University Hospitals of Leicester NHS
NHS Trust

MANAGEMENT OF SCREENING PROGRAMMES AND PROCEDURES

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REVIEW DATES

First written: February 2013,

Reviewed November 2016: ToR added and other minor amendments pertaining to new screening committee. Also added need for DNA's to have SOP to ensure they are not missed.

KEY WORDS

Screening Procedures, National Screening, Local screening

1 INTRODUCTION

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust's Policy and Procedures for the Management of Screening Procedures.

1.2 This strategic document will provide direction for the development of guidance for specific screening procedures which may be based on nationally agreed standards of measurement.

1.3 University Hospitals of Leicester NHS Trust is involved in the management and delivery of national and local screening procedures. It is important that these are handled in a locally agreed manner to ensure standardised care and patient safety. There is an added ethical imperative for screening procedures to ensure that the benefits significantly outweigh the harms because apparently healthy individuals are invited to be screened.

Key elements likely to prevent incidents in screening programs include:

- Clear allocation of accountabilities.
- Clear oversight of the screening pathway including the onward referral mechanism for screen positives.
- Existence of a robust comprehensive quality assurance process.
- Fail-safe mechanisms or checks at strategic points in the pathway.
- Systematic, open sharing and learning from incidents.

Conversely, poor management of results (poor follow up) is recognised as one of the major area of risk in screening procedures contributing to unsafe patient care and suboptimal clinical outcomes, with potential medico-legal implications.

1.4 Trust screening procedures are required to have a "local procedural or standard operating document(SOP)", the purpose of which is to inform staff of their duties when involved in managing screening requests and results, outline the process of handling screening requests, processing the results and informing the patient and other relevant health professionals of the result and acting on them.

1.5 All SOPs must ensure there are robust plans for effective monitoring, evaluation and review of the program.

1.6 This policy provides Trust-wide guidance for the development of risk-assessed, local procedural documents for the management of screening procedures. These must cover how the screening procedure is requested, how the clinician treating the patient is informed of the result (including timescales), how the patient is informed of the result (including timescales),how the patient is followed-up or referred (including timescales), how these processes are recorded, and how these elements of the local pathways will be monitored for compliance.

1.7 This document also applies to National Screening Programmes which work to specific National Screening Committee (NSC) guidelines and are commissioned. by NHS England and Improvement as part of its Section 7a responsibilities. Accountability is through NHS England and Improvement Midlands region and through them to NHS England and Improvement nationally.

2 POLICY AIMS

2.1 Objectives

This document gives guidance to screening leads on how to develop, and monitor compliance with, local Procedural documents for the management of screening procedures. This will help to ensure that screening results are appropriately managed within the Trust, thus improving patient outcomes, and the quality of care.

2.2 Intended Outcomes

Risk-assessed local procedural documents (SOPs) should exist for the management of screening procedures. These must include:

a. identifying and offering screening to all the eligible cohort;

b. identifying systems that are in place for the screening procedure;

c. identifying healthcare staff with the authority to authorise and proceed with the screening procedure;

d. making sure that informed consent occurs, with the requirement for a verbal discussion and the use of specific patient information, giving due consideration to confidentiality and the specific needs of the patient;

e. having systems in place to make sure that the sample(s), where relevant, have been taken, are correctly identified and labeled, prepared and transported to comply with the agreed protocols/standing operating procedures (SOPs);

f. having a clear and agreed escalation policy with named leads to make sure that samples/test results are followed up if there is insufficient information and a repeat screen is required;

g. identifying when it is appropriate to request an acknowledgement from the receiving laboratory for specific samples;

h. ensuring that screening results are received within agreed timeframes by the appropriate individual or electronic system;

i. dissemination of the screening results, by telephone, paper or electronic means;

j. informing all patients who undergo a screening procedure of their results (including screen negative or low risk results). Where the patient is pre-advised of the expected timeframe for feedback of results they should be actively encouraged to enquire when results are not received within agreed timeframes;

k. all patients who receive a screen positive result or high risk result to have access to an appropriately trained healthcare professional to discuss options for further management to make sure that action to be taken is timely;

l. recording the outcome and any subsequent follow up required;

m. ensuring that all screening processes are the subject of effective systems of monitoring, evaluation and review; and

n. ensuring robust processes are in place for managing patients who “do not attend” appointments that are made to follow them up.

