent the principal threat to patient safety and the effectiveness of the symptomatic breast imaging service. Key risks and issues include:

   - Inability to access critical prior imaging, especially from external sources, leading to delays, system overload, and reliance on incomplete records.
   - Manual intervention required for image integration, with insufficient administrative resource, resulting in backlogs and gaps in patient records.
   - Reports of misdirected or lost findings, risking time-critical results not being acted upon.
   - Lack of on-site specialist PACS support and clear system ownership, with insufficient investment in dedicated PACS management, leading to the PACS issues that clinical staff have identified not being resolved.

   The review team heard examples of the direct patient impact of the above, including reports of wrong patient selection, wrong side imaging, near misses, repeat and unnecessary biopsies, and clinic delays due to IT failures. The review team was told by multiple participants that these issues have been repeatedly raised to Care Group level as red risks, with reports of clinical teams resisting attempts to downgrade their severity.

2. **Potential unnecessary radiation**

   There is no set process to check, prior to patients attending the symptomatic breast imaging service, whether patients have had a mammogram within the last six months. This gap in administrative and booking processes represents a potential risk that some patients may receive unnecessary mammograms, resulting in avoidable radiation exposure and

inconvenience. This would constitute a reportable safety incident under IR(ME)R regulations and requires revision of administrative processes to incorporate appropriate safety checks, and to ensure prior imaging is integrated into patient records prior to clinic appointments. A clear approach to reporting and responding to any future incidents of this kind must be established and implemented.

Overall, these issues represent a tangible threat to patient safety and service quality, requiring immediate and sustained attention to prevent harm.

Recommendations: Symptomatic breast imaging services

The review identified several actions for consideration as part of the Trust's ongoing review and development of the symptomatic breast imaging service.

1. **Improvements to patient flow**

   The review highlighted that patient flow and communication between imaging and surgical teams in the one stop breast clinic at Darlington are hampered by inefficient layouts and frequent changes in clinic location, leading to frustration for staff and confusion for patients. Establishing a permanent clinic base—ideally at the Women's Centre—and co-locating ultrasound services alongside surgical services would bring much-needed consistency, improve communication, and streamline the patient journey. Staff experience could be further improved by providing radiology teams with access to and training on the Electronic Patient System, with appropriate 5MP workstations, enabling better oversight of patient movement through the clinic (e.g. in Durham, PowerChart where clinic activity can be tracked). The waiting area at the Women's Centre was also found to be unwelcoming, and a patient-led redesign, informed by patient feedback and facilitated by the PLACE team, is recommended to create a more supportive environment. Until such time as a decision is made regarding the future configuration and delivery of breast services, continuing efforts to further align service models and sharing best practice across both Darlington and Durham sites will help deliver more efficient, patient-centred care. Further optimisation may be achieved by co-locating breast ultrasound with surgical teams in outpatient suites at Durham as well, if feasible.

2. **Clinical staffing**

   The review team found that limited cross-cover and isolated working are ongoing challenges at both sites. In breast radiology, low staffing levels leave the service particularly vulnerable to absences, and while bank radiographers have been appointed to help, their integration into the team remains unclear. Staff shortages mean that consultant radiologists and consultant radiographers are frequently interrupted with general radiology department queries during breast clinics, impacting efficiency and patient care. Relocating clinics to the Women's Centre and ensuring consultants are dedicated to breast imaging during clinic sessions would improve communication and workflow.

3. **Governance: structure and oversight**

   The review identified significant gaps in governance culture, structures, and accountability within breast radiology, and confirmed that breast radiology currently lacks formal governance meetings, which are essential for regularly reviewing service quality and addressing emerging

risks. This gap is in part due to insufficient administrative support and reflects limited opportunities for team communication, collaborative learning, and the sharing of best practice. Staff described the service as vulnerable and struggling, with concerns about stagnation and a lack of professional curiosity. While efforts are underway to improve communication and foster a more open culture, clearer and more structured opportunities for whole-team engagement are needed.

Plans to establish a dedicated breast-specific REALM and governance meeting are to be welcomed. However, at the time of the review, no terms of reference for these meetings had been established or shared. The review team emphasised that, beyond setting up meetings, it is crucial to build a fundamental, shared understanding of good governance, ensure effective leadership, and sustain staff engagement in governance processes.

Stronger whole-team communication structures are also needed, including regular meetings and huddles to share learning, enable staff at every level to express concerns or raise emerging risks, discuss professional practice, and ensure staff contributions are valued. This will help address concerns that good ideas brought back from external engagement have previously not been acted upon.

4. **Leadership and mentoring support**

There is a lack of clear leadership within breast radiology, with no designated lead and unclear decision-making processes regarding team operations, quality improvement, and succession planning. This fragmented leadership poses a significant risk to the service's resilience and long-term sustainability. While external consultant support has recently provided valuable direction and improved consistency across sites, the review highlights the urgent need to establish and appoint to a dedicated breast radiology lead post. This role should be empowered with the authority and support necessary to drive sustainable service development, foster collaboration, and guide the team through upcoming changes. The service may wish to assure themselves that the arrangements in place for supervision are in line with Trust policy, and are effective. Additionally, the Trust should formalise ongoing mentoring arrangements for the new lead, once appointed, and support leadership development, ensuring sustainable internal capacity beyond the current external agreement. Current team capacity is insufficient to deliver the changes highlighted in this report at the required pace, and continued external support is therefore strongly recommended.

5. **Extended practice**

The Trust should assure itself that clinical staff with extended roles are practising within their documented scope and that robust governance and supervisory frameworks are in place to maintain the safety, sustainability, and quality of service delivery.

6. **Quality assurance and standards**

Effective governance in breast radiology depends on a continuous programme of audit and quality assurance, with outcomes used to drive improvements in care. While some audit activities and engagement with national standards was evident, these efforts are not yet part of a structured, ongoing process, and there is no formal forum for discussing audit results, missed cancers, or updates to clinical guidelines. The service is working towards greater

alignment with best practice in screening centres, including equipment quality assurance and participation in external QA schemes, but further steps such as annual inspections and enhanced collaboration are recommended.

Establishing regular governance meetings with clear terms of reference, and a breast-specific REALM, will be crucial for embedding transparency, accountability, and evidence-based decision making. These meetings should cover audit planning, incident reporting, risk register updates, patient feedback, and professional development. The review also noted positive initiatives to improve communication and transparency, such as audit noticeboards, which could be extended to breast radiology to share performance and improvement priorities with the wider team.

7. Culture and behaviours

Processes for escalating concerns were described as dysfunctional, and multiple examples were cited of staff being discouraged from recording or raising risks. While recent staffing changes have begun to foster a more open reporting culture, this shift will take time to embed. Staff must be able to raise concerns freely and expect an active, appropriate response, including feedback on how their concerns will be addressed. Routinely acknowledging those who raise issues and sharing resulting improvements helps build psychological safety and encourages a culture of openness and continuous improvement. Achieving this requires consistent leadership messaging and genuine behavioural change. In response to the Aubrey Review, there is an urgent need to educate all staff on how to respond appropriately to concerns, what constitutes an acceptable response, and the escalation routes available if concerns are not properly addressed (e.g. via the Freedom to Speak Up[1] Guardian).

8. Reporting governance: breast radiology

Within breast screening services, all mammograms are double reported as standard, but there is no comparable requirement for symptomatic breast mammograms. At CDDFT, internal double reporting is being carried out by the local reporters. There was some misunderstanding among senior leadership about the process, specifically whether there was external involvement in double reporting, highlighting the need for clearer oversight, a formalised approach to peer review, and appropriate written procedures for identifying and resolving discrepancies within the breast radiology team.

9. Multidisciplinary Team Meetings

Multidisciplinary team meetings (MDTMs) have undergone significant positive changes to address previous concerns, including poor record-keeping, IT issues, and behavioural challenges. MDTMs are now unified across sites under the leadership of a consultant breast surgeon, with cases categorised by discussion type to improve workflow and resilience.

Efforts have been made to reduce the number of cases discussed and improve outcome recording, though further streamlining is possible. Some reliance on MDTMs for consensus reflects a lack of confidence in independent decision-making, and updated protocols requiring all reporting disagreements to be referred to MDTMs may be overly cautious. Adjusting

[1] NHS England » Freedom to Speak Up

submission deadlines could ease pressure on coordinators, and reviewing job planned MDT preparation time should ensure improved equity across the consultant radiologists and consultant radiographer who present cases at the MDTM.

Technical challenges persist, particularly with IT support and software compatibility, affecting meeting efficiency. The upcoming PACS upgrade is expected to improve image sharing, but reliable radiology IT support remains essential for the smooth running of MDTMs.

10. **Future service reconfiguration**

The review team noted the current, ongoing major capacity challenges in breast radiology at CDDFT, worsened by the cessation of independent sector services. This capacity reduction is also having an impact in increasing referrals to neighbouring Trusts. The ICB and Northern Cancer Alliance are evaluating future service models, aiming for equitable access, care close to home, workforce resilience, futureproofing, cost efficiency, and continuous quality improvement. Two main options were presented for consideration: centralising services at Bishop Auckland, or delivering one-stop clinics at surrounding screening centres. While most favoured centralisation for its potential sustainability and consistency, concerns remain about transferring existing issues to a more remote site and about patient travel.

A third, hybrid model that maintains clinics and surgery at Darlington and Durham, aligns breast radiology with screening centres, and enables staff rotation could benefit from exploration. This approach would support equitable access, workforce resilience, and quality standards, while making roles more attractive and sustainable. It would also reduce the likelihood of the service becoming isolated and not as visible to senior leaders.

Across all options, urgent attention is needed to address succession planning and establishing a regional workforce strategy, including recruitment and development of advanced practice roles, with a focus on building resilience. Equipment upgrades should be aligned with the chosen service model and accompanied by improvements in team functioning and patient flow.

A timely decision on the preferred model is essential to maintain momentum for sustainable service improvement. The review team welcomes the ICB's intention to discuss the hybrid option and looks forward to further details on the reconfiguration plan and timeline.

