Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Weston Area Health NHS Trust

14 March 2017

Public Health England leads the NHS Screening Programmes

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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

Antenatal and newborn screening quality assurance (QA) covers the identification of eligible women and babies and the relevant tests undertaken by each screening programme. It includes acknowledgement of the referral by treatment or diagnostic services as appropriate (for individuals/families with screen-positive results), or the completion of the screening pathway.

The findings in this report relate to the QA visit of the NHS antenatal and newborn screening services at Weston Area Health NHS Trust held on 14 March 2017.

Purpose and approach to quality assurance (QA)

QA aims to maintain national 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 comes from the following sources:

- routine monitoring of data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider, commissioner and external organisations
- information shared with the regional SQAS as part of the visit process

Description of local screening service

The antenatal and newborn screening service at Weston Area Health NHS Trust (WAHT) delivers screening to an eligible population of approximately 210,000 living in North Somerset. 60% of the pregnant population is characterised as predominantly white British, with an average age of 32 (April 2015 to March 2016). WAHT is a small maternity service in a district general hospital. Senior midwifery support is provided by University Hospital Bristol NHS Foundation Trust under a service level agreement.

Local screening services are commissioned by NHS England and North Somerset Clinical Commissioning Group (CCG). Services delivered by WAHT include the maternity service, the sonography services for screening for Down's, Edwards' and Patau's syndromes and the 18 to 20+6 week fetal anomaly scan, newborn and infant physical examination and laboratory services for sickle cell and thalassaemia screening. Delivery of this screening service involves interdependencies with other providers for parts of the pathway and all other services have had a quality assurance

review. There are identified leads to coordinate and oversee all the antenatal and newborn screening programmes.

The scope of this QA visit includes the maternity service, the laboratory service for sickle cell and thalassaemia screening, sonography and the newborn physical examination. Interfaces between WAHT and partner providers for the remaining screening services are included within the report.

Findings

This is the first QA visit to this service. The service is patient centred and delivered by a team which is motivated and works well across all disciplines.

Immediate concerns

The QA visit team did not identify any immediate concerns.

High priority

The QA visit team identified two high priority findings as summarised below:

- screen positive referrals from the newborn and infant physical examination screening programme are not tracked to ensure entry into care and treatment services
- key performance indicator data for the newborn and infant physical examination screening programme is not submitted in accordance with the national service specifications

Shared learning

The QA visit team identified several areas of practice for sharing, including:

- a large percentage of the midwifery staff are trained to perform newborn physical examination
- education and training for staff working within the screening programmes is mandatory and all staff attend annually. New staff spend half a day with the screening midwives as part of their induction
- appropriate information on screening services is easily accessible to women via the trust website
- there is a system to ensure all antenatal screening results are checked within 10 days of the test being taken. This includes women who move in to the area during pregnancy

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Timescale	Priority	Evidence required
1	Ensure that signed contracts or service level agreements are in place with all providers and subcontractors	12 months	Standard	Contracts or service level agreements
2	Revise the terms of reference for the Avon antenatal and newborn screening governance group	6 months	Standard	Revised terms of reference to include membership and the management of risk as a core function
3	Revise the terms of reference for the antenatal and newborn screening (clinical) governance group meeting	6 months	Standard	Revised terms of reference to include membership (all parts of the screening programme), accountability, frequency of meetings, review of risks and escalation of issues to commissioners and to the screening quality assurance service
4	Ensure that incidents are reported to screening quality assurance service and to the public health commissioning team	3 months	Standard	Incidents in NHS screening programmes reported to the screening quality assurance service and to the public health commissioning team
5	Ensure the incident management in NHS screening programmes guidance is referenced in Weston Area Health NHS Trust policies	3 months	Standard	Incident management policy implemented and process reflects managing incidents in NHS screening programmes guidance

No.	Recommendation	Timescale	Priority	Evidence required
6	Undertake a risk assessment of a screening sample within the sickle cell and thalassaemia screening laboratory	12 months	Standard	Risk assessment Standard operating procedure detailing journey of a screening sample through the laboratory
7	Revise all screening guidelines to ensure that local practice is in line with current national guidance	12 months	Standard	Revised guidelines which have been benchmarked against NHS screening programme service specifications and standards Cross-reference guidelines with University Hospitals Bristol NHS Foundation Trust
8	Describe processes for managing women through the screening pathway in standard operating procedures	6 months	Standard	Standard operating procedures
9	Ensure standard operating procedures for the sickle cell and thalassaemia laboratory reflect current work practice and national guidance	12 months	Standard	Revised standard operating procedure
10	Produce a guideline to ensure pregnant women with pre-existing diabetes are referred for eye screening	6 months	Standard	Guideline
11	Develop and formally agree an audit schedule	12 months	Standard	Audit schedules, written audit reports and arising action plans available for the maternity, sickle cell and thalassaemia screening laboratory and the sonography service
12	Undertake a user satisfaction survey specific to antenatal and newborn screening pathways	12 months	Standard	User satisfaction survey completed and presented to the antenatal and newborn screening (clinical) governance group meeting

