Public Health England

Protecting and improving the nation's health

Quality Assurance report

Countess of Chester Hospital NHS Foundation Trust, Antenatal and Newborn Screening Programmes

17 July 2016

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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Executive summary

The findings in this report relate to the quality assurance (QA) review of the antenatal and newborn screening programme at Countess of Chester Hospital NHS Foundation Trust (COCHFT), held on 8 and 9 June 2016.

1. Purpose and approach to Quality Assurance (QA)

The aim of QA in NHS Screening Programmes is to maintain minimum standards and promote continuous improvement in antenatal and newborn screening. This is to ensure that all eligible people have access to a consistent high quality service wherever they live.

QA visits are carried out by the PHE Screening Quality Assurance Service (SQAS).

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

- routine monitoring data collected by the NHS Screening Programmes
- data and reports from external organisations as appropriate
- evidence submitted by the provider(s), commissioner and external organisations as appropriate
- Information shared with the North West Regional Quality Assurance Service as part of the visit process

2. Description of local screening programme

COCHFT provides hospital and community services to a local population of approximately 445,000 patients per year from an area covering Western Cheshire, Ellesmere Port, Neston and North Wales. The local population is characterised as 85% ‘White British’, 8.6% as ‘White Other’, 0.8% as ‘Chinese’ and 0.9% recorded ‘other’.

Full maternity care, including obstetric services, are provided at COCHFT and serves the population of Cheshire West, with some women from North Wales also choosing to book there (19% of total bookings). ‘Out of area’ pregnant women are able to book at COCFT if they choose to. An independent midwifery provider of NHS maternity services (One to One Midwifery North West Ltd), operate in the area. Some women who book with this provider also book with COCHFT and local commissioning arrangements are in place for these bookings.

Antenatal and newborn screening services provided by the trust are commissioned by the NHS England Cheshire and Mersey Screening and Immunisation regional team. The wider maternity services are commissioned by Cheshire West Clinical

Commissioning Group (CCG). The service specifications for the screening programmes are embedded in the maternity contract which is headed by the Cheshire West CCG.

3414 women booked at COCHFT for their maternity care during April 2014 to March 2015 (2015 Trust annual antenatal and newborn screening report). A local screening coordinator is responsible for the delivery of the antenatal and newborn screening programmes (ANNBSP) in line with national standards, and for the auditable data collection requirements. Furthermore, named leads take responsibility for specific aspects of some of the screening programmes (for example, fetal anomaly screening and newborn hearing screening).

3. Key findings

There is evidence of strong leadership and a committed team delivering screening services to women and their families booking at COCHFT. Through innovative work and a focused desire to continually improve, the ANNB screening programmes function well and good practice is seen throughout the entire pathways (see section 3.1 below). Staff should be commended for their dedication to ensuring quality within the screening programmes and for the structures and processes that are in place. COCHFT demonstrate a commitment to work collaboratively in order to meet and improve upon standards, implement failsafe mechanisms and mitigate risks in order to deliver a quality screening service.

Areas of good practice that are worth sharing, along with high priority issues, are summarised below.

3.1 Shared learning

The review team identified several areas of practice that are worth sharing and considered good practice. Strong leadership and understanding of the screening programmes and pathway has led to the following areas of good practice:

- local tracking audits to demonstrate the highly effective and quality focussed delivery of antenatal and newborn screening programmes
- strong commitment to leadership across all ANNBSP pathways
- demonstrable understanding of the screening pathway across all ANNBSP with committed focus on continued improvements
- development of innovative and focused interventions in order to strengthen failsafe mechanisms and data triangulation
- shared interfaces between the IT in laboratory medicine and maternity to enable electronic transfer of results
- effective triangulation of eligible screening population data and recorded outcome to evidence safe screening pathways

- robust failsafe mechanisms implemented across screening pathways
- linkages between failed nuchal translucency scans and referral to quadruple screen testing
- acquisition of quiet room on maternity unit to assist with effective newborn hearing screening
- blood spot results reports sent from Child Health to GPs

3.2 Immediate concerns for improvement

No immediate concerns were identified by the review team

3.3 High priority issues

The review team identified two high priority issues, as grouped below:

- to ensure the processes around reporting of local incidents includes reporting to the regional screening quality assurance team (SQAS) and the screening and immunisation team (SIT) in line with guidance in the ‘Managing Safety Incidents in NHS Screening Programmes’ (2015) document. Incidents are managed locally, but reporting to SQAS and SIT needs to be reflected in the trust policy and practice
- recording of maternal hepatitis B status and NIPE and NHSP screening tests by CHRD needs to be implemented

4. Key recommendations

A number of recommendations were made related to ‘High Level’ issues identified above. These are summarised in the table below.

Level	Theme	Description of recommendation
High	Test	Implement audit around pre-transfusion samples to evidence full compliance in light of standard breach, on any baby entering neonatal unit.
High	Test	Review second trimester screening coverage with view to complete more screens for those who consent in the first trimester.
High	Diagnose and inform of results	Develop a system to log communications between CHRD and maternity/laboratories when enquiring about blood spot results.
High	Diagnose and inform of results	Enable CHRD recording of hepatitis B status, NIPE and NHSP screens by CHRD.
High	Whole pathway all programme governance	Ensure NHS screening programmes guidance document ‘Managing safety incidents in NHS screening programmes’ is implemented into local policy.
High	Whole pathway all programme governance	Review the current model of training updates and monitoring of competencies for NIPE Practitioners to include identified learning objectives/plan (eg completion of e-learning).

5. Next Steps

This QA visit report will be sent to the Chief Executive of the Countess of Chester NHS Foundation Trust and a wide variety of stakeholders. The Chief Executive should ensure that the report is considered at executive board meetings and an appropriate clinical governance forum.

The Screening and Immunisation Lead in the local NHS England Locality Team will work with the provider to develop an action plan that will address the recommendations made.

The Screening Quality Assurance Service will check on progress against this action plan at regular intervals, and will continue to provide expert assistance to the programme in addressing recommendations.