Recommendations: Radiology and the wider organisation

As noted above, the review team identified a number of other matters that go beyond breast radiology. They are relevant to radiology as a whole, and potentially to the Care Group and the wider organisation. Many of the concerns outlined below mirror unresolved systemic structural, cultural, workforce, and governance deficiencies first documented in the RCR's report of the invited review of the radiology department undertaken in 2013. These long-standing issues now pose heightened risk within a cancer specialty where variation or delay is far less tolerable.

1. **Working practices**

The review team inferred, based on comments from several participants in the review, that there was a perception of a lack of staff in the department on a day-to-day basis, with

pressure on the remaining staff in the department for cover, particularly in relation to interventional procedures. There is a need to review some core working practices across radiology, including reviewing the agreed approach to interruptions, provision of a suitable alternative contact, and communication of appropriate on-site and remote cover for common scenarios, to ensure that interruptions to breast clinics or interventional lists are minimised. Homeworking was perceived as a prominent contributing factor to the current level of interruptions, and these arrangements require review to ensure sufficient on-site presence for safe, effective, and patient-centred care. RCR guidance highlights the importance of balancing home reporting with adequate on-site leadership and collegial support. The Clinical Director, with HR support, should review and revise current home working practices and rotas to build greater resilience and better meet the needs of patients and the wider service.

2. **Management of concerns, risks and other information**

The review highlighted a lack of ownership and accountability in responding to concerns, with escalation processes described as dysfunctional and staff sometimes actively discouraged from reporting risks. The Care Group layer in the organisational hierarchy was seen by some as a barrier to escalating issues beyond specialty level, contributing to a culture that prioritised performance over governance and left specialty teams feeling unsupported. Although recent staffing changes have begun to encourage more open reporting, embedding this shift and reinforcing the importance and value of reporting concerns will take time.

The current risk register for radiology is limited and would benefit from redevelopment to support better risk management and escalation, including clearer prioritisation and tracking. Staff need to feel confident in identifying and documenting risks, reinforcing shared responsibility for risk management, and consideration should be given to supporting staff understanding and practice through training on risk management. Consistent reporting of even minor issues, using systems like Datix, should be encouraged to improve visibility, drive consistent responses, and support a culture of quality and audit. There is also a need for clearer processes and oversight for risks that span multiple departments, as current practices are siloed and lack coordination.

The service needs to strengthen how it gathers and acts on feedback from patients, visitors, and staff. Embedding the Friends and Family Test (FFT) is essential so that patient feedback is routinely and actively sought, with recognised mechanisms introduced to make feedback easy (e.g. QR codes, experience pods, text messages, freepost envelopes) and ensure staff at all levels review this feedback, including as a standing agenda item at quality meetings.

Routine reporting on adherence to Quality Standard for Imaging (QSI) requirements, particularly XR-1 (Information and Support for Patients and Carers), should form part of strengthened governance and ongoing quality improvement. The review team recommends that the service familiarise itself with the core QSI standards and engage the QSI Quality Improvement Partner to support adoption where applicable. Clear improvement actions across radiology, including breast imaging, will help reinforce a vision for ongoing service development and enhance both staff and patient experience.

3. **Reporting governance and outsourcing**

Radiology reports are a key professional communication and must include the reporting clinician's name, registration number, and other identifying details to ensure transparency and meet national standards. A snapshot review of reports at Darlington and Durham revealed that internally reported cases did not display the required information about the reporting clinician on the EPR. There was an assumption by radiology staff that this would be automatically picked up from the RIS into the report seen by hospital clinicians, but this is not currently the case. This should be promptly addressed through departmental agreement, formal documentation of the solution, and an appropriate IT intervention.

While teleradiology and outsourced reporting are common, clear governance is needed to determine which cases should be outsourced and which should remain in-house to optimise resources and avoid duplication. Outsourcing cancer staging imaging has led to inefficiencies, so it is recommended that these cases be retained within the breast radiology team, potentially with input from general radiologists, with a formal approach agreed for other staging work.

Looking ahead, the implementation of a new PACS system in March 2026 will enable improved image sharing and regional collaboration. Funds released from the cessation of third-party imaging services should continue to be reinvested to support service development and manage cost pressures.

Failure to clarify outsourcing criteria and develop regional in-sourcing risks ongoing inefficiencies, increased costs, and reduced clinical effectiveness.

Acknowledgements

The review team was able to engage openly and thoroughly with a wide range of staff across the service, and with the management team within the Trust, Northern Cancer Alliance and North East and North Cumbria ICB, over the two days spent on-site. The review team's gratitude is extended to all of those who took the time to share their impressions of the service as it currently stands, and the opportunities to improve it for both patient and staff benefit.

The College is keen to support CDDFT colleagues in realising their ambitions for the service during a time of organisational re-setting, and the opportunity to contribute to the leadership team's understanding of the current challenges the service – and its staff team – are facing is appreciated. The College welcomes CDDFT's stated commitment to learning from engagement with the review findings and looks forward to hearing more about the actions taken as a result.

The Trust is encouraged to consider the commissioning a follow-up review of the breast radiology service at an appropriate point time, to establish the pace and sustainability of progress made against the recommendations outlined in this report. Serious consideration should also be given to the merits of commissioning a further invited review of the wider radiology department, whether as a separate or combined exercise.

1. Introduction and background

1.1 The Royal College of Radiologists (RCR) undertook an invited review of the symptomatic breast imaging service delivered by County Durham and Darlington NHS Foundation Trust (CDDFT) on 2 and 3 December 2025.

1.2 This is a symptomatic-only breast radiology service operating across the Darlington and Durham sites, with screening services provided elsewhere in the region (North Tees, Gateshead and Newcastle). The service contributes to delivery of one-stop breast clinics, with patients referred from both general practice and secondary care pathways. The service provides digital mammography, breast ultrasound, ultrasound-guided biopsies and breast MRI. Capacity for each clinic session is now capped at 12 patients to ensure adequate time for imaging, reporting, discussion, and patient support. Members of the review team were able to spend time at both Darlington Memorial Hospital and University Hospital of North Durham over the course of the two days.

1.3 The RCR's invited service review of the breast radiology service was commissioned by North East and North Cumbria ICB following an invited review of breast surgery undertaken by the Royal College of Surgeons[2] (RCS) in January 2025. In response to the recommendations made by the RCS team, the Trust commissioned the Aubrey Review[3], which assessed governance within breast surgery services at the Trust. The review also examined wider Trust governance to identify lessons learned from other external reviews, including those undertaken by GIRFT and by the Northern Cancer Alliance, and following concerns raised by the CQC as well as by clinicians in neighbouring NHS Trusts. There is a fundamental redesign of clinical governance structures underway, with new leadership and a focus on improving safety culture, openness, and quality improvement across services.

1.4 The initial request for the RCR review centred around a desire for clarity and assurance in relation to the safety and effectiveness of the service, the fitness for purpose of relevant organisational structures and systems, and the effectiveness of the interface between breast radiology and other relevant services. The review team was also asked to comment on plans for future service reconfiguration. These terms of reference are set out in more detail in the next section of this report.

1.5 The report of the Aubrey Review was published in November 2025. For convenience, the key issues identified within the report are outlined below:

- Governance breakdown and lack of Board-level oversight, challenge and escalation.
- Failure of executive and clinical leadership to act on repeated warnings and to implement improvements.
- A persistent culture of silence and lack of psychological safety for staff.
- Patient harm caused by outdated clinical practices and unnecessary procedures.
- Failure to follow national guidance and modern standards.
- Contract management and governance failures.
- Loss of training status and absence of surgical trainees.
- Delayed and inadequate Duty of Candour.
- Ignored external warnings and failure to act on national guidance.
- Equipment and diagnostic gaps undermining quality of care.
- Impact on workforce morale, retention, and professional development.

[2] Royal College of Surgeons invited service review report - breast surgery
[3] Aubrey Review of Governance within the Breast Surgery Service

- Failure to escalate and act on patient experience data.
- Consequences: Avoidable patient harm, loss of public trust, regulatory and reputational risk, and financial loss.

1.6 The Aubrey Review findings, and the Trust's response[4] to this and other external reviews, were discussed at an open meeting of the Trust Board held on 27 November 2025, the week prior to the RCR review taking place. The Trust's response confirms acceptance of the Aubrey Review's recommendations, and addresses the support in place for patients, and changes made and being planned – with patient input – to ensure that the breast service provides safe, effective care. The response also sets out six programmes of work that are designed to deliver:

- Effective leadership and corporate governance.
- More effective clinical governance.
- An organisational culture which prioritises quality and responds to the views of patients and staff.
- A more collaborative medical culture with better managed and supported medical staff.
- Appropriate financial governance.
- A modern, safe and sustainable breast surgery service.

1.7 The review team sought to discharge its responsibility in a balanced way, and on the basis of evidence, though it was clear from conversations with several participants that media coverage during the preceding week had impacted on morale and confidence. The review team was keen to gain as rounded a view as possible of the breast radiology service as it currently stands, and of the adequacy of the improvement plan that is in place. Governance culture, or lack thereof, nonetheless dominated a significant proportion of the team's discussions with review participants. The team also noted a sense of inertia, with some reluctance to take decisions or make changes until clarity is available regarding future service reconfiguration. These matters are discussed fully in section 4 of this report.

1.8 The review followed the process set out in the RCR's Service Reviews: Process guidance for clinical oncology and clinical radiology, dated November 2022. The review was broadly informed by the evidence-based standards set out in the Quality Standard for Imaging (QSI 2024), and by relevant guidelines published by the RCR and other appropriate external reference points, which are set out in full in section 5.

1.9 It should be noted that the RCR undertook an invited service review of the wider radiology department at CDDFT in 2013. A number of the points of feedback identified in the 2025 review to which this report pertains feature in the 2013 report, though it should be noted that the 2013 review predates the radiology and senior leadership team's tenures in their current roles. Many of the concerns identified by the review team during the current review represent a continuation of unresolved systemic deficiencies – structural, cultural, workforce, and governance – first documented 12 years ago. These issues are now evident within a high-risk cancer specialty, where tolerance for variation or delay is minimal.

