Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes
York Teaching Hospital NHS Foundation Trust

Executive Summary

23 October 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.

www.gov.uk/phe/screening Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
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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 York Teaching Hospital NHS Foundation Trust screening service held on 23 October 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 visits to commissioning teams on 10 October 2019
- information shared with the regional SQAS as part of the visit process

Local screening service

The York Teaching Hospital NHS Foundation Trust (YTHFT) provides care for a population of approximately 800,000 in York, Scarborough and the wider population of North Yorkshire across an urban and rural geographical area.

Low and high risk maternity services are provided from two main hospital sites with outreach services being delivered from a further 3 community hospitals, GP surgeries and children’s centres.

In 2018 to 2019, 5,454 women booked for maternity care at York Teaching Hospital NHS Foundation Trust. There were 4,538 births in the same year.

York Teaching Hospital NHS Foundation Trust (YTHFT) offers all 6 NHS antenatal and newborn screening programmes.

NHS Vale of York CCG, Scarborough & Ryedale CCG and East Riding CCG commission the majority of the trust's services. NHS England/ NHS Improvement North East and Yorkshire (Yorkshire and the Humber) commission antenatal and newborn screening.

Findings

This is the second quality assurance visit to the York Teaching Hospital NHS Foundation Trust, the first was in March 2015. All previous recommendations were closed.

The service is delivered by a team of dedicated staff who are committed to quality improvement. There is evidence of excellent working relationships between staff across the screening programmes.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 8 high-priority findings, summarised below as:

- lack of governance and oversight for the newborn hearing screening programme
- there are no local guidelines and standard operating procedures in place for the newborn hearing screening programme
- limited audit to provide assurance of the end to end screening pathways to drive quality improvement
- unclear lines of accountability between obstetric ultrasound and maternity

Shared learning

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

- implementation of a shared competency based training package which has reduced the newborn blood spot avoidable repeat rate
- the diabetic specialist nurse has close links with the screening team and reports into the antenatal and newborn screening meeting
- standard operating procedures are in place to demonstrate processes in the event of the absence of midwifery screening staff

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	NHS England/NHS Improvement Yorkshire and Humber public health commissioning team to make sure that SQAS advice can inform the quarterly contract performance meetings	1	6 months	Standard	Meeting schedule / action notes
2	Make sure the current review of maternity governance arrangements includes oversight for antenatal and newborn screening	1	6 months	High	Revised Governance arrangements and reporting structures
3	Update the terms of reference for York Teaching Hospital NHS Foundation Trust screening meeting to include current reporting arrangements for antenatal and newborn screening	1	3 months	High	Terms of reference
4	Make sure minutes and action logs provide an accurate record of the screening meeting	1	3 months	High	Minutes and action logs

5	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	3 months	High	Documentation of ratified arrangements and structure
6	Put in place a process for the head of midwifery to have oversight of the key performance indicators and breaches for the Newborn Hearing Screening Programme (NHSP)	1, 3	6 months	High	Completed reporting template shared with HoM
7	Make sure there is documented governance arrangements and accountabilities in place for the role of the team leader for the NHSP	1	6 months	High	Documentation of ratified arrangements and structure
8	Amend trust risk management and incident policy to include reference to managing screening incidents in accordance with ‘Managing Safety Incidents in NHS Screening Programmes’ (2017)	4, 5	6 months	Standard	Updated ratified policy presented at antenatal and newborn screening oversight group
9	Update screening guidelines and standard operating procedures (SOPs) to make sure that they meet national guidance including the correct use of terminology and include current practice	1, 7 to 14	12 months	Standard	Updated guidelines ratified within the trust and presented at the antenatal and newborn screening governance group

10	Make sure audit of antenatal and newborn screening including equity audit is included on the trust audit schedule	1 to 14	12 months	Standard	Audit schedule completed Audits presented at the local antenatal and newborn screening meetings Action plan to address gaps
11	Complete a user satisfaction survey to gather views about the antenatal and newborn screening pathways	1 to 14	6 months	Standard	Outcome of survey and action taken discussed at the antenatal and newborn screening meeting

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Make sure cross cover arrangements are in place for the newborn hearing screening service	1	6 months	Standard	Written evidence of arrangements formally agreed at the antenatal and newborn screening meeting
13	Make sure that hearing screener training is in line with programme requirements/standards as detailed in the NHSP ‘Screener Competence Assessment’	13	3 months	High	Email confirmation of training compliance

14	Identify a named person in the neonatal unit with responsibility for newborn screening	1, 6, 13, 14	3 months	Standard	Named person in place
15	Make sure neonatal unit staff attend the Trust mandatory training sessions on the newborn screening programmes	1, 13,14,15	6 months	Standard	Training logs and attendance sheets

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Implement a process in the newborn hearing screening programme to ensure business continuity in the event of a failure in the maternity IT system	1, 13	6 months	High	Business continuity document presented at the screening meeting

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Make sure that sonographers have access to the medical and obstetric history of women prior to screening	10	12 months	Standard	Guidelines for antenatal booking

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Implement and monitor a plan to address NH2 (Timely referral into audiology)	1, 2, 3, 13	6 months	Standard	Action plan agreed with maternity and audiology team leader and monitored via the newborn screening operational group confirmed in minutes

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Implement and monitor a plan to meet the achievable threshold for NP2 (timely assessment of developmental dysplasia of the hip)	1,2, 3,14	6 months	Standard	Action plan that is agreed and monitored by newborn screening operational meeting Submission of KPI NP2

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Implement and monitor a plan to meet key performance indicator NB4 (coverage for movers in)	1,2, 3,15	12 months	Standard	Action plan that is agreed and monitored by screening operational group confirmed in minutes