Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS antenatal and newborn screening programmes the Rosie Hospital, Cambridge University Hospitals NHS Foundation Trust, including the Pathology Partnership

18 and 19 January 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

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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 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 four 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.

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Executive summary

Antenatal and newborn screening quality assurance (QA) 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 (QA) visit of the Rosie Hospital, Cambridge University Hospitals NHS Foundation Trust antenatal and newborn screening service held on 18 and 19 January 2017.

Purpose and approach to quality assurance (QA)

Quality assurance aims to maintain national 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 comes from the following sources:
- routine monitoring of data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider(s), commissioner and external organisations
- information shared with the QA visit team as part of the visit process

Description of local screening service

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified the following high priority findings:

- the trust need to consolidate outstanding antenatal and newborn screening action plans into one document to enable coordination and performance management (see recommendation 1.3)

- the trust and the Pathology Partnership need to be able to identify the eligible population for antenatal screening and be able to provide matched cohort data (see recommendation 3.1, 6.1 and 7.1)
- the trust need to make sure an auditable pathway is in place for newborn infant physical examinations including failsafe processes for identification and tracking the eligible newborn population in line with national programme standards (see recommendation 10.1)

See consolidated table of recommendations below.

Shared learning

The QA visit team identified the following areas of shared learning:

- all antenatal and newborn screening programmes: Screening incidents are managed in line with the national “Managing safety incidents in NHS screening programmes” guidance. Screening incident assessment forms (SIAF) are completed and sent to the screening quality assurance service team and screening and immunisation team. Incidents and associated action plans are discussed at the bi-monthly antenatal and newborn local screening meetings and followed up at the quarterly antenatal and newborn screening programme board

- all antenatal and newborn screening programmes: The Rosie Hospital screening newsletter is produced monthly and available to all staff in electronic and paper formats. The newsletter is used to highlight updates to screening programme standards, shared learning, performance against quarterly key performance indicators and learning from screening incidents

- all antenatal and newborn screening programmes: All midwives new to the trust have a mandatory one-to-one meeting with the screening team to discuss the antenatal and newborn screening programmes. Screening induction packs have also been created to supplement this training meeting

- sickle cell and thalassemia screening programme: All screen positive results are fed back to the screening coordinator via telephone or by nhs.net email. The coordinator receives a preliminary result and a request for ‘father of the baby’ testing. Improvements to the screening pathway have been made. Face to face appointments are offered to women and their families to discuss screen positive results and ‘father of the baby’ testing is included in this appointment. The patient tracking list has been improved to collect these results and record gestation

- infectious diseases in pregnancy screening programme (IDPS): Learning from a recent screening safety incident has resulted in changes to the screening pathway

The screening coordinators now have overall responsibility for all IDPS screen positive results. They offer a face to face appointment to discuss these results with the woman and refer her to the appropriate multidisciplinary team (MDT) at the appointment

- fetal anomaly screening programme: Double auditing of nuchal translucency measurements and crown rump length image reviews involve the whole team rather than just the screening support sonographer

- newborn bloodspot screening programme: The bloodspot buddy is a laminated template that is placed over the bloodspot card to draw attention to the crucial areas. Data collected from the regional laboratory was used to analyse the reasons for a repeat request and the template reflects these key areas. Since implementing the bloodspot buddy in November (quarter 3 2016-17) the avoidable repeat rate reduced from 3.9% (annual 2015-16) to 3.1% (quarter 3 2016-17)
(data taken from the regional bloodspot laboratory quarterly reports)

- newborn bloodspot screening laboratory: Contingency plans to send newborn bloodspot samples to an alternative laboratory in the event of reduced staffing, equipment failure or other difficulties are approved and embedded in standard operating procedures

- newborn hearing screening programme: A comprehensive orientation pack for trainee hearing screeners supplements the local training package and mandatory training requirements. In addition all newborn hearing screeners observe an auditory brainstem response (ABR) test in the Audiology department every two years. Screener training days to support continuous professional improvement are in place across the East of England network

Table of consolidated recommendations

All the recommendations relate to Cambridge University Hospital NHS Foundation Trust (CUHFT) unless where indicated.