1.10 The Trust may wish to seek membership of the Royal College of Radiologists and College of Radiographers QSI Hub, which will provide access to support in tackling many of the common quality and governance challenges that imaging departments deal with on a day-to-day basis, with a view to considering working towards the QSI Quality Mark in time. Further information is available on our website (www.rcr.ac.uk/qsi) or by emailing qsi@rcr.ac.uk. If resources are not available to support membership of the QSI Hub at this time, advice and support is nonetheless

[4] CDDFT response to the independent reviews of breast services, leadership and governance

available free of charge from one of our Quality Improvement Partners, and we would strongly encourage the Trust to explore this.

1.11 The review team is keen that the findings set out in this report assist the Trust in implementing the recommendations made in the Aubrey Review, and in continuing to improve the quality of care provided to patients. The review team noted the recommendations outlined in the Aubrey Review report which, whilst specific to breast surgery, have applicability to breast radiology and the organisation more widely. Likewise, we anticipate that our recommendations in relation to breast radiology will be similarly scalable to the wider radiology department and beyond.

2. Terms of reference

2.1 The review set out to examine the following:

- **Safety and effectiveness:** Review the design and delivery of the symptomatic breast imaging service, with a view to considering the extent to which the service is safe, effective and up-to-date, and that it meets patients' needs.
- **Organisational structures and systems:** Review the organisational structures, systems and processes that underpin delivery of a safe and effective breast radiology service, including multidisciplinary working, provision of quality assurance, identification of variation from accepted good practice, and implementation of solutions where risks and issues are identified.
- **Alignment with strategic objectives:** Review the proposed alignment of screening and symptomatic services, and specifically provide commentary on whether service reconfiguration has the potential to improve quality for patients in a way that is sustainable and which aligns with the strategic objectives of North East and North Cumbria ICB and the Northern Cancer Alliance.
- **Interface with other services:** Consider the effectiveness of the interface between breast radiology and other relevant services (surgery, non-surgical oncology), both within CDDFT and across the Norther Cancer Alliance, and identify opportunities that exist for tangible improvement.

The review findings are presented holistically in this context, rather than systematically in the order suggested by the Terms of Reference.

2.2 Assessment of individual performance or competence was explicitly outside of the scope of the invited service review.

3. Methodology of the review

3.1 Planning for the review began in August 2025 and Terms of Reference were agreed between members of the senior leadership teams from the ICB, the Northern Cancer Alliance, CDDFT and the RCR. A range of contextual documentation was requested by the RCR and uploaded to a secure SharePoint site by CDDFT, with various additional updates made ahead of the visit. A list of the documentation provided is included in Appendix 1.

Survey

3.2 A confidential online survey link was shared by email four weeks before the visit, and was distributed to staff in the breast radiology department via the Associate Director of Operations. Responses were viewed and collated by the RCR and were not visible to CDDFT staff. Just 4 responses were received from clinical staff. The survey asked general questions seeking to establish respondents' views on what worked well in the department, what could be better, and what outcomes they hoped to see as a result of the review. The low number of responses made it difficult to discern any key themes for further exploration during the review.

On-site review

3.3 The review took place over two full days on-site, during which review team members were able to meet with a range of CDDFT staff and external stakeholders who held a variety of roles within and/or perspectives on the service. Role details of those who contributed are listed in Appendix 2. Participants were assured of confidentiality, and that whilst the review would result in the production of a report no individually attributable comments would be included. Staff appeared to feel comfortable talking to the reviewers, and displayed evident care to present an honest and balanced view of the breast radiology service, though media coverage surrounding breast surgery and the Aubrey Review had evidently impacted a number of individuals. The review team took care to be as mindful of context, and as approachable as possible.

3.4 The final timetable for the review broadly enabled sufficient allocation of time for interviews, and time for collaborative discussions amongst the review team, though some interviews did extend beyond their allotted time, and additional meetings were arranged with some individuals (as well as with individuals who had not initially been asked to meet with the review team) to ensure they had adequate opportunity to share their experiences and opinions. Members of the review team spent the majority of their time on the Darlington site and were able to observe the layout and patient flow in place for one-stop breast clinics. Some members of the team were also able to spend some time on-site in Durham. The support provided by the Trust in setting up the timetable for the visit and in managing the logistics of transfers, room bookings and catering was appreciated.

Feedback and reporting

3.5 Verbal feedback was provided to the Acting Medical Director (CDDFT), Chief Medical Officer (ICB), Clinical Director for Secondary Care (Northern Cancer Alliance) and Clinical Director for Radiology (CDDFT) at the end of the two-day visit.

3.6 A letter outlining the review team's initial findings was sent to the Acting Medical Director on 17 December 2025, copied to the Chief Executive of CDDFT and the Chief Medical Officer of the ICB. A further clarification meeting was held on 22 December 2025.

3.7 The senior leadership team was provided with a draft of this report and offered the opportunity to raise any matters of factual inaccuracy prior to the report being finalised.

4. Service review findings

Safety and effectiveness

PACS and IT

4.1 Persistent and significant issues with PACS and IT represent the principal threat to the safety and effectiveness of the symptomatic breast imaging service. The review team heard repeated, consistent reports from multiple participants in the review regarding persistent issues with PACS, particularly on the Darlington site. Our reviewers were able to view staff members loading images via PACS in both Darlington and Durham to witness PACS performance and compare staff experiences.

4.2 Staff cannot easily access critical prior imaging, particularly when this has been performed in the screening service, with delays in image transfer and attempts to load images frequently causing system overload. The service is moving to a new PACS system in 2026 (see para. 4.8 below); this has the potential to make image transfer easier but will not lead to on-the-ground improvements if the images cannot be efficiently sourced, loaded and displayed and if clinicians need to rely on written reports alone. An example was given of a written report being referred to for an ultrasound with the report indicating the wrong side, necessitating a recall for ultrasound of the correct side once the mammographic images were available for review. The service has invested in new 5MP monitors in the ultrasound rooms at the Darlington site, which is welcomed, but these are not yet operational, leaving staff unable to view imaging. The review team also heard reports that users have to manually optimise mammography images; this requires them to navigate a convoluted folder process in the CRIS reporting system to select a mammography specific report setting manually each time an image is loaded for viewing.

4.3 Imaging that is undertaken outside of CDDFT, whether by the screening service, by Alliance Medical (PET-CT service) or elsewhere in the independent sector, requires manual intervention from health informatics colleagues: prior images cannot be automatically retrieved. They are required to code and manually organise image files so that they can be linked to the correct patient record for viewing. It appears that insufficient resource has been allocated to this critical task, and the review team heard reports of the administrative team that supports the service being understaffed, and experiencing high turnover. The team learned that at the time of the review, the backlog of PET-CT imaging from Alliance Medical that was waiting to be integrated to the correct patient records dated back around 8-10 weeks, to September 2025. This is causing gaps in patient records and is leading to clinicians needing to rely on written reports only.

4.4 There is potential for reports to be misdirected to the wrong person, or to get lost if the original referrer has left the organisation. This presents a risk that time critical and/or significant findings may not be acted upon in a timely way. This is a patient safety concern. Academy of Medical Royal Colleges guidance on alerts and imaging notifications[5] sets out the minimum standards that should be achieved, and the Trust should take steps to rectify this urgently.

4.5 The review team heard multiple reports of interoperability issues impacting on MDT workflows and image sharing in the MDT meeting. Where issues have occurred and have delayed the MDT meeting being able to commence, there has been a lack of urgency from IT support to rectify the issue, leading to wasted clinician time and increased pressure on already limited resources. This is discussed in further detail in para. 4.48 below.

[5] Recommendations on alerts and notification of imaging reports

4.6 There is a lack of on-site, specialist PACS support on either site. The review team noted that IT support appears to work more effectively in Durham than in Darlington, with a member of the IT team available on site, though the staff member providing that support does not have dedicated PACS responsibility. The review team identified some options for reconfiguring aspects of the current PACS set up to resolve some commonly experienced difficulties and has provided practical advice outwith this report.

4.7 The Trust needs to invest in a dedicated PACS Manager, based in radiology, and more readily accessible and available on-site IT support across all sites. Clear system ownership, administration and management responsibilities, and accountability for resolving issues, is crucial to ensure robust, interoperable IT systems (notably EPR/CRIS/ICE) which enable fail safe mechanisms when an unexpected, significant or time-critical finding is identified. This is a specialist system that underpins the work of the whole radiology department and requires specific ownership, oversight and support; the PACS Manager will need adequate time and appropriate competencies to manage the system. Whilst the General Manager will be in a position to collate views from modality leads and others regarding their day to day experience of interacting with PACS, and the data they would wish to be able to access via this system, the PACS Manager role requires specific system administration capabilities that enable oversight of the digital systems that store, manage and share imaging across the department, the wider organisation and the regional imaging network. This is a technical role with a focus on workflow, data governance, and data integrity, referral permissions, and on ensuring system performance and interoperability with other clinical systems. PACS Managers also often coordinate vendor management, system optimisation and upgrades. Whilst radiographers are experts in image acquisition, clinical decision making and safe and effective patient care, PACS Managers bring a different professional expertise centred on digital infrastructure. These roles are not interchangeable.

4.8 A replacement PACS system is anticipated by March 2026. This deadline has been extended from the original project plan which was recognised as perhaps too ambitious, and to allow appropriate time for data migration, quality assurance and testing, but the review team cautions that this timeframe must not extend any further. Based on reports from multiple participants in the review, the lack of informatics and system administration support in place directly impacts patient safety and requires rectification. The review team was told that these matters had been raised repeatedly as red risks, with requests for downgrading the severity of the risk made by a previous member of the management team having been resisted by the clinical team (see paras. 4.33 and 4.36 below). Ongoing investment in installing and optimising the new PACS is needed as a priority to ensure that the system, once available, continues to meet users' needs. This should include support for collaboration with other units that have used the new system to enable replication of good practice, sharing of settings and protocols, and avoidance of known issues.