All Local and National Screening Programmes will have UHL corporate oversight

via the Screening Committee in order to ensure that both national & local Key Performance Indicators (KPIs) are achieved.

3 POLICY SCOPE

3.1 This policy applies to all University Hospitals of Leicester NHS Trust staff involved in Screening Procedures and all non-UHL staff providing screening services on behalf of UHL
It also applies to some Screening procedures carried out outside UHL where other organisations are involved in delivering part of the Screening programme and risks associated with these interfaces.

3.2 Inclusions

This policy applies to National Cancer Screening, National Screening Programmes, nationally mandated screening programmes and other local screening programmes which are consistently applied within the Trust. The list of current screening procedures carried out on the Leicestershire, Leicester and Rutland population and the organisation's own patients to which this policy applies is available in Appendix A. This may be updated as necessary without recourse to full policy review.

3.3 Exclusions

Screening programmes may be excluded from this policy if one or more of the following applies:

- Assessments which constitute part of routine patient care, e.g. urinalysis, Venous Thrombo-embolism (VTE) assessments, unless stated otherwise,(e.g. MRSA screening.)
- Testing which is not universally applied to a defined population.
- Testing which, in context, constitutes diagnostic work up rather than screening (e.g. genito-urinary medicine testing.)
- Testing which is carried out to exclude disorders in order to allow therapeutic interventions (e.g. pre-biological therapy TB screening in rheumatology patients.)
- Occupational health testing.
- Developmental reviews unless part of established screening programme.

4 DEFINITIONS

4.1 Screening Procedure

The NHSLA define a Screening Procedure as 'Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition'.

4.2 National Screening Programmes (NSPs)

NSPs are population health programmes, which invite large numbers of apparently healthy individuals for screening, and, if their screening test is positive, offer further diagnostic investigation. NSPs are the whole system of activities needed to deliver high quality screening. They range from identifying and informing those to be

offered screening through to the treatment and follow-up of those found to have an abnormality, and support for those who develop disease despite screening.

4.3 Nationally mandated screening Programme

These are screening programmes that are not designated as National Screening Programmes but have been mandated by NICE and by national specialist consensus (e.g. contact screening for tuberculosis).

4.4 Local systematic screening programmes

Local systematic screening programmes are those which have been locally agreed e.g. HIV testing of patients under 80 years of age admitted to AMU.

4.5 Local screening Standard Operating Procedures (SOPs)

All screening programmes should have a clear, step-by-step instruction of how to carry out agreed actions that promote uniformity to help clarify and augment such processes. SOPs document the way activities are to be performed to facilitate consistent conformance to requirements and to support data quality. SOPs provide individuals with the information needed to perform a job properly and consistently. Local SOPs will be held in the Policy and Guideline library.

5 ROLES AND RESPONSIBILITIES

5.1 Chief Executive

Has ultimate accountability for the quality of care provided to patients undergoing screening procedures within the Trust. They have overall responsibility for implementation of this policy.

5.2 Medical Director

The Medical director is the executive director that has responsibility and accountability for screening programmes in the Trust.

5.3 Associate Medical Director

The Associate Medical Director has responsibility for developing a Trust policy on the management of screening programmes and procedures, and for providing Board assurance, via the Screening Committee, that the policy is implemented.

The Associate Medical Director is the Co-chair of the Screening Committee

5.4 Director of Clinical Quality

The Director of Clinical Quality Co-chairs the Screening Committee.

5. 5 CMG Director

Has responsibility for identifying Clinical Screening leads where applicable within each Specialty.

5.6 Clinical Screening Leads

Clinical Screening Leads will attend the Screening Committee quarterly.

They will be responsible for ensuring;

5.6.1 The development of a risk-assessed local SOP document to manage the risks

associated with managing screening procedures, as per this policy.

5.6.2 Implementation of the local procedural document.

5.6.3 Monitoring compliance with the local procedural document.

5.6.4 Assurance of clinical integrity of all staff involved in screening procedures.

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5.7 Screening specialists or operational leads.