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1.1	Strengthen the governance of the trust wide screening committee to make sure risks for antenatal and newborn screening are escalated and action is monitored	Service specifications no.15 to 21	Within 6 months	Standard	Governance structure demonstrating links. Agreed Terms of Reference
1.2	Formalise the bi-monthly antenatal and newborn screening meetings and embed into the trust governance structure	Service specifications no.15 to 21	Within 3 months	Standard	Trust formatted agendas, minutes, actions logs and agreed terms of reference
1.3	Consolidate outstanding action plans into one document to enable coordination and performance management	Service specifications no.15 to 21	Within 1 month	High	Antenatal and newborn screening action plan with clear leads for actions, timescales and exception reporting arrangements
1.4	Include reference to screening incidents and the “Managing safety incidents in NHS screening programmes” guidance in the perinatal services incident reporting and investigation policy and the trust incident reporting and investigation policy and procedure	Managing Safety Incidents in NHS Screening Programmes Service Specification no. 15 to 21	Within 6 months	Standard	Updated incident policy documents including reference to national guidance.
1.5	Add antenatal and newborn screening risks to the trust risk register	Service specifications no.15 to 21	Within 3 months	Standard	Antenatal and newborn risks documented on trust risk registers

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1.6	Include antenatal and newborn screening in the programme of audits and provide a feedback mechanism for reporting results and actions	Service specifications no.15 to 21	Within 12 months	Standard	Bi-monthly antenatal and newborn screening meeting papers including Audit feedback reports
1.7	Regularly seek out the views of service users, families and others and demonstrate how those views will influence service delivery.	Service Specification no. 15 to 21	Within 12 months	Standard	User survey report presented at least annually to bi-monthly screening meeting Antenatal and newborn screening action plan

Infrastructure

No recommendations were identified in this section

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
3.1	The Pathology Partnership to implement an antenatal request form to support the identification of matched cohort data.	Key Performance Indicators NHS screening programmes 2016-17	Within 3 months	High	Single antenatal request form in use by community midwives. New form identifies hospital of booking/delivery. Cohort matched data submitted in quarterly key performance data returns

Identification of cohort – newborn

No recommendations were identified in this section

Invitation, access and uptake

No recommendations were identified in this section

Sickle cell and thalassaemia screening

All recommendations in this section relate to The Pathology Partnership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6.1	Include version 3 of the family origin questionnaire (FOQ) for sickle cell and thalassemia screening on the antenatal request form, to support the identification of matched cohort data.	Key Performance Indicators NHS screening programmes 2016-17	Within 3 months	High	Single antenatal request form in use that includes version 3 FOQ. Submission of accurate cohort data for quarterly key performance indicator ST3 (completion of FOQ).
6.2	Document and test the contingency plan for samples to be sent to Ipswich Hospital NHS Trust and include the findings in the screening risk assessment	Service specification no.18: NHS Sickle Cell and Thalassaemia Screening Programme	Within 6 months	Standard	Antenatal screening risk assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6.3	Develop a mechanism to make sure that there is a linked antenatal and newborn sickle cell and thalassemia screening service	NHS sickle cell and thalassaemia screening programme: standards for the linked antenatal and newborn screening programme second edition October 2011	Within 12 months	Standard	Standard operating procedure / workflow documenting the linked service. This should include recording of at risk pregnancies and case review of unexpected screen positives in the newborn.
6.4	The Pathology Partnership should revise the screen positive report with the input of users so that the information they need is clear and in a logical sequence	ISO 15189 standards Service specification no.18: NHS Sickle Cell and Thalassaemia Screening Programme	Within 6 months	Standard	Screen positive report

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
7.1	The Pathology Partnership should make sure the antenatal request form meets the minimum data requirements for the infectious diseases in pregnancy screening programme, to support the identification of matched cohort data	NHS Infectious Diseases in Pregnancy Screening Programme Laboratory Handbook 2016 to 2017 Key Performance Indicators NHS screening programmes 2016-17 Service specification no.15: NHS Infectious Diseases in Pregnancy Screening Programme	Within 3 months	High	Single antenatal request form in use. Submission of accurate cohort data for quarterly key performance indicator for HIV coverage (ID1). This should match the data submitted for sickle cell and thalassaemia coverage (SCT 1).