Patient impact

4.9 The ongoing difficulties related to PACS and IT outlined in the previous section have contributed to wrong patient selection, wrong side imaging, near misses and repeat and unnecessary biopsies having been undertaken, clinic delays due to constant rebooting of computers, staff frustration and burnout.

4.10 In addition, there is no set process in place to check, prior to patients attending whether patients attending the symptomatic breast imaging service, whether patients have had a mammogram within the last six months. It was noted that the current process involves the mammographer checking this information during the appointment, and requesting imaging where necessary (with images usually arriving within 20 minutes). Adequate booking and PACS administrative resource

needs to be in place to support the creation of one stop clinic patient lists, ensuring either that the date of the patient's previous mammogram has been checked or that if this is not available (e.g. if patients have undergone imaging in the independent sector), that all prospective patients are asked this question. Where prior imaging has been undertaken, patients' images should be requested and integrated into the patient's record *before* their clinic appointment. Because this information is not being requested as part of arranging clinic appointments, there is potential that patients are receiving unnecessary mammograms, resulting in inconvenience and unnecessary irradiation that would require reporting under IR(ME)R, although it was noted that patients would not automatically be re-imaged without prior discussion with the breast radiologist. A revised administrative process, incorporating appropriate safety checks in advance, needs to be put in place.

4.11 Introduction of text message reminders, which evidence suggests could reduce patient DNA (Did Not Attend) rates, was reported as being not feasible due to IT constraints, despite being implemented elsewhere in the Trust, as well as in other organisations with the same IT systems. This reflects a lack of 'can do' attitude within IT within the Trust, and would benefit from being revisited.

Patient flow in one stop clinics

4.12 The review team was able to observe patient flow during the one stop clinic on the Darlington site. The team noted the frustration experienced by colleagues staffing the clinic, in relation to the difficulties that the layout presented for communication between surgeons and x-ray/mammography, particularly towards the end of the clinic to see whether further patients were on their way following mammograms. A suggestion was made for a phone link to be established. The review team observed a similar clinic in operation in Durham, and noted that the EPR system includes a tool called PowerChart, which indicates whether the patient has left the clinic. EPR was reported to be available to all staff across all sites, although patient information is not always up to date. Nonetheless, a consistent approach to PowerChart will offer immediate improved oversight of patient flow for all members of the clinical team who need it. These experiences suggest a need for improved cross-site collaboration and sharing of experiences and good practice.

4.13 The team noted that the location of the one stop breast clinic in Darlington alternates between two different locations (the Women's Centre on Tuesdays and Floor D on Thursdays), which creates confusion for patients and a lack of consistency for staff. It is recommended that a permanent location for the clinic is agreed; the review team recommends the Women's Centre as the preferred site, with the breast ultrasound service being relocated here alongside surgical services. It is noted that investment in a further ultrasound machine would be needed, or alternatively sourcing of complementary machines already in the Women's Centre. The Women's Centre is some distance away from the x-ray department where the mammography and ultrasound service is provided. Women and patients under 40 do not regularly require mammography, so a significant proportion of the clinic could be seen, scanned and discharged in the single breast surgery and ultrasound location.

4.14 The waiting area in the Women's Centre would benefit from a patient-led redesign by the Patient-Led Assessments of the Care Environment (PLACE[6]) team, taking into account patient and visitor feedback. A number of participants in the review commented on how 'unfriendly' the

[6] Patient-Led Assessments of the Care Environment (PLACE)

current facilities are to patients, despite various improvement efforts having taken place over time.

4.15 The review team heard that historically the breast imaging services have operated differently across the Darlington and Durham sites: the Darlington site has had a one-stop clinic offering mammography, ultrasound, and biopsy since around 2005, while the Durham site previously used a multi-appointment pathway with delays between imaging and biopsy. More recently, the Durham site has moved closer to the Darlington one-stop model. There was not sufficient time during the visit to review the outpatient department layout in Durham, but if feasible, consideration of co-locating breast ultrasound to outpatient suites working alongside the surgical team may allow for more optimal flow. Until such time as a decision is made regarding the future configuration and delivery of breast services, implementing the improvements to patient flow and experience highlighted in this section of the report, and continuing efforts to further align service models and sharing best practice across both Darlington and Durham sites will help deliver more efficient, patient-centred care.

Staffing and working practices

4.16 The team noted that there appears to be limited cross-cover and isolated working at both sites. For breast radiology specifically, low staffing levels which are at the threshold of acceptability leave the service vulnerable in case of staff absence, and although steps have been taken to mitigate this risk through appointment of a number of bank radiographers, the extent to which they have been integrated as part of the breast radiology team was unclear. The review team heard from multiple participants that those running breast clinics, particularly the consultant radiographer on the Darlington site, are frequently interrupted during clinic activity due to a shortage of staff on site in the main radiology department. Removing the consultant radiographer from the main radiology department when running clinics (assuming that the team's recommendation to relocate the clinics to the Women's Centre is supported) will help with communication and flow, allows for a dedicated breast imaging resource, and supports more efficient running of the breast clinic.

4.17 Participants in the review shared their perception of a lack of staff in the department on a day-to-day basis due to current home working practices, with pressure on the remaining staff in the department for cover, particularly in relation to interventional procedures. The review team considered that concerns regarding home working potentially reflect a series of related factors that warrant review and (re)communication to the wider department. These include reconfirming an agreed approach to the following:

- Segregation of specialist work
- Permissible interruptions (only when rostered for non-specialist work)
- Directing queries to the most appropriate, available person
- Requesting and considering regular and ad hoc home working to ensure that current working arrangements and rotas enable the delivery of a safe, effective, patient-centred service.

RCR guidance on home working[7] specifically signposts that 'While home reporting offers flexibility and reduced commuting as well as uninterrupted reporting time, an adequate on-site presence remains important to provide leadership for teams and appropriate input for clinical colleagues and trainees.' Current practice across the department, on all sites, therefore needs to be reviewed by the Clinical Director, potentially with HR support, and if necessary revised

[7] Homeworking for radiologists

arrangements need to be agreed that offer greater resilience and ability to more consistently meet the needs of both patients and those services with which radiology regularly interacts.

Organisational structures and systems: Governance

4.18 The review team sought to consider the governance culture within the breast radiology service, and within the Trust more broadly. In pursuit of this aim, the team considered 'governance' to be an umbrella term reflecting the framework of leadership, accountability and assurance that ensures safe and effective care and 'ward to board' reporting. The team considered a number of dimensions of the governance framework that they would typically expect to be in place in a breast imaging service, and in an NHS organisation of this kind, notably:

- The structure, oversight and leadership that is in place.
- The quality assurance and standards that are collectively agreed to be important.
- The culture and behaviours that are demonstrated, and the ways in which these underpin effective and psychologically safe risk and information management.
- The ways in which the system supports and develops those who are in leadership roles and who are driving service development.
- The ways in which senior and executive level managers are fully informed and sighted on what is happening at department or team level.

4.19 The review team also considered what an effective governance framework should feel like 'on the ground', expecting that in such an environment:

- Governance structures and mechanisms would be visible to all staff, who would engage as part of their role and job planned time.
- Staff would understand governance processes, feel safe to raise issues that concern them, and see their input welcomed, valued, and where appropriate, acted upon.
- Decisions would be based on evidence, not assumptions (or on assurance, rather than reassurance).
- Risks would be identified early, acted upon promptly, and learning would be proactively shared.
- Governance would feel like a supportive framework and a shared responsibility.

Structure and oversight

4.20 The review team noted that, currently, no formal governance meetings are in place for breast radiology. It would generally be expected that meetings are in place to regularly review the quality of the services provided (QSI standard XR-604), with clear terms of reference agreed. Participants in the review acknowledged that there is currently a gap and that no regular, minuted breast-specific governance meetings take place, with the lack of available administrative support cited as a key barrier. The extent to which consultant radiologists and the consultant radiographer contribute to formal meetings of this kind within the wider radiology department was unclear (though was not specifically within the terms of reference for the review); no minutes of general radiology department executive meetings were shared, which might have provided clarity regarding how issues and performance in breast radiology are discussed alongside that of other imaging modalities. The review team's primary concern in this regard is the apparent vacuum with regard to opportunities for discussion of: emerging risks and current issues, and options for resolution or escalation; audit findings and local quality improvement action to be taken forward; or discussion of complex or interesting cases to inform planned service improvement. The need to address this gap was acknowledged. Several participants acknowledged the efforts that are

underway to improve communication, support staff wellbeing, and foster a culture of openness where concerns can be raised and addressed effectively.

4.21 Attention should be paid to establishing more regular and structured opportunities for whole-team communication, for example in relation to their collective and individual professional practice, to share learning from engagement with external colleagues or events, or the introduction of huddles. The lack of such meetings, and the lack of a designated lead (see para. 4.23 below) was acknowledged to be a limiting factor in the team's ability to share and discuss practice and ideas for service improvement. Some participants described the breast radiology service as 'vulnerable', 'fragile' and 'struggling', particularly given that consultant radiologists often work alone without trainees, limiting collaborative learning and professional curiosity. Participants generally expressed their hope that the options being considered for future service reconfiguration would encourage better team working and collaboration; that said, some concerns remain that the current vulnerability of the service may enable poor behaviour to go unchecked, though specific examples were not offered to illuminate this comment. There was recognition of stagnation in practices and a lack of dynamism in adopting improvements. The review team heard examples where ideas that individuals had brought back to the unit had not been afforded appropriate consideration, and it did not appear that there were channels that enabled proactive sharing of learning beyond one-to-one conversations. This has left some staff feeling that they do not have the opportunity to influence the development of practice in the service despite seeing good ideas working well elsewhere. Provision of clearer opportunities for such learning and discussion may be a good first step towards addressing this perceived stagnation and remotivating staff to contribute good ideas (see para. 4.30 below). The review team saw examples of appropriate CPD at individual consultant level, but no formal programme of learning for the breast team as a whole that individual respondents could recall.