Staff with a responsibility for overseeing screening programmes within their role should:

- monitor compliance with screening guidance and provide reports both locally and nationally as required.
- Provide clinical expertise in screening and act as a resource for other Health Professionals.
- Be responsible for updating and maintaining relevant policies or procedures; being aware of any changes to or introduction of standards in the area of practice relating to the screening procedure and should, where necessary, provide a revised local procedural document within three months of the publication of new or revised standards.

5.8 Trust Board and Executive Quality Board

For effective implementation of the Organisation-wide Document for the Management of Screening Programme and Procedures there must be active support from the most senior members of the organisation. The chief executive and the nominated directors will be provided assurance that this document is being implemented within the organization through the associate medical and medical directors.

5.9 Screening Committee

The role of this committee is to provide corporate oversight of all the screening activity that occurs in the Trust; and to receive assurances that they are operating safely and meeting the relevant standards and levels of quality assurance. Terms of Reference of the Committee are appended to this policy.

5.10 Duties External to the Organisation

- External bodies which have a role in the effective management of the systems to provide and manage screening procedures such as:

  - Accredited Laboratories
    External assurances required as part of contractual agreements.
  - Independent Contractors
    External assurances required as part of contractual agreements.

5.10.1 Clinical and administrative staff

All health care staff involved in screening are responsible for their own practice In respect of:

- Adherence to local procedural documents or equivalent guidelines.
- Being able to demonstrate competency, and undertaking training as necessary
- Being aware of policy updates.

6 POLICY STATEMENTS, STANDARDS*, PROCESSES*, PROCEDURES* AND ASSOCIATED DOCUMENTS

6.1 Screening Procedures Carried Out in the Organisation

- A full list of all the screening procedures carried out in the organization is provided in Appendix A. This list will be kept up to date by the Screening Committee.

6.2 Minimum Content of Guidance for Specific Screening Procedures

- This section will form the basis of the structure and content of the guidance for each specific screening procedure.

6.2.1. Development of local SOPs

Local processes should take notice of national guidance.

- adherence to standard operating procedures or equivalent protocols;
- ensuring all eligible populations are identified and offered screening;

Where the use of a laboratory service is required that the information includes:

- the recording of the correct patient details;
- the request for the correct screening procedure;
- the details of the appropriate healthcare staff member for return of the screening result and subsequent action;
- fail safe procedures if a sample is incorrectly labelled or insufficient, inappropriate or contaminated samples are received;

Where a screening procedure does not require laboratory analysis that the undertaking and outcome of this activity should be documented in the designated SOP;

The process for recording the receipt of the screening result, the interpretation and the subsequent management plan in the appropriate SOP;

How results are communicated to the patient and other appropriate healthcare staff members including timescales;

ensuring that identified actions are taken and documented, and that the method of communication is recorded, face to face contact, phone call, letter, email, fax, etc;

ensuring that robust systems are in place which involve the receipt and filing of paper held records; and the continuous performance management and monitoring of the screening procedures ordered and the management of results

6.3 Introduction and Purpose

For each screening procedure, an overview of the rationale for the development of specific guidance should be provided. This section may refer to the specific risks of that screening procedure.

6.4 Explanation of Terms

This section should list and describe the meaning of the terms used within the context of the screening procedure document.

6.5 Duties

This section should provide a brief overview of the roles and responsibilities of the individuals who are involved in the process for the specific screening procedure, ensuring that all screening procedures are undertaken by authorised healthcare staff following specified training where necessary , for example:

6.5.1 Healthcare Staff

This section should include the responsibilities of healthcare staff, by discipline/role, that the organisation has identified are involved for all stages of the screening procedure. This may include adherence to standing operating procedures or equivalent protocols; requesting a screening procedure; and undertaking training as required and agreed.

6.5.2 Administrative Staff

This section should include the role expected of administrative staff in the processes surrounding screening procedures

6.6 Requesting the Screening Procedures

This section should state the process for requesting a specific screening procedure. As a minimum this should include the levels of authority required to request the procedure. This section should state how the request for a screening procedure is recorded.

6.7 Performing the Screening Procedure

This section should outline the process for performing the screening procedure. As a minimum this should include levels of competency and authority required to undertake the screening procedure.

