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England



Protecting and improving the nation's health

# Screening Quality Assurance service report

## Observations and recommendations from visit to East Cheshire NHS Trust on 14 September 2016

9 November 2016

**Public Health England leads the NHS Screening Programmes**

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading 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 4 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 East Cheshire NHS Trust (ECNHST), held on 14 September 2016.

## 1. Purpose and approach to Quality Assurance

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

East Cheshire NHS Trust (ECNHST) provides hospital and community services to a local population of approximately 450,000 within eastern Cheshire, the wider geographical area of central Cheshire and cross borders including a number of women choosing to book from Staffordshire and Derbyshire. The maternity service, including obstetric services, are provided at Macclesfield District General Hospital (MDGH) which includes a midwife led unit. No cross border issues have been identified.

The local catchment area for the trust in East Cheshire for the ante natal screening programme eligible population is approximately 2000 women. The maternity service booked 1,998 women for pregnancy care between 1 April 2015 to 31 March 2016 with 1809 babies born of which 12.5% were out of area women from the surrounding areas. Of those women booked, 93.1% were booked by 12+6 weeks gestation. For 2015 to 2016, 55% of women were booked by 10 weeks gestation. The age range of women at booking is 14-50 years. The mean age of women booked at East Cheshire NHS Trust is 30 years old. 25% of the booked population are aged 35 or over. The home birth rate for 2015 to 2016 is currently 1.4%.

The pregnant population at MDGH is mostly of white British background with a limited ethnic variation; this has remained fairly static since last year. For the period 1 April 2015 to 31 March 2016, the interpreting services were accessed for 23 individual women on 60 occasions. Interpreters for 11 different languages were requested, the majority for Polish speaking women. One woman required a sign language interpreter. The interpreting service 'The Big Word' is utilised by the maternity and the newborn hearing screening teams.

There are identified leads to co-ordinate and oversee the antenatal and newborn screening programmes within ECNHST for maternity and sonography. There are also local managers for the hearing screening programme and for the child health information service. ECNHST does not undertake CVS diagnostic testing, but does perform some amniocentesis procedures. Women are referred to the Fetal Medicine Unit at Central Manchester Foundation Trust (CMFT) for specialist care.

Delivery of the screening services involves interdependencies with other departments and providers for parts of the pathway:

- analysis of newborn blood spot samples is provided by Alder Hey NHS Foundation Trust, Liverpool
- analysis of the biochemical markers and risk calculation for Down's syndrome screening (T21) and for Edward and Patau's syndromes (T18/T13) screening tests are performed at the Wolfson Institute of Preventative Medicine, London: the sonography service for Down's syndrome screening and the 18-20+6 week fetal anomaly scan is provided by ECNHST
- laboratory services for the infectious disease programme are provided by ECNHST
- analysis of samples for the confirmation of the infectious diseases programme is performed at the PHE laboratory Manchester
- the child health records service which covers two maternity providers, is provided by East Cheshire NHS Trust
- laboratory services for sickle cell and thalassaemia are provided by Mid Cheshire NHS Foundation Trust
- when required tertiary referral for fetal medicine services are provided by St Mary's Hospital Central Manchester NHS Foundation Trust

### 3. Key findings

There is firm evidence of a committed team with effective communication delivering screening services to women and their families in the East Cheshire area. Staff involved with the screening programmes should be commended for their commitment to ensure a high level of quality for the structures and processes that are in place. It is evidenced that there are several examples of notable best practice with individual components of the screening programmes functioning well. The management of women and babies with screen positive results meets national standards.

Commissioners and ECNHST demonstrate a commitment to work collaboratively to mitigate risk and deliver a quality screening service. There are identified leads to coordinate and oversee the screening programmes.

Key performance indicators (KPIs) for the NHS screening programmes indicate that the provider met the achievable level for: all hepatitis B screen positive women seen by a consultant within 6 weeks (ID2); ID1 the number of women tested for HIV with conclusive result and the newborn hearing screening KPI NH1, in the 4 quarters prior to the visit. The newborn hearing screening team maintain a high achievable level for the newborn hearing KPI NH1 with 99% data submission.