4.22 The review team was able to consider some information regarding the general Radiology Events and Learning Meetings (REALMs[8]) that take place, though the documentation provided was sparse and it did not appear that cases specific to breast radiology were mentioned. It was acknowledged that a breast-specific REALM needs to be developed, with a view to also addressing safety, protocol standardisation, and quality improvement. Much emphasis appears to be being placed on the development of a breast REALM, alongside a governance meeting, as a single operational solution to the current governance gap. However, the review team noted that, at the time of the review, no terms of reference for either the governance meeting or REALM had been shared with participants. Whilst these meetings are clearly needed to address the evident absence of governance around the breast service, a much more fundamental piece of work remains to be done, particularly given concerns that colleagues have been actively discouraged from reporting incidents and significant events (see para. 4.33). Attention to cultural change as well as operational change is needed to ensure that there is a shared understanding of what good governance looks and feels like so that any operational solutions are well led, meaningfully implemented, and so that staff engagement in governance (in all its forms) can be sustained.

Leadership and mentoring support

4.23 Delivery of the breast radiology service is principally overseen by three substantive consultants: two consultant radiologists and a consultant radiographer, totalling 2.6 WTE. Leadership of the breast radiology service was described by some participants in the review as fragmented, with no clear chain of command. Participants in the review were unclear which of the three consultants, if any, was designated as the breast radiology lead; the key factors contributing to

[8] Standards for Radiology Events and Learning Meetings

this lack of clarity included the tendency for each of the three consultants to work predominantly on a single site, and the differences in delivery at each site, rather than there being a single cross-site approach in place. As such, it was unclear how decisions are made regarding overarching ways of working across the team and across sites, effectiveness and appropriateness of SOPs in place, and audit, peer review and service development activity that needs to be undertaken. There is an absence of realistic succession planning for service leadership or for the consultant body as a whole, presenting a grave risk in terms of the resilience and longevity of the service overall. There are operational links in place between the General Manager and the Lead Mammographer, but it was not clear how they contribute – if at all – to the leadership of the breast radiology service overall. The review team noted that radiology site leads are in place in both Darlington and Durham, but the scope of their leadership roles was unclear, particularly with regard to any decision-making responsibilities they carry, and how the needs of the breast imaging service are represented to the Clinical Director to enable their oversight of emerging and current risks and issues, other than via informal conversations with individual members of staff. Some participants suggested that the site lead roles lacked the broader mandate needed to contribute meaningfully to development of the breast radiology service. Further, there was a lack of clarity around accountability and responsibility for the breast imaging service: Whilst the three substantive consultants are located within general radiology, within the Clinical Specialist Services Care Group, breast clinics and surgery come under the auspices of the Surgery Care Group, resulting in no clear overall leadership of the service.

4.24 The engagement of external breast radiology consultant support from Newcastle-upon-Tyne Hospitals NHS Foundation Trust more recently has highlighted the extant leadership vacuum and has provided much needed direction to efforts to harmonise working practices across the Durham and Darlington sites, and to drive collaboration and effective decision-making. Positive impact is already being felt, particularly in moving towards greater uniformity of approach across sites, and taking decisions where needed. This intervention has demonstrated the value and necessity of having a designated breast lead post in place (QSI standard XR-202). The Trust should re-establish this post and seek to recruit to it, and steps should be taken to ensure that appropriate breast radiology leadership continues to be embedded once the future configuration and delivery of the service is agreed. The postholder will need to be responsible and accountable for short-term service development and engagement across the breast imaging team – including all radiologists and radiographers/mammographers – for continuing to foster collaboration across breast imaging and breast surgery, and for leading breast radiology through the changes that will arise from the service reconfiguration process. They will need the authority and support (including administrative support) to lead the service effectively.

4.25 The Trust should explore opportunities to formalise mentoring support for the future designated lead, once confirmed in post, perhaps via the current external consultant, with a view towards building sustainable internal leadership capacity. The review team notes that this may go beyond the life of the current SLA that is in place with Newcastle. The review team also learned that one of the consultant breast radiologists will be leading the development of the breast-specific REALM and governance meetings, and may benefit from support from a REALM lead in another service as this work develops, as well as the opportunity to observe effective practice in this regard elsewhere. The review team noted that the Clinical Director is engaged with the RCR Clinical Directors' Professional Network, which provides one avenue through which to seek appropriate connections.

Extended practice

4.26 The review team learned about the range of work undertaken in breast radiology as well as in the wider department by those with extended roles, specifically consultant radiographers (both substantive and locum/bank appointments). The team heard reports of a range of practice that is potentially broader than might typically be seen. Consideration of individual competence was specifically excluded from the terms of reference for the review, and it is important to stress that no evidence was seen or reported of a lack of appropriate competence. However, it is expected that the Trust has a clear process in place to support role extension[9] for sonographers, mammographers and radiographers. This includes processes for ensuring that individuals have undergone the appropriate education and training, evidencing the support necessary for individuals to meet the ongoing requirements for consultant-level practice[10] through supervision and professional development, and for documenting and signing off an appropriate scope of practice. The review team considered it unusual for a consultant breast radiographer to undertake such a wide range of other radiological practice, including ascitic drainages and other IR procedures, and CT guided biopsies, which was reported to the review team to be the case. It may well be that these procedures have been documented as being within the scope of practice for this practitioner. Nonetheless, the Trust should a) assure themselves that an appropriate governance and sign off process is in place internally in line with the Centre for Advancing Practice multi-professional framework[11]; b) that it has been followed for all consultant radiographers and any other advanced practitioners within breast radiology and the wider radiology service, whether employed substantively or on a bank/locum basis; c) that the documented scope of practice reflects the range of procedures identified in this report; and d) that day-to-day activities are within the documented scope of practice.

Quality assurance and standards

4.27 Effective governance should be underpinned by a rolling programme of audit of compliance with guidelines, protocols and clinical best practice (QSI standard XR-703), with the outcomes of such audit activity driving sustainable improvements in care. Planned audit activity that is reported in the appropriate fora to the relevant colleagues has the potential to provide regular, structured assurance on the safety, effectiveness, and quality of the breast imaging service.

4.28 The review team saw evidence that some audit activity has been undertaken by one of the consultant radiologists, including efforts to initiate engagement with the BSBR AVOID[12] audit (a national audit to quantify the volume of disease on axillary ultrasound in the axilla, by assessing the cortical thickness and number of abnormal nodes, to support surgical management of the axilla). Similarly, several (though not all) of the Standard Operating Procedures (SOPs) note associated audit and quality assurance measures. However, this did not appear to be part of a rolling programme of activity, and it was unclear whether or how such data would feed into formal consideration of how the service assures itself of the quality of care that is being provided to patients. It was also unclear, in the absence of a formal breast radiology governance meeting or regular whole-team meetings, where and how the team would discuss core measures such as missed cancers and failed biopsies, or updates to external standards and guidelines (e.g. RCR/BSBR[13], NICE) and any implications for service delivery, other than informally.

[9] Education and Career Framework (ECF) (4th edition)
[10] Consultant Level Practice - Advanced Practice
[11] NHS England Centre for Advancing Practice
[12] AVOID - British Society of Breast Radiology (BSBR)
[13] Guidance on screening and symptomatic breast imaging, fifth edition

4.29 The service is a symptomatic-only service and, unlike other services that are part of a combined screening and symptomatic service it is therefore not required to routinely engage with NHS Breast Screening Programme (NHSBSP) standards or screening quality assurance reviews. Efforts are already underway to establish greater alignment with routine quality assurance practices in screening centres, including: working with medical physics to ensure that QA process for breast radiology equipment and monitors replicates that in screening centres; looking at breast MRI image acquisition to ensure that it is optimised and in keeping with screening QA technical guidelines; and supporting the radiologists to opt into taking part in the PERFORMS[14] external quality assurance scheme. Consideration might also usefully be given to engaging with the Screening Quality Assurance Services (SQAS) team from an adjacent local breast screening unit to undertake an annual QA review with a view to strengthening understanding of relevant, key quality metrics across the breast imaging team, validating performance (e.g. in relation to image quality, equipment and compliance with IR(ME)R regulations), and driving continuous quality improvement. However, it is noted that reporting volumes for symptomatic imaging will be low, relative to those seen in screening units, so thought will need to be given to the volume of work that it is appropriate for consideration via such a QA exercise. Appendix 4 of the RCR/BSBR guidance[13] sets out relevant professional standards. Other opportunities to foster collaboration and benchmarking internally and externally should be encouraged.

4.30 As noted above in relation to the development of a breast-specific REALM (see para. 4.22), establishing an agreed programme of audit and peer review activity and a formal forum in which to consider its outcomes is not merely an operational solution to a demonstrable governance gap; it is a crucial element of how structures and systems embed transparency and accountability, record the evidence upon which decisions are based, and provide opportunities for staff to input into that decision making. Establishing evidence-based decision making and an open approach to addressing risk is an essential element of behaviour change that will be needed to drive the organisational reset to which the Trust leadership team aspires. As part of establishing a regular breast radiology governance meeting alongside REALM, formal terms of reference should be developed, and in addition to considering audit (planned programme of work as well as emerging audit and assurance needs) these should incorporate the plans shared with the review team which include: incident reporting and responses (which are currently considered in the general radiology governance meetings); review and update of the risk register; consideration of patient feedback (see para. 4.37 below); compliance with relevant national guidelines; and learning from professional development activities, including good practice observed elsewhere.

4.31 The review team noted during their tour of the Darlington site that radiographers in the department have taken the initiative to implement noticeboards within the radiographer hub, including an audit noticeboard, to improve communication and transparency. A similar approach might be considered for breast radiology to share current performance and priorities for improvement with the wider staff team, taking care regarding positioning of any noticeboards to avoid inadvertently highlighting quality issues to patients as they move through the clinic.

