Document Control

Title **Alerting appropriate advisors/managers to antenatal & Newborn screening incidents Standard Operating Procedure**			
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1.0	April 2016	Final	Approved by Maternity Services Guideline Group.
2.0	February 2019	Final	Removal of obsolete hyperlinks. Ratified at the Maternity Governance meeting.
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1. Background

Screening is a process of identifying apparently healthy people who maybe at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce the risk and/or any complications arising from the disease or condition disease or condition.

The characteristics specific to screening programmes mean that safety concerns and incidents require special attention and management. This is because:

- There is potential for safety incidents in screening programmes to affect a large number of individuals of the service. This means that seemingly minor local incidents can have major and population impact.
- As asymptomatic people are invited to participate there is an ethical responsibility to do as little harm as possible.
- Poor quality screening can do more harm than good.
- Incidents often affect the whole screening pathway not just the local department or Trust where the problem occurred.
- Incidents may involve several Trusts across geographical boundaries
- Local incidents cam affect public confidence in a screening programme beyond the immediate area involved.
- Investigation and dissemination of learning from safety incidents, 'potential' incidents and near misses should be shared with NHS screening programmes to help prevent incidents elsewhere and to inform guidance and training.

2. Purpose

2.1. The Standard Operating Procedure (SOP) has been written to:

- Set out the Northern Devon Healthcare NHS Trust's, antenatal & newborn screening programmes procedure for alerting appropriate managers, Quality assurance and screening & immunisation teams to incidents within the screening programmes.
- It provides a clear process to ensure a consistent approach across the trust.

3. Scope

3.1. This Standard Operating Procedure (SOP) relates to the following staff groups who may be involved in the investigation of incidents within the antenatal and newborn screening programmes.

- Midwives
- Support workers
- Medical staff
- Ancillary staff

This standard operating procedure will be implemented on notification from the Datix team that an incident has occurred by the antenatal & newborn screening coordinator/deputy or delegated colleague.

4. Location

Not applicable.

5. Equipment

Not applicable.

6. Procedure

- Any incident within one of the antenatal & newborn screening programmes must, be reported within 24 hours, via the 'Datix' e-form available on the home page of the Trust intranet site, in accordance with the Trusts incident management policy.

- Any member of staff may complete and submit an incident report direct without agreement from their manager.

- Screening safety incidents include:
  - Any unintended or unexpected incident, acts of commission or acts of omission that occur in the delivery of an NHS screening programme that could have or did lead to harm to one or more persons participating in the screening programme, or to staff working in the screening programme.
  - Harm or risk of harm because one or more persons eligible for screening are not offered screening.
  - An individual error or a failure of a system, equipment or an IT application.
  - Systematic failure to comply with national guidelines or local antenatal & newborn screening guidelines that has an adverse impact on screening quality or outcome.

- The completed incident form is reviewed by the Datix team. Appropriate advisors and managers are alerted to the incident and where required the incident is escalated to the investigation team, as per local guidance.

http://ndht.ndevon.swest.nhs.uk/policies/?p=11462

- On notification from the Datix team of a Suspected screening safety incident or serious incident the antenatal & newborn screening coordinator/deputy or delegated colleague report to the external quality assurance and screening & Immunisation team. Suspected serious incident the responsible commissioner is also notified.

- Antenatal & newborn screening coordinator/deputy or delegated colleague to commence initial investigation in to suspected incident.

- Antenatal & newborn screening coordinator/deputy or delegated colleague to confirm suspected incident in writing to the external quality assurance team and screening & immunisation team, using the screening incident assessment form within 5 working days.

- Any action plans resulting from further investigations, 72 hour report, serious event audit(SEA), serious incident requiring investigation(SIRI) to be forwarded to the external quality assurance and screening and immunisation team.

7. References

- Managing Safety Incidents in NHS Screening Programmes: NHS England 2015.

8. Associated Documentation

8.1. Northern Devon Healthcare NHS Trust Policies for :

- Incident management policy
- Alerting appropriate advisors/managers to incidents-Standard Operating Procedure.