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
7.2	The PHE microbiology laboratory should document and test the contingency plan with the buddy laboratory and include the findings in the screening risk assessment.	Service specification no.15: NHS Infectious Diseases in Pregnancy Screening Programme	Within 6 months	Standard	Screening risk assessment
7.3	The PHE microbiology laboratory should include an antenatal screening audit as part of the audit schedule and make sure results are acted upon	NHS Infectious Diseases in Pregnancy Screening Programme Laboratory Handbook 2016 to 2017	Within 12 months	Standard	The results from this audit should be fed back at the bi-monthly antenatal screening meeting and appropriate laboratory meetings.

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
8.1	The Pathology Partnership prenatal screening laboratory should document and test the contingency plan for combined and quadruple screening samples with the Norfolk and Norwich University Hospitals NHS Trust and with the Wolfson Institute of Preventive Medicine and include the findings in the screening risk assessment	Service specification no.16: NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 & 13)	Within 6 months	Standard	Antenatal screening risk assessment

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
8.2	The prenatal screening laboratory should work towards achieving the minimum workload of at least 8,000 screening specimens per annum per testing strategy	Service specification no.16: NHS Fetal Anomaly Screening Programme - Screening for Down's, Edwards' and Patau's Syndromes (Trisomy 21, 18 & 13)	Within 12 months	Standard	DQASS laboratory summaries including throughput data showing meeting minimum workload Inclusion in a laboratory network

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9.1	Provide assurance of staff safety for home visits	Service specification No.20: NHS Newborn Hearing Screening Programme	Within 3 months	Standard	Lone worker risk assessment completed in line with the trust lone worker policy
9.2	Update all local newborn hearing screening policies to reflect current programme standards.	NHS newborn hearing screening programme standards 2016 to 2017	Within 6 months	Standard	Policies conform with programme standards and include ratification date, version control, review date and author Ratified through trust governance structures.

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
9.3	Use all the failsafe reports from Smart4hearing to make sure that the newborn hearing screening service is operating in accordance with national programme standards	NHS newborn hearing screening programme standards 2016 to 2017	Within 6 months	Standard	NHSP service provides assurance to the bi-monthly newborn screening meeting.
9.4	NHSP screeners to use the correct version of the template for all quality assurance checks on the equipment	NHS newborn hearing screening programme standards 2016 to 2017	Within 3 months	Standard	Quality assurance equipment logs
9.5	Investigate the reasons behind the continued non-achievement of the referral to test key performance indicator (NH2) and take appropriate action to improve timeliness.	Service specification no.20 Key Performance Indicators NHS screening programmes 2016-17	Within 6 months	Standard	Root cause analysis actions included in overall action plan. Acceptable standard of performance for key performance indicator is reached.

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
10.1	Make sure an auditable pathway is in place for newborn infant physical examinations including failsafe processes for identification and tracking the eligible newborn population in line with national programme standards	Service specification no.21 Newborn infant physical examination programme standards 2016 to 2017	Within 3 months	High	NIPE SMART implementation. Quarterly data returns including robust cohort data for coverage (NP1) and timely assessment (NP2).

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
11.1	Include actions to demonstrate how newborn bloodspot screening programme standards 3, 4, 5 and 6 will be met in the overarching action plan for antenatal and newborn screening (see recommendation 1.3).	Newborn bloodspot programme standards 2016 to 2017 Service specification no. 19	Within 6 months	Standard	Antenatal and newborn screening action plan Quarterly key performance data returns for NB2

I = Immediate
H= High
S = Standard

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/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. 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.