Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Great Western Hospitals NHS Foundation Trust

13 September 2016

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 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 or families with screen positive results), or the completion of the screening pathway.

The findings in this report relate to the quality assurance visit to the Great Western Hospitals NHS Foundation Trust antenatal and newborn screening service held on 13 September 2016.

Purpose and approach to quality assurance (QA)

Quality assurance (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 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 south regional SQAS as part of the visit process

Description of local screening service

The antenatal and newborn screening service at Great Western Hospitals NHS Foundation Trust (GWH) delivers screening to an eligible population of approximately 217,100 people. The local population is characterised as 95.2% white, 1.3% Indian and 3.5% other.

Local screening services are commissioned by Swindon Clinical Commissioning Group on behalf of NHS England South (South Central). Services provided at GWH include laboratory services for sickle cell and thalassaemia and infectious diseases in pregnancy screening; and the sonography service for first trimester screening and the 18 to 20+6 week fetal anomaly scan.

Delivery of the service involves interdependencies with other providers for parts of the pathway and laboratory services for Down’s syndrome and newborn blood spot

screening. When chorionic villus sampling is required for prenatal diagnostic testing, services are commissioned outside of the trust. The newborn hearing screening programme is a community model managed by GWH and delivered by health visitors employed by Virgin Care Limited and by Swindon Borough Council. Child health information services are provided by Swindon Borough Council.

There are identified leads to coordinate and oversee the screening programmes including clinical leads for fetal anomaly, newborn physical examination and hearing screening.

Findings

The overall impression is of a committed team with effective communication delivering a screening service to women and their families. The management of women and babies with screen positive results meets national standards. Key performance indicators for the NHS screening programmes indicate that the trust met the achievable level for coverage for sickle cell and thalassaemia, HIV and newborn hearing screening in the four quarters prior to the visit.

Immediate concerns

The review team identified no immediate concerns.

High priority

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

- the child health information service is being re-procured from six providers to one and this may introduce risk to the local screening service
- risks relating to screening services are recorded on the trust risk register under one screening heading, which may lead to an individual issue being overlooked
- the trust incident management strategy does not reference the national guidance for managing incidents in NHS screening programmes. Incidents are not managed in line with this guidance or reported to commissioners and the screening quality assurance service once identified within the trust
- the hearing screening service is currently without a local manager. Whilst interim arrangements are in place with other professionals performing local manager tasks this is not a long-term solution. The performance of the service may be affected by insufficient senior management cover
- there is no system which identifies and tracks women who are eligible for fetal anomaly screening (18 to 20+6 week scan)
- the trust has chosen to implement a local system to identify and track the eligible population for newborn physical examination screening. This system has recently

been implemented and needs to be closely monitored to ensure that the functionality meets the requirements of the national screening programme including completion of screening within 72 hours and timely referral following hip examination into treatment
- the child health department does not currently provide all functions in line with the national service specifications. The department is not informed of the completed newborn physical examinations and results are not recorded on the information system. There is also no provision within the department to identify the eligible population for screening if IT systems are unavailable
- the haematology laboratory does not hold a valid United Kingdom accreditation service (UKAS) certificate

Shared learning

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

- weekly meetings between the screening and immunisations lead and the public health commissioning team, where performance and risk within the local screening services is a standing agenda item
- there is a generic standard operating procedure for many of the functions of the screening team which supports resilience within the screening service at Great Western Hospital
- a weekly failsafe is in place to cross check the booked cohort of women with antenatal screening results. Any woman with missing results identified is followed up by the screening team and remains on an active list until all results are obtained
- four members of staff are available to oversee the failsafe systems
- information that is available on the trust website regarding all of the screening programmes is easily accessible to both women and staff, and includes a link to a YouTube video of women discussing their screening options. The national hearing screening website can also be accessed from the trust screening page
- the child health records department is able to export a copy of the newborn blood spot results from the information system to the GP IT system

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Timescale	Priority *	Evidence required
1.1	Review the terms of reference for the antenatal and newborn screening programme board to include membership, expectation of attendance, oversight of incident management and escalation of issues	6 months	Standard	Revised terms of reference
1.2	Ensure contracts are in place for externally commissioned services, to support monitoring of the screening service	6 months	Standard	Agreed contracts in place for the external screening laboratories and the newborn hearing screening service
1.3	Strengthen processes to encourage more engagement between NHS England and CCG commissioners	6 months	Standard	Screening programme board minutes
1.4	Ensure process mapping and risk mitigation for the re-procurement of the child health records service is in place as it moves into the implementation phase	6 months	High	Risk register Communication plan shared with the antenatal and newborn programme board
1.5	Ensure engagement of all stakeholders within the screening programmes at the antenatal and postnatal forum	6 months	Standard	Revised terms of reference Minutes from meetings
1.6	Review the current terms of reference for the multidisciplinary team meeting to ensure screening and associated complexities of unexpected screen positive results for newborn screening are standing agenda items	6 months	Standard	Revised terms of reference, minutes from meetings

