Public Health England

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Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Southport & Ormskirk NHS Hospital Trust

25 September 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 January 2020
PHE publications
gateway number: GW-977

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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 Southport & Ormskirk NHS Hospital Trust the screening service held on 25 September 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 the following sources:

- 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 visits telephone calls to child health at Blackpool Teaching Hospitals NHS Foundation Trust on 28 August 2019
- information shared with the North West regional SQAS as part of the visit process
- telecom with Newborn Hearing Screening Programme service on 4 October 2019

Local screening service

Southport & Ormskirk Hospitals NHS Trust (SOHT) serves a population of approximately 124,000. The area represents a static population of varying levels of socioeconomic status, with pockets of high levels of deprivation and areas of high affluence.

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

Acute and high-risk maternity services are provided at SOHT with tertiary referral links to The Liverpool Women’s NHS Foundation Trust (LWH).

Between 1 April 2018 and 31 March 2019 2,621 women booked for maternity care with the trust, with 2,250 births recorded.

Findings

This is the second quality assurance visit to the trust, the first was in June 2015. 46 of the 47 recommendations are closed. The service is delivered by a team of dedicated staff who are committed to quality improvement.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 2 high priority findings as summarised below:

- screening incidents are not reported in line with ‘Managing Safety Incidents in NHS Screening Programmes’ national guidance
- capacity within the ultrasound and screening team is reducing resilience to deliver the screening service and assure the safety of all the screening programmes

Shared learning

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

- proactive approach to sharing learning through shared dashboard for KPI’s, theme of the week and the use of alert ‘Tiles’ on the IT system to keep staff up to date
- every woman is reviewed by a midwife following a scan
- use of communication sheet to alert staff of outstanding appointments following DNA’s
- use of a template booklet for peer review for sonographers
- offer of consultant review for needle phobic women
- use of the positivity board for NHSP to aid communication
- positive working relationship with paediatric wards to ensure NBS programme delivered effectively

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 terms of reference (TOR) of the trust ANNB screening operational group to make sure that roles are clearly defined and inclusive of all stakeholders to improve the effectiveness of the group and information sharing between disciplines	1 to 14	12 months	Standard	Ratified TOR, revised membership, agenda and minutes to evidence attendance
2	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	12 months	Standard	Policies updated and ratified and presented at local ANNB screening operational meeting
3	Make sure that screening incidents are reported in line with ‘Managing Safety Incidents in NHS Screening Programmes’ national guidance	4	6 months	High	Evidence that screening incidents on Datix are reporting via Screening Incident Assessment Form
4	Make sure ANNB screening programme guidelines and standard operating procedures (SOP’s) are	1 to 15	12 months	Standard	Presented at local ANNB screening operational

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	updated in line with current national screening standards and guidance				meeting, minutes shows ratified guidelines, SOP's
5	Make sure ANNB screening audits are included within the formal trust audit schedule	1, 2, 6	12 months	Standard	Trust audit schedule showing ANNB planned and completed audits
6	Undertake and equity audit to identify barriers to accepting the screening offer for the population of SOHT	1 to 15	12 months	standard	Audit presented at ANNB screening operational meeting. Action plan in place to address gaps identified
7	Update the public facing trust website to include current national guidance and links to national information about antenatal & newborn screening programmes	1 to15	12 months	Standard	Screen shot

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8	Review capacity of the screening and ultrasound team to assure safe delivery of the screening programmes	1 to 6, 10, 11, 12	6 months	High	Completed capacity review with a plan in place to address and monitor any gaps
9	Make sure all staff involved in the screening pathway for ANNB complete the appropriate screening training requirements	1 to 14	6 months	Standard	Training log, training needs analysis and related action plan

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Develop a process with community midwifery teams to provide auditable assurance of end to end tracking of the eligible cohort antenatal screening	1, 2, 6	6 months	Standard	Ratified standard operating procedure
11	Screening team to work with IT to develop a process for cohort tracking that identifies exclusion criteria for all KPI's	1 to 14	12 months	Standard	Screenshot identifying exclusion reports KPI submissions
12	Put in place a process for the screening support sonographer (SSS) and deputy to have access to cohort tracking system	1 to 8	6 months	Standard	Email confirming SSS and deputy has access and uses the cohort tracking System
13	To work with the Diabetic Eye Screening (DES) service to develop cohort tracking for referral, screening and outcome for pregnant women with pre-existing diabetes	1 to 6	12 months	Standard	Ratified standard operating procedures presented at local ANNB screening operational meeting

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Implement a process for notifying stakeholders and screening IT systems about deceased babies	1,2,13,14	6 months	Standard	Screen shot Ratified standard operating procedure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	CHIS to develop a process for identification of missing NHSP screens	1 to 6, 13	6 months	Standard	Email confirmation of CHIS read only access to S4H. Ratified Standard operating procedures/flow charts
16	Put in place an agreed system for recording birth and NIPE exam onto the new child health information system across the child health information services (CHIS) footprint	1 to 6, 14	12 months	Standard	Email confirmation of CHIS has read only access to S4N. Screenshot, showing outcome of examination recorded on Child Health information system. Ratified standard operating procedures/flow charts operational meeting
17	Develop a process with community midwifery teams to provide auditable assurance of end to end tracking of the eligible cohort and newborn screening	1, 2, 6	6 months	Standard	Ratified standard operating procedure

Invitation, access and uptake

No recommendations

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	To implement an electronic family origin questionnaire (FOQ)	1 to 7	12 months	Standard	Email of confirmation
19	Implement a plan to meet the SCT programme standards ST2 consistently	1 to 7	12 months	Standard	KPI SC2 met Standard monitored through local ANNB screening operational meeting

Infectious diseases in pregnancy screening

No recommendations

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Implement a process to make sonographer local files available to support nuchal translucency / crown rump length (NT/CRL) image review and quality improvement	1 to 8	6 months	Standard	Image review log and DQASS reports reported into local ANNB screening operational meeting
21	Implement a plan to meet the FASP programme standards	1 to 7	12 months	Standard	Standards monitored through local ANNB screening operational

	8a and 8b				meeting
22	Put in place a plan to make sure obstetric ultrasound nuchal translucency and crown rump length audits are undertaken and monitored in line with national recommendations and guidance	1,2,4,6,10,11	6 months	Standard	SSS to evidence audit and present findings through local ANNB screening operational meeting

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	Develop and monitor an action plan to meet KPI NH1 acceptable threshold	1, 2, 6, 13	12 months	Standard	Minutes local ANNB screening operational meeting. Acceptable level for KPI NH1 met
24	Develop and monitor an action plan to meet KPI NH2 acceptable threshold	1, 2, 6, 13	12 months	Standard	Minutes local ANNB screening operational meeting. Acceptable level for KPI NH2 met
25	Develop local SOPs across the screening pathway that are in line with programme standards	1, 2, 6, 13	12 months	Standard	Ratified standard operating procedures presented at local ANNB screening operational meeting

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Put in place referral pathways for all NIPE referable conditions and a process for recording outcomes	1 to 6, 14	6 months	Standard	Ratified guideline demonstrates referral pathways and outcomes for all 4 NIPE conditions Minutes of local ANNB screening operational meeting and clarifies

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Implement and monitor a plan to meet NB2	1 to 6, 9	6 months	Standard	Minutes local ANNB screening operational meeting Acceptable threshold for KPI NB2 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.