6.8 Communication of Screening Results

This section should describe the processes in place to inform the patient and other relevant healthcare staff of the results of the screening procedure, giving due consideration to confidentiality, sensitivity of results and the specific needs of the patient. This should also include the process for documenting this communication.

- how the clinician treating the patient is informed of the result, including timescales;
- where the result is recorded;
- how the interpretation of the result is recorded; and
- how the patient is informed of the result, including timescales.

6.9 Taking Action on Screening Results

This section should state the actions to be taken by the clinician following the result of the screening procedure. As a minimum this should include:

- ensuring that identified actions, for example, referral and follow-up, are documented;
- if communication with other healthcare professionals is required; and
- that the method of communication is recorded, face to face contact, phone call, letter, email, fax, etc.
- An SOP for following up patients when they do not attend appointments should be in place.

6.10 How 6.8 to 6.9 are monitored for compliance

Outline how compliance with national screening programmes and local procedural documents will be monitored and by whom.

Whilst monitoring of every step described is not expected, at least one national or local KPI or Auditable Standard should relate to each process

If monitoring highlights non-compliance, additional local KPIs may be included in future monitoring in order to better understand compliance problems.
Monitoring is not required for processes which are not the responsibility of this Trust.

Outline clinical governance arrangements for how the monitoring results will be dealt with. Consider:

- Who will perform the monitoring?
- When will the monitoring be performed?
- How are you going to monitor?
- What will happen if any shortfalls are identified?
- Where will the results of the monitoring be reported?
- How will the resulting action plan be progressed and monitored?
- How will learning take place?
- Identification of Failsafe person or procedures in terms of patient tracking and quality

6.11 Process for approving local procedural documents

All local procedural documents for managing screening requests and results must be approved by the relevant CMG group whose terms of reference reflect this requirement and has appropriate knowledge of the procedure being approved. A quality assurance check by the Screening Committee is mandated to ensure that the document meets the standards set out in this policy. These documents will be Category C trust documents and stored within the Policy and Guideline Library.

6.12 Process for Risk-Assessing screening procedures

Local procedural documents for managing screening procedures must be risk assessed (appendix B) by the C MG Clinical Screening Leads supported by the screening specialists or operational leads. If any of the processes described within the local procedural document are assessed as >5% likely to fail, a description of the risk identified (i.e. reasons for non-compliance), and mitigation measures should be included. The risk assessment should also identify those results that would be likely to result in a significant risk to patient's health if reported incorrectly or result

missed.

The risk assessment should be available to the approving CMG committee/group alongside the local procedural document, as part of the CMG approval process. Risks must be reported to the Screening Committee.

6.13 Equality Impact Assessment

All local procedural documents should have an Equality Impact Assessment carried out.

6.14 Incidents in NHS screening programmes

Please refer to “Managing Safety Incidents in NHS Screening Programmes” document developed by Public Health England in collaboration with NHS England August 2017 for further details on Quality Assurance of screening programs.

This guidance sets out the requirements for managing safety concerns, safety incidents and serious incidents in NHS screening programmes. It provides clarity for staff providing and commissioning NHS funded services who may be involved in identifying or managing a screening incident.

6.15 Definition of a screening safety incident

Screening safety incidents include:

6.15.1 any unintended or unexpected incident(s), 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

6.15.2 harm or a risk of harm because one or more persons eligible for screening are not offered screening.

Characteristics are:

6.15.3 they occur at a particular point of the screening pathway, at the interfaces between parts of the pathway or between screening and the next stage of care

6.15.4 they can affect populations as well as individuals. Although the level of risk to an individual may be low, because of the large numbers of people offered screening, this may equate to a high population risk

6.15.5 the root cause can be an individual error or a failure of a system(s), or equipment or IT

6.15.6 there is a systematic failure to comply with national guidelines or local screening protocols that has an adverse impact on screening quality or outcome

6.15.7 due to the public interest in screening, the likelihood of adverse media coverage with resulting public concern is potentially high even if no harm occurs. Examples include breach of patient confidentiality or data security.

