Public Health England

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Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes
North Cumbria University Hospitals NHS Trust

11 July 2019

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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 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. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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Published:
PHE publications
gateway number: GW-859

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

The findings in this report relate to the quality assurance visit of the North Cumbria University Hospitals NHS Trust screening service held on 11 July 2019.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in antenatal and newborn (ANNB) 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:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-review telephone calls to child health at Cumbria Partnership NHS Foundation Trust on 27 June 2019
- information shared with the North West regional SQAS as part of the visit process

Local screening service

North Cumbria University Hospitals NHS Trust (NCUH) serves a population of approximately 320,000 across a large geographical area with 51% of residents living in rural settings. It also provides services to parts of Northumberland and Dumfries and Galloway.

All 6 NHS antenatal and newborn screening programmes are offered to pregnant women booking at NCUH and identified leads coordinate and oversee the antenatal and newborn screening programmes.

Acute and high risk maternity services are provided at NCUH with tertiary referral links to The Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH).

Between 1 April 2017 and 31 March 2018 3,101 women booked for maternity care with the trust, with 2,811 births recorded.

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 3 high priority findings, summarised as:

- there is no system in place to provide auditable assurance of end to end tracking of completion of screening for the eligible population
- limited strategic oversight and leadership for the screening support sonographers
- there is no process described to monitor training requirements and compliance for obstetric ultrasound staff

Shared learning

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

- use of video conferencing with the tertiary referral unit for case reviews in real time in the fetal anomaly screening programme where travel is difficult for women
- video conferencing is promoted to engage staff across the sites at NCUH and allow participation in the local screening board meetings
- actions and service quality improvements are overseen by a monthly local antenatal screening committee that is in addition to the quarterly local screening board
- the screening team present screening incidents or case investigations at the trust patient safety panel
- child health have a process to request screening data on the day of being notified of movers in
- CHIS weekly triangulation of data with GP systems to identify any unknown movements into or out of the area
- local screening coordinators support the local university in providing an annual teaching session on antenatal and newborn screening for midwifery students

Recommendations

The following recommendations are for the provider to action unless otherwise stated

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Formalise the departmental accountability structure to make sure that the communication mechanism between the screening team and the head of midwifery is documented and includes oversight of the screening programmes	1 to 15	6 months	Standard	Copy of the structure and escalation routes
2	Make sure there are documented governance arrangements and clear lines of accountability between obstetric ultrasound and maternity so that the head of midwifery can have clinical oversight and account for risks	1,2,4,6,10,11, 12	3 months	Hight	Documentation of ratified arrangements and structure
3	Develop systems to provide auditable assurance of end to end tracking of the eligible antenatal and newborn screening population that are undertaken by the community midwifery teams	1, 2, 6	3-6 months	High	Standard operating procedure for managing the tracking process with roles and responsibilities clearly outlined

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Update relevant local policies to include reference to managing screening incidents in accordance with “Managing Safety Incidents in NHS Screening Programmes” for all NHS screening programmes	1, 5, 5	12 months	Standard	Policies updated and ratified and presented at local ANNB screening board meeting
5	Make sure ANNB screening programme guidelines and standard operating procedures are updated in line with current national screening standards and guidance	1-15	12 months	Standard	Standard operating procedures reviewed, updated, ratified and presented at local ANNB screening board meeting
6	Make sure that ANNB screening audits are included within the formal trust audit schedule.	1,2,6	12 months	Standard	ANNB planned and completed audits added to the trust audit schedule
7	Put in place a plan to make sure obstetric ultrasound audits are undertaken and monitored in line with national recommendations and guidance	1,2,4,6,10,11	3 months	High	SSS to evidence audit through local ANNB screening board meeting
8	Complete an equality audit to identify any local barriers to accepting the offer of screening by the population using antenatal and newborn screening services at NCUH	1	12 months	Standard	Audit to be presented to local ANNB screening board meeting
9	Complete an equality audit to identify any local barriers to accepting the offer of screening by the population using antenatal and newborn screening services at NCUH	1	12 months	Standard	Audit to be presented to local ANNB screening board meeting
10	Update the public facing trust website to include current national guidance and links	1 to 15	12 months	Standard	Confirmation of update local ANNB screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	to national information about antenatal & newborn screening programmes				board meeting

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Review the roles and responsibilities of the screening support sonographer and deputy to make sure the functions are carried out in line with national guidance and specifications	1, 2, 3, 6, 10, 11, 12	3 months	High	Roles and responsibilities for SSS and deputy are clearly defined and confirmed through a job description and the appraisal process
12	Make sure all staff involved in the screening pathway complete the appropriate screening training requirements	1	12 months	High	Log of completed training monitored by screening team. Compliance reports presented at local ANNB screening board meeting
13	Put in place a plan to monitor capacity in the newborn hearing screening programme	1, 2, 6, 13	12 months	Standard	Capacity and service delivery to be added as an agenda item at local ANNB screening board meeting

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Make sure the CHIS guideline for movers in the newborn blood spot screening programme is finalised and operational	1, 6, 15	6 months	Standard	Confirmation of process completed to be reported at local ANNB screening board meeting

Newborn hearning Screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Develop local SOPs that are in line with programme standards and informed choice procedures	1, 2, 6, 13	6-12 months	Standard	Ratified standard operating procedure presented at local ANNB screening board meeting
16	Implement and monitor a plan to report against the screening standards for the NHSP and make sure national protocol is followed	1, 2, 6, 13	6 months	Standard	Audit data and report presented at local ANNB screening board meeting
17	Review the local programme management tasks and put in place a supportive plan to assure compliance	1, 2, 6, 13	3 months	Standard	Compliance monitored by NHSP manager
18	Implement and monitor a plan to meet KPI NH2 and screening standards 5.	1, 2, 6, 13	6 to 12 months	Standard	Acceptable level for KPI NH2 and standards met

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 and progress in response to the recommendations made for a period of 12 months after the report is published. 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.