No.	Recommendation	Timescale	Priority *	Evidence required
1.7	Include screening as a standing item within the agenda and terms of reference for the microbiology laboratory meeting	6 months	Standard	Revised terms of reference, minutes from meetings
1.8	Ensure risks within the screening programme are documented on the risk register individually and assessed to improve appropriate follow up	3 months	High	Risk register
1.9	Ensure the trust incident management strategy references managing safety incidents in NHS screening programmes	3 months	High	Updated incident management policy implemented and process reflects managing incidents in NHS screening programmes guidance
1.10	Review all screening pathways to ensure they reflect current national recommendations	6 months	Standard	Revised guidelines which have been benchmarked against NHS screening programme service specifications and standards
1.11	Establish an annual audit schedule and ensure there is a systematic process for audit of antenatal and newborn screening pathways. This should include failsafe audits to ensure entry into care for screen positive cases	12 months	Standard	At least two audits completed with action plans presented at the antenatal and newborn programme board meeting
1.12	Undertake vertical and horizontal audits of screening samples in the sickle cell and thalassaemia screening laboratory	6 months	Standard	Audits completed detailing findings and action plan presented at the antenatal and newborn programme board

Infrastructure

No.	Recommendation	Timescale	Priority *	Evidence required
2.1	Review the staffing resource within the screening team to ensure the requirements of the NHS screening programmes are fulfilled	6 months	Standard	Documented workforce plan including succession planning
2.2	Undertake a staffing review of the haematology department to ensure that professionally qualified staff are available for supervision of new staff in training and there is resilience at times of shortage to meet the requirements of the screening programme	6 months	Standard	Documented workforce plan including training plan for new staff
2.3	Progress recruitment to the hearing screening local manager post	3 months	High	Local manager in post
2.4	Develop a training plan for members of staff within the hematology and microbiology laboratories involved in the screening pathways	6 months	Standard	Training plan in place and attendance at training/completion monitored for all relevant laboratory staff
2.5	Ensure competency reviews for all hearing screeners are completed and incorporate training needs into the site training plans	12 months	Standard	Competency assessments and updates in place and attendance monitored for all hearing screeners
2.6	Formalise competency assessments for practitioners undertaking newborn physical examination screening	12 months	Standard	Competency assessments and updates in place and attendance monitored for all NIPE practitioners
2.7	Ensure an agreed capital replacement programme is in place for the re-provision of ultrasound machines	12 months	Standard	Programme for replacement of ultrasound machines in place

No.	Recommendation	Timescale	Priority *	Evidence required
2.8	Ensure equipment replacement within the hearing screening service is funded through local arrangements	3 months	Standard	Funding streams in place for hearing screening equipment replacement

Identification of cohort – antenatal

No.	Recommendation	Timescale	Priority *	Evidence required
3.1	Develop a system which identifies and tracks women who are eligible for fetal anomaly screening (18 to 20+6 week scan) to include referral for screen positive cases	3 months	High	System implemented Failsafe processes defined and documented to include identification of the eligible population, offer, acceptance or decline, results and onward referral if appropriate

Identification of cohort – newborn

No.	Recommendation	Timescale	Priority *	Evidence required
4.1	Audit the system used to identify and track babies who are eligible for newborn physical examination to ensure it meets the requirements of the national screening programme including tracking babies to completion of screening within 72 hours and timely referral into treatment	3 months	High	Completed audit and action plan presented to the programme board Key performance data submitted for quarter 2, 2016 – 2017
4.2	Ensure the child health records department provides functions in line with the national service specifications including failsafes	3 months	High	Child health records department contract performance indicators Failsafes in place to identify the eligible population for screening if IT systems are unavailable Documentation of results for newborn physical examination

Invitation, access and uptake

No.	Recommendation	Timescale	Priority *	Evidence required
5.1	Review the local policy for the re-offer of infectious disease screening for women who decline screening at booking	3 months	Standard	Revised policy in place

Sickle cell and thalassaemia screening

No.	Recommendation	Timescale	Priority *	Evidence required
6.1	Ensure the application for United Kingdom accreditation service (UKAS) certificate for the sickle cell and thalassaemia screening laboratory is achieved and escalate within the trust and to the commissioners if this review is delayed	3 months	High	United Kingdom accreditation service certificate
6.2	Update the standard operating procedures for the sickle cell and thalassaemia screening laboratory to ensure that they reflect current practice and are accessible to all relevant staff members	6 months	Standard	Revised standard operating procedures

Fetal anomaly screening

No.	Recommendation	Timescale	Priority *	Evidence required
7.1	Review the facilities within the day assessment unit to ensure women have access to a private area for counselling	12 months	Standard	Facilities review ensures women have access to a private area for counselling

Newborn hearing screening

No.	Recommendation	Timescale	Priority *	Evidence required
8.1	Investigate and rectify the cause of high referral rates from automated oto-acoustic emission (AOAE)1 to AOAE 2 and low yield in the hearing screening service and implement an action plan to address issues	6 months	Standard	Investigation undertaken and action plan developed Evidence of improvement monitored by the screening and immunisation team
8.2	Develop a singular system to follow up children who are being monitored outside of the screening programme to ensure records within the eScreener Plus (eSP) IT system are current and can be closed in line with national recommendations	6 months	Standard	Report from eSP evidencing appropriate current cases

Newborn blood spot screening

No.	Recommendation	Timescale	Priority *	Evidence required
9.1	Ensure a process is in place to give results to parents of other conditions screened for, where a baby has one screen positive result for newborn blood spot screening	6 months	Standard	Documented process for ensuring parents receive results for all newborn blood spot screens
9.2	Review the process for offering newborn blood spot screening to movers in under one year old to ensure that screening is completed and results are recorded on the child health information system within 21 days of the baby being notified to the child health records department	6 months	Standard	Monitor performance of KPI NB4 Take remedial action if fail to meet the acceptable standard

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.