Culture and behaviours

4.32 There must be no impediment to individuals raising concerns, who should expect an active, appropriate response and, where appropriate, confirmation of how that concern will be taken forward. Routinely thanking those who raise concerns and sharing the improvements that have been made as a result, where it is appropriate (in the context of the concern raised) to do so, helps build psychological safety and, over time, will encourage colleagues to feel supported and

[14] PERFORMS | PERsonal perFORmance in Mammographic Screening

empowered to propose ways of delivering a better service and a more positive patient experience. However, it requires consistent messaging from those in leadership positions over the short, medium and longer term, as well as demonstrable behaviour change. As part of the organisation's response to the Aubrey Review, and to prevent further incidence of those raising concerns feeling unheard, there is an urgent need for education of all staff regarding:

- How to respond specifically and appropriately when a member of staff raises a concern; and
- For those reporting a concern, what constitutes an acceptable response and what to do if an acceptable response is not forthcoming (i.e. escalation routes).

Management of concerns, risks and other information

4.33 Throughout the review, the team heard and observed examples of an absence of ownership and accountability for responding appropriately to concerns, with processes for escalating concerns described as 'dysfunctional' by multiple participants. Those participants shared multiple, specific examples of individuals being actively discouraged from recording and/or escalating risks by senior staff with specific leadership and management responsibilities. Whilst the review team is not able to confirm these allegations as matters of fact, the findings of the Aubrey Review would suggest that these claims are likely to have credibility. There is a pressing need to establish a more transparent culture that explicitly encourages the identification and reporting of concerns, underpinned by the reasonable expectation that all such concerns will be listened to, and where appropriate, responded to. The ability to add risks to a centrally-held risk register may offer one way of making issues and concerns visible to senior managers.

4.34 More than one participant described the Care Group level of the organisational hierarchy as a 'wall', beyond which it was rarely acceptable to escalate matters requiring a higher-level response than those within the Care Group felt able to provide. Participants perceived that the Trust's culture has prioritised performance over governance. Specialty teams feel a lack of ownership of their issues, with the Care Group layer of the organisational hierarchy reported as functioning as a barrier rather than a conduit for communication and accountability. Some participants raised concerns that medical engagement has been poor, with a lack of support for those in leadership roles and potentially a lack of clarity around expected leadership behaviours. Risk registers at specialty level were reported by some to have been underutilised or discouraged, hindering visibility of issues and risk mitigation at specialty levels; structures that enable effective specialty-level communication and ownership were felt by some to remain under-developed. The review team also noted, however, that the apparent prevailing culture of suppressing concerns is beginning to shift, with recent staffing changes encouraging open reporting and tracking – although it is reasonable to expect that these changes will take some time to fully embed and to extend to those who remain in leadership roles within the Care Group more broadly.

4.35 The review team had sight of the radiology 'issues log' (though the document file name referred to this as a 'risk register'), which exists outside of the Ulysses system that is used to hold risks, issues and reported events at Care Group level and above. Whilst the scope of the review did not extend to the radiology department as a whole, given that risks relevant to breast radiology would be captured and managed at department level in the first instance, the review team agreed that the current radiology risk register would benefit from redevelopment to support effective, centrally held, and corporately supported risk management and escalation. In particular it would be helpful to include a residual risk score (likelihood x impact once any identified mitigations have been implemented) to assist with prioritisation, and escalation status, to reinforce the value of articulating and recording risks effectively. At present, only five open risks

are recorded for radiology, with just one specific to breast radiology, indicating either lack of concern (over-optimism), lack of understanding of what the risk register is intended to achieve, and/or under-reporting, on the basis of the issues highlighted within this report. It was reported that the departmental risk register/issues log is reviewed at monthly departmental governance meetings, and feeds into the Care Group register; previously, only severe risks were recorded, but it was confirmed by multiple participants that the Trust now encourages documenting all risks to prompt follow-up. There is more work to be done to ensure that staff across all groups feel confident in identifying and documenting risks, reinforcing that risk management is a shared responsibility. However, given that breast services are not managed within the general radiology service, and given that there is currently no breast governance meeting, the current process for identifying, documenting and acting on risks is functionally inadequate for breast radiology.

4.36 Staff should be actively encouraged to report near misses (or safety catches) and all incidents, even if there is no or low harm as a result, e.g. via use of an appropriate system such as Ulysses, or equivalent. This will assist in providing greater visibility of issues that are reported, as well as driving consistency of response, and could usefully support an organisational attitude change towards quality, audit and reflection at both an individual and a service level. A review of reported incidents should be included in the quality meeting as a standing item, to identify any themes or cases where incidents could have been prevented or predicted. It may also assist with identification and reporting of issues and risks that cross departmental boundaries. The review team heard that where risks span multiple services (for example, those related to IT), there is no clearly understood process for oversight of such risks: staff described the practices that are currently in place as 'siloed', and reported that cross-departmental visibility is limited, and coordinated risk management is precluded. A clearer process will need to be defined, communicated to staff, and monitored if appropriate governance oversight is to be attained.

4.37 With regard to information management within breast imaging and within radiology as a whole, there is a need to refresh mechanisms for gathering and acting on feedback from patients, visitors, and staff. The service must work to embed the Friends and Family Test (FFT) so that patient feedback is routinely and actively sought, and the staff team should continue to identify other appropriate means by which patients' voices can be integrated into future service evaluation and development. Mechanisms should be introduced to make it easy for patients to feed back (e.g. QR code, experience pods, text feedback, freepost envelope), and for staff at all levels to consider this feedback, including as a standard agenda item at quality meetings. The Quality Standard for Imaging (QSI)[15] incorporates a number of ways in which working in partnership with patients and their families/carers might be achieved (particularly with reference to XR-1: Information and Support for Patients and Carers) and may therefore act as a useful resource for underpinning any future improvement efforts in this regard.

4.38 The review team would encourage that the clinical team work towards implementation of the QSI standards as part of strengthened governance arrangements and to inform general ongoing quality improvement activity. Where standards are unable to be met, these should be reported and support for implementation sought. Where the relevant QSI standard is underpinned by legislative or regulatory requirements, non-compliance and proposed mitigation should be captured in the risk register. The review team recommends that the service engages the support of the QSI Quality Improvement Partner in working towards adopting these standards where they apply. Clear improvement actions across radiology, including breast imaging, would help to reinforce a vision for ongoing service development, and enhance both the staff and patient experience.

[15] Quality Standard for Imaging (QSI)

Organisational structures and systems: Reporting governance

4.39 Within breast screening services, all mammograms are double reported[16]. No such standard practice is in place for double reporting of symptomatic breast mammograms, but the review team confirmed in clinic that double reporting is undertaken internally by two of the three substantive consultants (i.e. the two consultant radiologists and one substantive consultant radiographer). Surveillance mammograms are reported post-session in draft form and assigned either to another consultant radiologist or to the consultant radiographer for double reporting, a process implemented since June 2025 to improve diagnostic accuracy without the expectation of same-day reporting. The senior leadership team had been under the impression that double reporting was being undertaken by one internal consultant and one external radiologist, but this is not the case. This suggests a need for more precise oversight of actions taken to assure quality, as well as an agreed approach to peer review of reports[17] across the breast radiology team, as well as to resolving discrepancies. The revised approach should be documented within a written procedure.

4.40 The radiology report is the primary professional communication between practitioner and referrer and should meet the same standards of accountability as any formal document. Inclusion of the reporting clinician's name and registration number ensures transparency, facilitates queries, and aligns with NHS expectations. RCR guidance, first issued in 2016 and updated in the 2025 third edition[18], requires identification of name, professional status, grade, position, and registration number within the report. A snapshot review of recent cases at Darlington and Durham revealed that internally reported cases did not display the required information about the reporting clinician in the EPR. There was an assumption by radiology staff that this would be automatically picked up from the RIS into the report seen by hospital clinicians, but this is not currently the case. This issue should be addressed promptly through departmental discussion, agreement, and formal documentation of the solution. The review team identified that this can be resolved through a simple settings change within CRIS. It should be noted that whilst the PACS is changing, the RIS is not, so unless action is taken these issues will persist even once the new PACS is rolled out.

4.41 The use of outsourced reporting is common across UK radiology services[19], but clear governance is needed to determine which cases should be outsourced and which should remain in-house to optimise resources and avoid duplication. The review team noted that outsourcing cancer staging imaging creates inefficiencies, as presenters at multidisciplinary team meetings spend significant time reviewing outsourced reports, the quality of which they do not trust – time that could have been more effectively used for direct reporting. It is recommended that cancer staging cases be retained within the breast radiology team and that a formal approach for other staging work be agreed internally.

4.42 Looking ahead, regional options for collaboration should be developed once the new PACS system is implemented in March 2026, enabling global worklists and improved image sharing. The recent cessation of third-party imaging services supporting private sector one stop breast clinics has freed up funds, which should be reinvested to support service development and address cost pressures.

Organisational structures and systems: Multidisciplinary team meetings

4.43 The review team learned about the changes that have been made to how multidisciplinary team meetings (MDTMs) have been run to address concerns raised in the Royal College of Surgeons'

[16] Guidance on screening and symptomatic breast imaging, fifth edition
[17] Standards for radiology events and learning meetings (peer review)
[18] Standards for interpretation and reporting of imaging investigations, third edition
[19] Clinical radiology 2024 workforce census report

invited review of breast surgery. MDT meetings were split between Darlington and Durham, with poor record-keeping and IT problems that hindered effective communication, particularly with oncology teams dialling in remotely. Behavioural and cultural issues within MDTMs were felt to have contributed to suboptimal outcomes. Improvements have been initiated: MDTMs now operate under the chairmanship of a consultant breast surgeon whose services are provided via a service level agreement with Newcastle-upon-Tyne Hospitals NHS Foundation Trust. The team noted that separate site-specific MDTMs now operate as a single weekly Trust-wide MDTM with a unified structure. Cases are now categorised by discussion type rather than by consultant, improving workflow and providing greater resilience to enable patient cases to be discussed even when an individual consultant is absent.