The newborn hearing screening team are firmly embedded into the maternity unit and are a noted valued team with well functioning lines of communication to keep the local manager fully informed. NHSP national quality standards are met or exceeded.

There was no submission for the KPI's NB1 and NB3 (now NB4) in quarter one. The avoidable repeat rate for newborn blood spot screening of 3% (NB2) is outside the acceptable level of <2%.

The child health records department (CHRD) has identified problems with the current information system which does not have a robust failsafe to ensure all older movement into ECNHST have a screening offer before the age of one year. A service review has been commenced by the commissioners in 2016 and a compliancy paper is now in operation. An action plan has been developed to map the compliancy of the existing system PARIS to the national service specification for child health informatics systems as an interim measure. A new CHRD IT system, EMIS Web, has been procured to deliver against the national service specifications and standards. However, no definitive date has been given for this to be launched and go live.

The high priority issues are summarised below as well as areas of good practice.

### 3.1 Shared learning

The following areas of best practice were found at the QA visit by the professional and clinical advisors:

- NHSP services are extremely parent/carer centred approach with the option a flexible 'drop-in' out patients facility on the childrens ward and SMS text reminder appointment system (Envoy messenger)
- early access to maternity care new initiative 'first point of care' telephone process for women to call a dedicated line to discuss their care and their booking appointment is automatically generated and given at this stage
- care of vulnerable women is supported by clear policies and pathways and is evidence with a screening specific equality audit

- robust electronic system which can track an individual at any point along the screening pathway
- comprehensive electronic failsafe process for minimising risk of missed quadruple testing within the fetal anomaly screening programme
- monthly dashboard audit by NICU team and communicated to NHSP local manager to ensure all babies admitted for >48 hours are under correct protocol for screening and comprehensive risk factor for hearing form completed for every baby (this acts as a failsafe for babies who meet the targeted follow-up criteria and excluded babies referred directly to audiology)
- NHSP screen results are populated on CHRD IT interface
- evidence of effective communication between the local health visiting service and NHSP team regarding any missed appointment follow ups
- notable improvement in the ultrasound sonographers Down's Syndrome Quality Assurance Support Service (DQASS) with evidence of local action plan evidence to improve the flag status of some sonographers from red which has resulted in all green/amber flags in the last two cycles
- there is a culture of audit within the laboratories and the maternity service with evidence of action plans and shared learning
- regular quality reports and turnaround times displayed on the pathology department dashboard
- failsafe reports are produced by both the haematology and microbiology laboratories are timely and contain information to enable the screening midwife to check for repeat samples to be taken

### 3.2 Immediate concerns for improvement

The review team identified no immediate concerns during this QA visit.

### 3.3 High priority issues

The review team identified two high priority issues, as grouped below. Please see section 4 for related recommendations:

- ensure the CHRD IT system and policies provides functions in line with the national service specifications and national standards
- compliance with Royal College and Obstetricians guidance for the number of in-house amniocentesis testing to uphold the quality and competencies of the single practitioner; risk of referral timeline of five days not always assured for women requiring fetal medicine care at CMFT
- avoidable repeat rate for the newborn blood spot screening is outside the acceptable level of <2% and a remedial action plan requires development by the screening team

## 4. Key recommendations

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

| Level | Theme                              | Description of recommendation   |
|-------|------------------------------------|---|
| High  | Identify and inform population     | Progression of commissioner led compliancy paper for the functionality of the CHRD system with action plans in place for interim solution embedded into practice to minimise screening safety incident risk |
| High  | Intervention treatment and outcome | Review contract or service level agreement with CMFT for the fetal medicine care to aid the monitoring of the quality of the service that all women are seen within the recommended five days               |
| High  | Test                               | Ensure progress against the strategy to reduce the avoidable repeat rate for newborn blood spot screening   |
| High  | Identify and inform population     | Ensure child health record department provides functions in line with national service specifications and standards   |
| High  | Governance                         | Progress with plans to restructure the child health records department to ensure capacity of staffing positions for service deliver and support of local functions  |

## 5. Next steps

This QA visit report will be sent to Chief Executive of the East Cheshire NHS 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 North will monitor progress against this action plan at regular intervals, and will continue to provide expert assistance to the programme in addressing recommendation.