6.16 External escalation requirements where necessary.

Managing Safety Incidents in NHS Screening Programmes (published 2017) states that a serious incident must be declared at the outset and can be scaled down as appropriate. In screening incidents it is often difficult to judge severity at the outset and there is a fact finding and assessment process that can be used to determine

whether a serious incident should be declared. Its purpose is to understand and mitigate risk.

Each local procedural document should describe the escalation process both internally and externally to UHL where appropriate.

When a screening safety incident is suspected or declared, the provider (Trust) will:

6.16.1 notify the screening QA service (regional) service and the PHE screening and immunisation team embedded in/associated with the commissioner of the service

6.16.2 fact find, manage and investigate the safety issue taking account of QA advice and reporting to the screening and immunisation team

6.16.3 collaborate effectively with other providers and, where agreed, assume a “lead provider” role

When a serious incident is suspected or declared, in addition to the above, the Trust will provide reports to the commissioner of the screening service and, if this is different, to the commissioner that leads on contracting with the provider. Commissioners should work with providers to ensure this is the case.

7. Education and training requirements

Any training requirements should be described in local procedural document.

8. Monitoring Compliance with Screening Procedures

8.1 Local procedural documents

All local procedural documents must include details of audit standards or key performance indicators that will be used for monitoring compliance and effectiveness and the frequency of monitoring / audit. These should be set out in a monitoring table.

Key indicators should relate to the aims and objectives of the screening procedure and be based on agreed standards.

8.2 National Screening Programmes monitoring

National Screening Programmes have national designated performance monitoring frameworks (KPIs) associated with them. The local procedural document must include any National Screening Programme KPIs and describe the process for ensuring these are audited and performance is acceptable.

9. PROCESS FOR MONITORING COMPLIANCE WITH THIS POLICY

All screening programs must have a standard operating procedure that complies with this policy and national guidance.

They should be registered within the CMG

A quarterly report will need to be submitted to the CMG Quality and Safety Board quarterly, and to the Screening Committee quarterly which in turn will be presented to the Patient Safety Committee.

10. EQUALITY IMPACT ASSESSMENT

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

11. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

11.1 Managing Serious Incidents in the English NHS National Screening Programmes. Guidance on behalf of the UK National Screening Committee (UK NSC). Version4.0.June 2010. Available at https://www.nhs.uk/conditions/nhs-screening/

11.2 Managing safety incidents in NHS Screening Programmes; NHS Screening Programs and NHS England October 2015 https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

11.3 Collaborative Commissioning of National Screening Programmes (2007)DH. https://www.england.nhs.uk/commissioning/pub-hlth-res/

a. An Organisation-wide Document for the Management of Screening Procedures; NHSLA 2012 https://secure.library.leicestershospitals.nhs.uk/PAGL/Shared%20Documents/Screening%20Procedures%20UHL%20Policy.pdf

12. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

12.1 This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

12.2 It will be reviewed by the NHSLA Screening Procedures Task Force biannually.

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APPENDIX A

List of National Screening Programmes which are carried out on University Hospitals of Leicester NHS Trust patients, to which this policy applies.

Name of National Screening Programme	**Lead**
ADULT	
NHS Abdominal Aneurysm Screening Programme	Clinical Lead- Consultant Vascular Surgeon Programme Lead
National Bowel Cancer Screening Programme	Clinical Lead- Consultant Gastroenterologist Manager
NHS Breast Screening Programme	Programme Manager for the National Breast Screening Service
NHS Cervical Screening Programme	Hospital Programme Based Coordinator
National Diabetic Eye Screening Programme	Clinical Lead- Consultant Ophthalmologist, Programme Manager
SCREENING FOR T13/18/21	
Maternal Antenatal Screening Tests, including: -Haemoglobinopathies -Infection (syphilis, hepatitis B,HIV) --Screening for aneuploidy (e.g. Trisomy21)-serum and /or nuchal translucency(Downs, Edwards, Patau and other anomalies, Neural Tube defects)	Clinical Lead for Women's and Children's Division
20 WEEK ANOMOLAY SCAN FOR STRUCTUREAL DEFECTS	Clinical Lead for Women's and Children's Division
NEWBORN	
NHS Newborn and Infant Physical Examination Screening Programme (congenital cataracts, heart disease, developmental dislocation of hip)	Named Consultant Paediatrician
NHS Newborn Blood Spot Screening Programme (cystic fibrosis, MCADD, PKU, congenital hypothyroidism, sickle cell, thalassemia, glutaric aciduria type 1, homocystinuria, maple syrup urine disease, isovaleric acidaemia)	Named Consultant Paediatrician
NHS Newborn Hearing Screening Programme	Clinical Lead-Leicester NHS Newborn Hearing Screening Programme; Screening Team Manager
Other screening programmes	
CHILD	
Growth	CMG director for Women's and Children's
Hearing(child)	CMG director for Women's and Children's
Vision defects(child)	CMG director for Women's and Children's