4.44 All members of the MDT are expected to be in attendance throughout (as far as is possible), connected via videoconference; this has supported a shift to more effective clinical discussion, challenge and decision-making. It is hoped that facilitating greater discussion across the MDT will contribute to building more effective relationships between breast radiology and surgery over the longer term. The change in MDT approach has also encouraged greater involvement by Clinical Nurse Specialists, which some participants indicated had contributed to improved communication and a better patient experience.

4.45 Work has been done to reduce the number of cases put before the MDTM, and to improve outcome recording. Case numbers per meeting currently stand at around 50-60; the review team considers that there may be scope to reduce this further over time. Some participants commented that there is perhaps still over-reliance on the MDTM to support a consensus view, reflecting a potential lack of confidence in independent decision-making among image reporters (e.g. It was reported that abnormal findings are referred back to the MDTM for further clinical management and to agree communication with the patient); this was attributed to the high level of scrutiny that breast surgery, in particular, has been under, and hence there appears to be some reluctance to streamline too much further too quickly. The review team noted that the updated SOP requiring all surveillance mammography reporting disagreements to be referred to the MDTM is overly cautious; such mismatches should instead be resolved within the imaging team through a third reader, with recall to clinic as appropriate, rather than through recourse to MDTM discussion by way of arbitration. Resolving this would contribute to further reducing the MDTM caseload.

4.46 Meetings are held weekly on a Wednesday, with the deadline for submitting cases for inclusion on the agenda being Tuesday at midday. Given the volume of cases, this places MDT coordinators under unnecessary pressure, and limits preparation time for both radiology and pathology teams. Given that further reduction of the number of cases going to the MDTM is likely to be dependent upon cultural change which will take time, the impact on MDT coordinators could be mitigated by bringing the deadline forward to the end of the day on Monday. This would allow a little more time to prepare case lists for circulation to participants and would ensure that cases are available in good time to ensure that those who are presenting cases have sufficient opportunity to prepare.

4.47 Job plans[20] for consultant breast radiologists and the consultant radiographer should also be reviewed to ensure equitable allocation of time for MDTM preparation and attendance. It was noted that where reporting (e.g. for cancer staging) has been outsourced, those presenting the case at the MDTM spend much of their preparation time effectively re-reporting the case (see

[20] Clinical radiology job planning guidance for consultant and SAS doctors 2022

para. 4.41). A more balanced approach to job planning could allow them to undertake the primary report, reducing outsourcing spend.

4.48 The Trust-wide MDTM involves participants located at Darlington, Durham and sometimes Bishop Auckland meeting on site at their respective locations and being connected via videoconference. The review team heard about the technical issues that have impacted the smooth running of MDTMs, including those relating to incompatibility between the video conferencing software used and PACS, with upcoming Windows 11 updates also being cited as a source of concern. Dedicated radiology IT support is no longer in place, and the review team heard different experiences of how available appropriate support is at the different Trust sites. From the MDTM perspective, this has impacted on system reliability and the capacity to share images on screen at all locations, and has at times meant that the MDTM has not been able to start on time, or has taken longer to run than planned. The IT available does not appear to be fit for purpose, and the absence of reliable radiology IT support needs to be reviewed.

Future service reconfiguration

4.49 The ICB and Northern Cancer Alliance shared their intended approach to evaluating models for the future reconfiguration and delivery of symptomatic breast imaging services. CDDFT faces significant breast radiology capacity issues, exacerbated by the discontinuation of independent sector services, which has resulted in a 50% capacity loss as well as increased referrals to neighbouring services. A phased approach is to be taken, focusing initially on the populations of County Durham and Darlington, before considering the extent and nature of any reconfiguration required elsewhere in the ICB's geography, with a series of commissioning principles set out by the ICB following consultation with clinical and operational teams. The principles and options appraisal also seek to take account of feedback from the National Cancer and Patient Experience Survey (NCPES). Specifically, the review team heard that the aims of any proposed new service delivery model need to ensure:

- **Equitable access** for all patients across the County Durham and Darlington geographical area, regardless of geographic location.
- Services delivered **as close to home as possible** whilst ensuring high quality care, reducing variation and promoting equity across the system.
- A stable and **resilient workforce** model that maximises existing skills, supports clinical development and enhances job satisfaction.
- **Futureproofed** breast cancer services to meet rising demand and evolving treatment modalities through strategic planning and capacity building.
- **Cost efficiency** and value driven through shared procurement, reduced duplication, and collaborative **innovation**.
- Embed **continuous quality improvement** and strong **clinical governance**, aligned with regional and collaborative expectations.

The review team notes that there is some tension between these principles and the current challenges faced by CDDFT, as described in this report: significantly reduced capacity, barely adequate staffing, inadequate estate and a lack of governance and leadership. This starting point will necessarily influence the levels of subsidiarity and centralisation present in the options under consideration, and which can reasonably be expected to succeed operationally. It is also noted that the scope for the review to which this report pertains was necessarily limited to breast radiology, and the ICB and CDDFT will have access to additional commentary on the wider systemic issues to inform future decision-making. It should be acknowledged that neither the RCR nor the BSBR sets out a preferred service delivery model for symptomatic breast services: this is a decision to be made by those commissioning services in the context of the specific

patient needs they are seeking to meet, the outcomes they seek to achieve, and the capacity within the system to deliver against those.

4.50 The review team was asked by the ICB and Northern Cancer Alliance to consider two proposed models for the future delivery, which had been developed following local consultation:

- **Option A:** CDDFT would provide a full symptomatic breast service, with clinical governance oversight from a single screening unit to ensure alignment with NHS Breast Screening Programme (NHSBSP) standards[21] and quality assurance[22], with diagnostic and surgical care centralised at a redeveloped Bishop Auckland site.
- **Option B:** One-stop clinics for symptomatic patients would be delivered by CDDFT clinicians at surrounding screening centres – likely one North (Gateshead or Newcastle) for population of County Durham and one South (North Tees) for the population of Darlington – with surgery remaining under CDDFT and delivered from an existing CDDFT hospital site. The relevant screening unit would oversee governance for their diagnostic element. This model is already in place across the Tees Valley geography within NENC.

4.51 Most participants the review team spoke with, favoured centralising services at a redeveloped Bishop Auckland site (option A), and it was generally recognised that consolidating services in some way had the potential to improve sustainability, staff collaboration and consistency of patient experience. The Bishop Auckland site offers an opportunity to address the challenges present in the existing estate, including access to radiological and clinical spaces that currently stand empty, as well as improved parking. Whilst this model provides potential advantages, particularly through unifying the current two-site model and investment in the care environment, the review team considered that the principal risk is that of transferring existing governance issues to a location that is perceived by some participants to be more disconnected than current service delivery locations, and isolated from/less visible to senior managerial oversight. The team considered option A against the ICB's commissioning principles and remained unconvinced, based on the information available, that these would be achieved – unless clear supportive mechanisms are put in place to underpin the effective integration of the staff team on the new site, and to safeguard the delivery of the new service. Likewise, the team considered option B against the stated commissioning principles. This offers potential advantages in relation to workforce sustainability and patient accessibility, though in both examples thought should be given to the potential for increased travel for some patients, and to ways in which this might be mitigated.

4.52 The team would encourage the ICB to explore a third, hybrid model that maintains one-stop clinics and surgery at Darlington and Durham while aligning breast radiology with screening centres and increasing the pool of rotating clinicians. This approach recognises the limitations within breast radiology at CDDFT currently and transfers responsibility for delivering and developing breast imaging services to the relevant partner organisation under an SLA.. Breast radiology staff would hold joint contracts with the partner organisation which would enable them to rotate between the two sites, with radiologists also potentially participating in screening clinics in the partner organisation. Under this model, the breast MDT would be for a combined screening and symptomatic service, which has the potential to have a positive impact in terms of attracting staff to these roles. The review team has limited information at the time of concluding this report as to whether this option had already been assessed in full. The decision rests with the ICB leadership team and CDDFT.

[21] Breast screening programme: standards - GOV.UK
[22] Breast screening: programme specific operating model - GOV.UK

4.53 Across all options, urgent attention is needed to put in place succession planning and a regional workforce strategy to build resilience. It was noted that CDDFT workforce plans include recruiting six radiologists over three years, with at least one dedicated to breast radiology. It will be important, once the preferred service model is agreed, to confirm the full establishment of consultant radiologists and consultant radiographers required to deliver and develop the service and recruit accordingly, allowing for any attrition that might reasonably be predicted. The regional workforce strategy should enable more sustainable provision of symptomatic breast services, with support from and effective integration with screening centres (e.g. through rotation of staff) and a consistent, planned approach to building advanced practice and consultant radiographer roles, as well as to recruiting and retaining breast radiologists. It is acknowledged that these types of role developments take time, and there is no time to lose in the context of the current consultant staff profile.

4.54 The review team noted some potential improvements to equipment that have been signposted over the course of the review, and have heard that requests for new mammography equipment and biopsy units have previously been declined due to cost concerns. The breast radiology team is keen to secure contrast-enhanced spectral mammography as an alternative to breast MRI, given that demand on existing MRI resources is high; it was noted that one of the current mammography units is overdue for replacement and procuring an upgraded unit with contrast enhanced mammography will provide the opportunity to future proof the service. Investment in vacuum-assisted biopsy (VAB) equipment has also been requested though it is unclear that there is sufficient throughput of patients to warrant specific resource investment of this kind on each site. It is the view of the review team that:

- New equipment will only be a worthwhile investment if the breast radiology team is working effectively and sustainably.
- Additional functionality to equipment such as contrast mammography or new techniques such as VAB would require further resource and training which may be limited in the immediate future by the current team's capacity.
- There is a distinction between large volume stereotactic biopsy and large volume excision. It is recognised that practice is largely moving to large volume biopsy of calcifications rather than standard stereotactic core biopsy, and the review supports procurement of large volume biopsy units in both sites.
- Large volume excisions would require a minimum number of procedures to maintain competence. Audit of current volumes and feasibility of investment are recommended. If option A is chosen, centralisation of services may allow such volumes for this activity, whereas option B or C may repatriate these services to supporting screening centres.

Any equipment upgrades that are to be supported should align with the chosen model and be accompanied by the required improvements in team functioning and patient flow.

