Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Royal Cornwall Hospitals NHS Trust

10 May 2016

Public Health England leads the NHS Screening Programmes

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Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

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 4 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.

PHE Screening, Floor 2, Zone B, Skipton House, 80 London Road, London SE1 6LH
www.gov.uk/topic/population-screening-programmes.Twitter: @PHE_Screening.
Blog: phescreening.blog.gov.uk. Prepared by: Screening QA Service (South).
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net

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Executive summary

The findings in this report relate to the quality assurance review of the Royal Cornwall Hospitals NHS Trust antenatal and newborn screening programme held on 10 May 2016.

1. Purpose and approach to quality assurance

The aim of quality assurance (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 screening QA service as part of the visit process

2. Description of local screening programme

The Royal Cornwall Hospitals NHS Trust provides hospital and community services to a local population of approximately 450,000 people. The maternity service booked over 4,800 women for pregnancy care during 2014 to 2015 and 4,330 babies were born. The population is characterised as 91.4% white British. Over 55% of women booked were in the 25 to 34 year age group.

Local screening services are commissioned by the NHS England South (South West) team and apart from analysis of the second trimester (quadruple) screens for Down's syndrome and the newborn blood spot samples, all services are provided by Royal Cornwall Hospitals NHS Trust (RCHT). The hearing screening service, while managed by RCHT, is delivered by health visitors from Cornwall Partnership Foundation Trust.

There are identified leads to co-ordinate and oversee the screening programmes. However, there is no clinical lead for the newborn infant physical examination providing oversight for the screening service.

3. Key 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. Where there is an unexpected outcome following screening all results are reviewed and followed up within a multi-disciplinary forum.

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 4 quarters prior to the visit. The trust failed to achieve the acceptable level for coverage for newborn blood spot screening.

The child health records department (CHRD) implemented a new information system in 2014 and encountered problems, which resulted in the trust being unable to identify all babies who missed newborn blood spot screening. A service review was undertaken by the commissioners in 2015 and an action plan developed. The CHRD is working towards completing the actions required to deliver against the national service specifications and standards.

The avoidable repeat rate for newborn blood spot screening is outside of the acceptable level of ≤2% and a remedial action plan has been developed by the trust screening team.

The immediate concerns 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.

3.1 Shared learning

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

- good communication links and partnership working between all stakeholders including effective working relations between NHS England, Kernow CCG, PHE and the local authority
- early access to maternity care and screening with over 76% of results available to women for sickle cell and thalassaemia screening before 10 weeks gestation
- care of vulnerable women is supported by clear policies and pathways
- good processes for identifying and tracking the eligible population for sickle cell and thalassaemia, infectious diseases and first trimester screening, the 18 to 20+6 week scan, newborn blood spot and newborn hearing screening

- all sonographers who are involved in screening for Down's, Edwards' and Patau's syndromes have been allocated green flags by the Down's syndrome Quality Assurance Support Service (DQASS)
- there is a culture of audit within the laboratories and the maternity service with evidence of action plans and shared learning
- facilitation of a parental forum to ensure engagement of users in the local hearing screening service

3.2 Immediate concerns for improvement

The review team identified no immediate concerns.

3.3 High priority issues

The review team identified 3 high priority issues:

- the eligible population for second trimester Down's syndrome screening cannot be accurately identified. A system needs to be implemented to ensure this happens and women are tracked through the screening pathway
- the eligible population for newborn physical examination screening cannot be accurately identified and a system needs to be implemented to ensure this happens and that babies are screened within 72 hours of birth
- there is no named clinical lead for the newborn infant physical examination service to oversee delivery of the screening programme on behalf of the trust

4. Key recommendations

A number of recommendations were made related to the high level issues identified above. These are summarised in the table below.

Level	Theme	Description of recommendation	Full recommendation found on page
High	Identify and inform population	Develop a system to support identification of the eligible population for second trimester screening for Down's syndrome	22
High	Identify and inform population	Ensure implementation of a system which meets national requirements to identify and track babies who are eligible for newborn physical examination, including referral into treatment	23

High	Whole pathway all programmes, governance	Ensure there is a named clinical lead for the newborn infant physical examination	48

For more information on expected timeframe for completion of recommendations, please see page 10.

5. Next steps

Royal Cornwall Hospitals NHS Trust is responsible for developing an action plan to ensure completion of recommendations contained within this report.

NHS England South (South West) team will be responsible for monitoring progress against the action plan and ensuring all recommendations are implemented.

The Screening Quality Assurance Service (South) will support this process and the ongoing monitoring of progress.