APPENDIX B

Other systematic screening tests not recommended but have a Clinical Practice or Risk Management Guidance covered by NICE (i.e. are nationally mandated) or are part of local screening e.g. for CQUIN:

NAME OF SCREENINGPROGRAMME	LEAD
ADULTS	
Dementia Screening for in-patients over65years	
MRSA screening	Lead Infection Control Nurse
Family History Breast Cancer Clinic	Breast Care Specialist
Tuberculosis	Consultant Respiratory Physician
HIV screening for in-patients on Acute Medical Unit	Consultant in Genito-Urinary Medicine
ANTENATAL	
-Blood group, rhesus status and atypical antibodies Maternal haemoglobin Mid-stream sample of urine for asymptomatic bacteria	Clinical lead for CMG

This list is not exhaustive

APPENDIX C

Management of National Screening Programmes

Name of National Screening Procedure:

Screening lead and contact details:

Evidence:
Based upon the standard operating procedures, national, regional and local National Quality Assurance Framework

Monitoring:
By Local Commissioners and National Screening Programmes Annual Report to UHL.

Key Performance Indicators
National Key Performance Indicators for non-cancer screening

APPENDIX D

Template Document for the Management of Specific Screening Procedures

University Hospitals of Leicester NHS Trust

Document for the Management of [insert name of specific screening procedure]

Version:	
Ratified by:	
Date ratified:	
Name of originator/author:	
Name of responsible committee/individual:	
Date issued:	
Review date:	
Target audience:	

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REVIEW and AMENDMENT LOG

Version No	Type of Change	Date	Description of change

Introduction and Purpose

Explanation of Terms

Duties

Requesting the Screening Procedure

Performing the Screening Procedure

Communication of Screening Results

Taking Action on Screening Results

	How the patient is followed-up or referred, including timescales
High risk results	
Moderate risk results	
Low risk results	

Process for monitoring compliance

As a guide, monitoring should cover:

a. How the screening procedure is requested
b. How the clinician treating the patient is informed of the result, including timescales
c. How the patient is informed of the result, including timescales
d. How the patient is followed-up or referred, including timescales
e. How points are to be recorded

Clinical governance arrangements. Consider:

- Who will perform the monitoring?
- When will the monitoring be performed?
- How are you going to monitor?
- What will happen if any shortfalls are identified?
- Where will the results of the monitoring be reported?
- How will the resulting action plan be progressed and monitored?
  How will learning take place?

Appendix E

Risk Assessment for Nationally Mandated and Local Screening Procedures

Name of Screening Procedure:
Date Risk assessed:
Risk assessed by:

Processes	Likelihood that processes fail					For processes with a failure risk >5% ONLY	
	0-5%	6-25%	26-50%	51-75%	76-100%	Risk identified in process	Mitigation
a. Process for requesting the screening procedure -capture -delivery							
b. Process for informing the clinician treating the patient of the result							
c. Process for informing the patient of the result							
d. Process for following-up, or referring, the patient							
e. Process for recording points at od (as above) a.							
b.							
c.							
d.							