4.55 The review team recognises that the senior CDDFT team had been in place for only a short time, with the Acting Medical Director still in the very first weeks of his role at the time the review took place. It is acknowledged that the new leadership and governance team that continues to be established in CDDFT is well equipped to provide further reassurance of close oversight of the breast unit whilst a decision regarding future service reconfiguration is being considered, and as the preferred option is rolled out.

4.56 Reaching a decision regarding the preferred future model is evidently a priority for the ICB and regional leadership team to ensure timely, strategic decisions that safeguard service quality and sustainability. The review team noted that the absence of a clear way forward, in consultation

with the senior leadership team in CDDFT, risks impacting on the momentum already generated to support sustainable service improvement. The review team was encouraged to learn of the ICB's intentions to discuss the third option identified above at a meeting of Chief Operating Officers on the day that the review concluded, and looks forward to hearing more about the reconfiguration plan and timeline that is to be put in place.

5. Conclusions and recommendations

The RCR's recommendations below outline the key actions that need to be taken in response to the issues raised in the report and are classified by urgency/priority.

Items marked as 'high priority' are tasks that must be started as soon as possible, even if they will take time to complete. These may include activities like recruiting to new roles, where it is important to begin the process rather than expecting immediate results. Actions marked with an asterisk (in the priority column) are those where the review team has identified a specific critical issue or patient safety implication in the main body of the report.

Medium priority actions are important tasks that should be planned and progressed after the high-priority actions are in motion. These actions matter for overall improvement, but require less urgent initiation. They can be scheduled into regular work plans and developed over time.

Low priority actions are tasks that are beneficial but not time-sensitive. These actions can be picked up when capacity allows or after more pressing work is completed.

Action	Priority	QSI standard
PACS and IT		
1. Confirm PACS system accountability and administration responsibilities (interim i.e. within current resource, and substantive, once PACS Manager is in post).	**High ***	XR-207
2. Address persistent PACS and IT issues, including access to prior imaging, system reliability, and failsafe mechanisms.	**High ***	XR-402
3. Establish accessible and available IT support on all sites	**High ***	XR-304
4. Ensure appropriate health informatics resource is available to accurately and efficiently integrate external imaging to patient records.	**High ***	XR-207
5. Recruit a PACS Manager, and necessary team.	**High ***	XR-202, XR-207
6. Expedite the implementation of the new PACS system by March 2026 and ensure no further delays.	**High**	XR-402
Prevent unnecessary irradiation		
7. Implement a process to check for recent mammograms before booking symptomatic breast imaging appointments, to avoid risk of unnecessary irradiation and comply with IR(ME)R regulations.	**High ***	XR-514, XR-601

Strengthen breast radiology governance		
8. Set up regular, minuted breast radiology governance meetings, with terms of reference that specify audit activities, safety, protocol standardisation, and quality improvement, with appropriate ongoing administrative support.	**High**	XR-603, XR-604, XR-701, XR-703
9. Implement and continue to develop a breast-specific REALM to support shared learning.	**High**	XR-704
10. Develop and deliver a programme of education and training for managers and leaders on how to respond specifically and appropriately to concerns (psychological safety).	**High**	XR-208
Strengthen breast radiology leadership		
11. Appoint a breast radiology lead with authority to drive service development, collaboration, and succession planning, and ensure they have access to adequate administrative resource to support them in their role.	**High**	XR-201, XR-202
Review and update working practices		
12. Urgently review overall capacity, arrangements for interruptions or emergency cover, and homeworking arrangements in the context of ensuring adequate on-site presence, resilience, and safe, effective patient-centred care.	**High**	XR-401, XR-203, XR-208
13. Apply the Centre for Advancing Practice framework to those in extended roles in the non-medical breast radiology workforce, specifically ensuring everyone (substantive and bank) has a defined scope of practice and is fully supported to work within that scope.	**High**	XR-203, XR-204, XR-205
14. Review job plans for equitable allocation of MDTM preparation and attendance time.	**Medium**	XR-203
Improve risk management and reporting		
15. Scrutinise the radiology risk register, improving documentation of escalation status and active management of current risks.	**Medium**	XR-603

16. Foster a culture which encourages consistent reporting of all incidents, including those with no or low harm, using systems such as Ulysses.	**Medium**	XR-603
Improve patient flow and clinic organisation		
17. Designate a permanent location for the one stop breast clinic in Darlington (preferably the Women's Centre) and co-locate ultrasound and surgical services.	**Medium**	XR-401, XR-605
18. Provide radiology staff with training in the appropriate tools to improve patient flow oversight.	**Medium**	n/a
Strengthen audit and quality assurance		
19. Implement a rolling programme of audit and quality assurance, with outcomes discussed, encouraging shared learning.	**Medium**	XR-703
20. Align quality assurance practices with screening centres and adopt regular QA inspections by external teams.	**Medium**	XR-605, XR-703
Improve team collaboration and communication		
21. Establish regular whole-team meetings and opportunities for sharing learning and best practice.	**Medium**	XR-208, XR-604, XR-707
Clarify reporting and peer review processes		
22. Ensure all radiology reports include clinician identification details.	**High ***	XR-508, XR-510
23. Formalise peer review and discrepancy resolution processes within the breast radiology team.	**Medium**	XR-508, XR-703, XR-704, XR-707
Implement service reconfiguration plans		
24. Continue to work with the ICB to enable rapid confirmation of the preferred model and timeline for service reconfiguration.	**High**	XR-605
25. Develop workforce plan (recruitment, retention and development across all roles) in line with planned service reconfiguration, and in collaboration with the ICB and relevant partners.	**Medium**	XR-203, XR-605
Refresh feedback mechanisms		

26. Update processes for gathering and responding to feedback from patients, visitors, and other teams.	**High**	XR-109, XR-511, XR-601
Continue to improve MDT meetings		
27. Address technical challenges with videoconferencing and PACS compatibility, ensuring reliable IT support.	**Medium**	XR-402, XR-601
28. Further streamline MDTM caseload, and adjust submission deadlines.	**Low**	XR-601
Patient-led redesign of waiting areas		
29. Engage the PLACE team to redesign waiting areas based on patient and visitor feedback.	**Medium**	XR-105, XR-107, XR-109
Equipment upgrades		
30. Align equipment investments (e.g., contrast-enhanced mammography, vacuum-assisted biopsy units) with the chosen service model and ensure team functioning and patient flow improvements accompany upgrades.	**Low**	XR-401

6. References

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The Royal College of Radiologists (2020). Standards for Radiology Events and Learning Meetings. (*note: updated standards are expected to be published in 2026*)

The Royal College of Radiologists (2022). Clinical radiology job planning guidance for consultants and SAS doctors.

The Royal College of Radiologists (2022). Service reviews: Process guidance for clinical oncology and clinical radiology.

The Royal College of Radiologists (2023). Homeworking for radiologists.

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The Royal College of Radiologists (2025). Standards for interpretation and reporting of imaging investigations (3rd edition).

The Royal College of Radiologists and the British Society of Breast Radiology (2025). Guidance on screening and symptomatic breast imaging (5th edition).

The University of Nottingham (2025). PERFORMS.

All links accessed and confirmed as correct December 2025.

Appendices

Appendix 1: List of documents supplied by CDDFT

The documents listed below were provided in advance of, during and/or following the review:

IR(ME)R Inspection draft report (June 2025) and action plan (October 2025 update)

Cancer PTL and Performance 2025-26 (November 2025)

SOPs:

- Annual surveillance mammography SOP
- Process for follow up mammography (south)
- Process for follow up mammography (north)
- Undertaking stereo biopsy
- Breast – pathology lab specimen
- Breast theatre specimen trust wide
- Theatre specimen – no mammographer on site
- Process for one stop breast clinic patients (draft)
- Symptomatic breast mammo

Summary of audit and service evaluation activity, plus:

- SCOUT service evaluation (2023)
- AVOID audit emails (2024)
- Benign breast lesions audit (2025)

Breast radiology CPD (for named consultant radiologists)

Bank worker agreements (x 3)

Breast clinic patient information

Breast incident reports and responses (x 2)

Breast MDT attendance (2025 to date) and outcomes (anonymised, last 4 weeks)

Complaints and incidents

Job plans (for named consultant radiologists)

MES equipment list (September 2025)

National Imaging Data Collection 2023-24

Overview of breast radiology improvements

Summary of recent developments in breast radiology service

Policy control sheet

Risk register (October 2025)

Workforce metrics

Breast service overview and process

CDDFT and radiology department overview (November 2025)

Radiology department structure

CSS structure (September 2025)

GIRFT report – breast surgery 2019

Mammogram activity (3 years)

Spire process – transfer of images

Draft SLA for breast radiology support

Breast service principles – regional breast model (NENC ICB document)

Breast services options (v2) (NENC ICB document)

Breast service lookback summary to date

Radiology mammogram review spreadsheet

RCS Invited Service Review – Breast Surgery (April 2025)

External review of governance within the breast surgery service (Aubrey Review, November 2025)

Safe, accountable, effective care (Trust response to Aubrey Review, November 2025)

Appendix 2: Roles of personnel involved in the review

People in the following roles took part in the review (all CDDFT staff unless otherwise stated):

Acting Medical Director
Associate Director of Operations (Clinical Specialist Services)
Associate Director of Medicine for Patient Safety
Chief Medical Officer (North East and North Cumbria ICB)
Clinical Director for Radiology
Clinical Director for Secondary Care (Northern Cancer Alliance)
Cancer Alliance Managing Director (Northern Cancer Alliance)
Consultant radiographers (substantive and bank)
Consultant radiologists
External breast radiology consultant (Newcastle-upon-Tyne Hospitals NHS Foundation Trust)
External breast surgeon (Newcastle-upon-Tyne Hospitals NHS Foundation Trust)
General Manager, Radiology
Radiographers/mammographers (including leads)
MDT Coordinators and administrative staff
Various attendees at breast MDT and colleagues within departments during tours of Darlington and Durham sites

The Royal College of Radiologists