Public Health England

NHS

Quality Assurance report

Antenatal and Newborn Screening Programmes. Observations and recommendations from visit to University Hospitals of Morecambe Bay NHS Foundation Trust on 28 and 29 September 2016

13 December 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 programmes held on 28 and 29 September 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 Regional QA service as part of the visit process

2. Description of local screening programme

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) is a large acute hospital provider serving the population of South Cumbria and North Lancashire.

ANNB screening programmes are commissioned through the Maternity Payment Pathway. The Commissioning Support Unit coordinates this commissioning arrangement on behalf of the local Clinical Commissioning Groups (CCGs). Lancashire Clinical Commissioning Group is the lead CCG for maternity services within UHMBFT. The lead commissioning team for screening is the NHS England North (Lancashire) Screening and Immunisation Team.

The trust provides services from three principal sites: Furness General Hospital (FGH) in Barrow; Royal Lancaster Infirmary (RLI) in Lancaster and Westmorland General Hospital (WGH) in Kendal. The trust serves a population of 365,000, which covers South Cumbria, North Lancashire and surrounding geographical areas.

Furness General Hospital and Royal Lancaster Infirmary provide consultant led obstetric services. There is a level two neonatal unit at the RLI, and a special care baby

unit at FGH. Westmorland General Hospital provides a stand-alone midwife led unit NHS antenatal and newborn screening services are provided by the maternity services at all three hospital sites.

3. Key findings

The immediate and high priority issues are summarised below as well as areas of shared learning. For a complete list of recommendations, please refer to the related section within the full report, or to the list of all recommendations at the end of this report.

3.1 Shared learning

The review team identified several areas of practice that are worth sharing:

- robust management of the newborn blood spot failsafe information technology (IT) system for babies requiring repeat blood spot screening samples
- robust management of the newborn infant examination failsafe IT system for babies requiring repeat blood spot screening samples
- gap analysis and service review of CHRD Cumbria leading to improved practice and protocols
- excellent leadership across obstetric ultrasound service trust wide
- obstetric ultrasound service review identifying shortfalls and gaps
- appointment of assistant screening practitioner to support local screening coordinator
- strong relationships with neighbouring trusts that led to increased availability of onsite amniocentesis testing by visiting consultant
- strong relationships between the local screening coordinator and NHS England Screening and Immunisation team

3.2 Immediate concerns for improvement

The review team identified two immediate concerns. A letter was sent to the Chief Executive of UHMBFT on 30 September 2016, asking that the following items were addressed within seven days:

- checks required on equipment used for hearing screening were not compliant with national standards
- there was an absence of robust data and tracking systems to provide assurance that the cohort eligible for screening is identified, screened appropriately and timely results communicated

A response was received on 6 October 2016 providing assurance that the risks identified were being appropriately addressed with a comprehensive gap analysis

completed and action plan developed. UHMBFT have engaged fully with SQAS, national team and commissioners to mitigate the risks. The local screening coordinator and assistant screening practioner undertook a full screening service review to ensure immediate concerns were addressed with fully compliant action plans in place.

3.3 High priority Issues

The review team identified nine high priority issues, as grouped in themes below:

- oversight, management and accountability within the newborn hearing screening programme
- safety of the newborn hearing screening programme (addressed in immediate concerns)
- identification of cohort screening population
- triangulation of data (eg auditable tracking of consented screening tests, tests taken and results received; valid KPI data across all screening programmes)
- implementation of robust failsafe mechanisms across entire screening pathway (action plan developed in response to immediate concerns)
- implementation of a robust appointment system in obstetric ultrasound
- review lack of available rooms and machines in obstetric ultrasound to offer scheduled appointment times in line with national standard
- review lack of administrative support in obstetric ultrasound
- review outdated guidelines and standard operating procedures which sometimes fails to reflect current UK National Screening Committee (UKNSC) standards, guidelines and recommendations

4. Key recommendations

Level	Theme	Description of recommendation
Immediate	All	NHSP review to meet national quality standards for screening
Immediate	All	Gap analysis of ANNB screening programmes to enable matched cohort data and tracking of test and results through pathway
High	Identify and inform population plus uptake of screening programmes; Test	Introduce a system to identify the eligible cohort of women for each antenatal screening test. To provide assurance that all women are offered screening and those that declined screening are identified for each test to enable appropriate follow up
High	Diagnose and inform of results	Further develop the system to identify eligible cohort order to allow tracking of those women to ensure each woman who wishes to be screened has a screening result available within a timely manner
High	Identify and inform population plus uptake of screening programmes; Test	Review the failsafe for the fetal anomaly screening pathway to assure the scan appointment booking process identifies failed/lost/missing requests
High	Whole pathway all programmes, Governance	Review Trust antenatal and newborn screening guidelines to reflect current NHS service specifications and programme standards
High	Whole pathway all programmes, Governance	Reinstate the local ANNB screening board with terms of reference and representation from all six programmes, laboratory and CHRD

5. Next steps

UHMBFT are responsible for developing an action plan within six weeks to ensure completion of recommendations contained within this report.

Public Health England North Lancashire Screening and Immunisation locality team will be responsible for monitoring progress against the action plan and ensuring all recommendations are implemented.

The Regional Screening QA Service will support this process and the ongoing monitoring of progress.