Monitoring Compliance with the Policy APPENDIX F

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
All identified Screening procedures have local procedural documents /systems (as per this policy), which include processes for: a. How the screening procedure is requested b. How the clinician treating the patient is informed of the result, including time scales c. How the patient is informed of the result, including timescales d. How the patient is followed-up or referred, including timescales How points a to d are recorded	CMG screening leads	Reporting template to be completed for screening committee (Chair Prof Garcea)	Quarterly	Patient Safety Committee for escalation
Management of Screening Procedures' local procedural documents are approved	CMG screening leads	Reporting template to be completed for screening committee (Chair Prof Garcea)	Quarterly	
'Management of Screening Procedures' local procedural documents are monitored for compliance	CMG screening leads	Reporting template to be completed for screening committee (Chair Prof Garcea)	Quarterly	
'Management of Screening Procedures' local procedural documents are risk assessed, as per this policy	CMG screening leads	Reporting template to be completed for screening committee (Chair Prof Garcea)	Quarterly	

Appendix G: UHL Screening Committee

TERMS OF REFERENCE

PURPOSE:

The purpose of the screening committee is to have corporate oversight of the screening programmes that the Trust participates in and to receive assurances that they are operating safely and meeting the relevant standards and levels of quality assurance.

AUTHORITY:

The committee has delegated authority from the Medical Director

DUTIES & RESPONSIBILITIES:

Assurance:

- To receive assurances that screening programmes (both national and local) operating in the Trust are compliant with relevant standards and quality assurance programmes
- To monitor action plans arising from external visits; or internally generated action plans for service improvement that arise from gap analysis
- To ensure that where the Trust is non-compliant with standards, that an appropriate risk assessment is performed and appropriate mitigations of the risk put in place
- To have oversight of external quality assurance visits and to ensure appropriate preparation for such visits

Safety and effectiveness:

- To receive SUIs related to screening programmes and where necessary identify and themes related to screening
- To monitor performance data and key performance indicators

Corporate oversight:

- To ensure that screening programmes have an up to date operating policy that meets national guidance and standards
- To have corporate oversight of the introduction of any new screening programmes
- To receive regular updates and exception reporting from each programme
- To promote best practice in screening
- To ensure that the Trust's policy for screening is followed

MEMBERSHIP:

- Associate Medical Director (Co-chair)
- Director of Clinical Quality (Co-chair)
- Screening programme clinical leads (AAA, bowel cancer, breast, cervical, diabetic eye, fetal anomaly, infectious diseases, newborn infant physical examination, newborn blood spot, newborn hearing, sickle cell and thalassemia)

- Screening programme managers (for areas as above)
- CMG screening leads

A suitably empowered and senior deputy may be sent by exception.

Others members may be co-opted onto the committee as and when specific issues arise.

ADMIN SUPPORT/SECRETARIAT

The PA to the Director of Clinical Quality will provide the administrative support and in his/her absence the PA to the Associate Medical Director will provide support.

QUORUM:

The Committee will be deemed to be quorate when 50% of the Steering group members are in attendance

ATTENDANCE:

It is expected that each Member will attend a minimum of 75% of meetings.

FREQUENCY OF MEETINGS:

Meetings will be held quarterly

MINUTES:

- Action notes will be taken
- Action notes of meetings will be circulated with the agenda papers to all members ahead of the meeting.
- These will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are competed within timescales.

REPORTING ARRANGEMENTS:

- The Screening Committee will provide reports to Patient Safety Committee and QAC
- Action Notes of the Committee will be retained corporately.
- Update reports will be presented to the Clinical Quality Review Group as required

SUB-COMMITTEES:

- There are no sub-committees of the Screening Committee although if the need arises sub-committees can be formed.

REPORTS RECEIVED:

- Reports from external Quality Assurance visits
- Action Plans arising from external visits
- Annual screening programme reports
- SUI reports into incidents related to screening
- Quarterly reports on uptake, coverage and other key performance indicators
- Reports destined for external reporting

MONITORING COMPLIANCE AND EFFECTIVENESS:

Effectiveness of the committee will be monitored annually with an annual report that sets out the attendance of group members and summarises the work that the committee has done

KPIs:

- Attendance
- Action plans – no actions > 6 months old (unless exceptional circumstances)

WORK PROGRAMME: • The committee will produce a work programme after its inaugural meeting. • The programme will be reviewed at each meeting and updated • A summary will appear in the annual report	
REVIEW: The Terms of Reference will be reviewed annually, or sooner should the need arise.	
VERSION CONTROL Final	
APPROVED BY: PSC	**DATE APPROVED**: 2nd Nov 16
DATE LAST REVISED: N/A	**VERSION NO**. 2