Infrastructure

No.	Recommendation	Timescale	Priority	Evidence required
13	Ensure there is adequate resource within the screening teams to implement the requirements of each screening programme	6 months	Standard	Documented work force plan including succession planning within the maternity and sonography departments and the sickle cell and thalassaemia screening laboratory Risks which are identified due to staffing shortages are recorded on the trust risk register
14	Review the process and the time allocated for 18 to 20+6 week fetal anomaly scans	6 months	Standard	Outcome of review
15	Ensure the role and functions of the screening support sonographer can be fulfilled	6 months	Standard	Job description Evidence of protected time within the work rota Image review documentation for first trimester screening
16	Ensure all staff involved in undertaking first and second trimester screening within the sonography department complete the required e-learning modules in line with the fetal anomaly screening programme requirements	12 months	Standard	Training records for staff

Identification of cohort – antenatal

No.	Recommendation	Timescale	Priority	Evidence required
17	Develop a process to ensure that women who have a miscarriage or termination receive screen positive results	6 months	Standard	Revised guideline

Identification of cohort – newborn

No.	Recommendation	Timescale	Priority	Evidence required
18	Develop a process for obtaining NHS numbers for babies in the event of failure of the maternity IT system	6 months	Standard	Standard operating procedure
19	Ensure the NIPE SMART system is used to its full potential to allow oversight of the programme and collection and reporting of key performance data	3 months	High	Submission of key performance data for NP1
20	Ensure there is a documented process for the maternity service to notify child deaths to all key stakeholders	6 months	Standard	Standard operating procedure for the notification of deceased babies with roles and responsibilities clearly outlined

Invitation, access and uptake

No.	Recommendation	Timescale	Priority	Evidence required
21	Develop a strategy for identifying vulnerable women	12 months	Standard	Support processes for vulnerable women are documented within the screening guidelines

No.	Recommendation	Timescale	Priority	Evidence required
22	Develop a process for monitoring declines of newborn blood spot screening	6 months	Standard	Standard operating procedure including clear communication pathways between the screening service, primary care and the child health records department

Sickle cell and thalassaemia screening

No.	Recommendation	Timescale	Priority	Evidence required
23	Document timescales for counselling of screen positive women for sickle cell or thalassaemia and subsequent referral to the fetal medicine service	12 months	Standard	Standard operating procedure

Fetal anomaly screening

No.	Recommendation	Timescale	Priority	Evidence required
24	Audit the referral pathway for screen positive women from the fetal anomaly screening programme to ensure that women are seen at the fetal medicine unit within 5 working days	12 months	Standard	Action plan following audit discussed at the antenatal and newborn screening (clinical) governance group meeting

Newborn and infant physical examination

No.	Recommendation	Timescale	Priority	Evidence required
25	Develop a system to monitor referrals and track outcomes for babies who screen positive for any of the 4 conditions identified by newborn physical examination	3 months	High	Submission of key performance data for NP2 Screen shot of tracking system Standard operating procedure in place for managing the tracking process with roles and responsibilities clearly outlined
26	Ensure there is a systematic process for review of all unexpected screen positive results in newborn sickle cell disease and newborn physical examination screening programmes by a multidisciplinary group	12 months	Standard	Terms of reference for the group Minutes of meetings demonstrating discussion, learning and action planning

Newborn blood spot screening

No.	Recommendation	Timescale	Priority	Evidence required
27	Ensure a process is in place to give results of other conditions screened for to parents, where a baby has one screen positive result for newborn blood spot screening	6 months	Standard	Standard operating procedure for the management of results for babies with clearly defined roles and responsibilities outlined
28	Implement and monitor a plan to meet the acceptable level for the key performance indicator for newborn blood spot screening for babies who move in to the area (NB4)	6 months	Standard	Action plan that is agreed and monitored at the Avon antenatal and newborn screening committee Submission of key performance data for NB4

Next steps

The screening service provider is responsible for developing an action plan in collaboration with the commissioners to complete the recommendations contained within this report.

SQAS will work with commissioners to monitor activity/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. After this point, SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.