Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Poole Hospital NHS Foundation Trust

3 October 2017

Public Health England leads the NHS Screening Programmes

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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 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.

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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 to 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 to the Poole Hospital NHS Foundation Trust antenatal and newborn screening service on 3 October 2017.

Quality assurance purpose and approach

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 the following sources:

- 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 shared with the South regional SQAS as part of the visit process

Local screening service

The antenatal and newborn screening service at Poole Hospital NHS Foundation Trust (PHFT) delivers screening to an eligible population of approximately 280,000 people from Poole, Purbeck and East Dorset. The population rises substantially during the summer months as Poole is a popular holiday destination. The pregnant population is characterised as 81% white British, 8.7% other white, 1.6% Asian, 1.8%. The remainder are categorised as any other ethnic group or unknown status (trust annual report 2016/17).

The service is commissioned by and on behalf of NHS England (Wessex).

Delivery of the screening service at PHFT involves interdependencies with other providers for some parts of the pathway as documented below:

Service	Provider	Within the scope of this visit
Sickle cell and thalassaemia screening laboratories	Haematology Laboratory PHFT	Yes
Infectious diseases screening (IDPS) laboratory services	Microbiology laboratory PHFT	Yes
Fetal trisomy screening – first trimester combined screening laboratory services	Royal Devon and Exeter NHS Foundation Trust	No
Fetal trisomy screening – second trimester quadruple screening laboratory services	Portsmouth Hospital NHS Trust	No
Fetal anomaly screening to include first trimester and anomaly scans	Poole Hospital Foundation Trust	Yes
Newborn infant physical examination	Poole Hospital Foundation Trust	Yes
Newborn bloodspot screening laboratory services	Newborn Blood Spot Screening Laboratory, Portsmouth Hospitals NHS Trust	No
Newborn hearing screening programme	Community model - Dorset Healthcare University NHS Foundation Trust	No
Child health records department	Dorset Healthcare University NHS Foundation Trust	No

There are identified leads within the provider organisations to co-ordinate and oversee the screening services.

Findings

Immediate concerns

The QA visit team did not identify any immediate concerns.

High priority

The QA visit team identified 10 high priority findings as summarised below:

- there is a lack of clarity around governance arrangements for screening and the process of escalation to the trust board
- it was not clear that all stakeholders within the screening programme identify, report and manage screening safety incidents and serious incidents in accordance with Public Health England (PHE) guidance and NHS England Serious Incident Framework, 2015
- an internal screening board for all stakeholders within the 6 screening pathways has not yet been established
- accurate cohort identification in a timely way has posed challenges
- screening samples are not always taken at the earliest opportunity in pregnancy
- there are difficulties in tracking the booked cohort in a timely way to ensure all women who accept screening as part of the fetal anomaly screening programme (FASP) have completed the pathway
- there is a risk of error when manually transcribing results from the analyser in the sickle cell and thalassaemia laboratory
- the blood request forms do not comply with the infectious diseases in pregnancy screening (IDPS) programme handbook
- some screen positive infectious diseases results may be released to the maternity service before the result is confirmed
- the screen positives identified following the newborn infant physical examination must be tracked in a timely way to ensure that all babies have entered treatment services

Shared learning

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

- the online booking referral system which promotes early booking, reducing the delay between referral and booking
- the ability to scan and attach the family origin questionnaire and results from external laboratories to the client's record in the laboratory information management system (LIMs)
- the use of generic NHSmail accounts in both laboratories and the screening department to support resilience within the team and reporting of SCT rejected samples on a daily basis
- the pathway for re-offer of infectious diseases in pregnancy (IDPS) screening if the woman declines at booking

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1.1	Revise the organisational accountability structure for antenatal and newborn screening service including detail of escalation routes for governance and performance issues	1 to 7	3 months	High	Organisational structure chart
1.2	Manage all screening patient safety incidents and serious incidents in accordance with 'Managing Safety Incidents in NHS Screening Programmes'	8 9	3 months	High	Reporting of screening incidents to the Screening Quality Assurance Service (SQAS) and public health commissioning team (PHCT) Completion of root cause analysis (RCA) in collaboration with other directorates (as appropriate) Oversight and sign off of RCA

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1.3	Develop and implement a quarterly trust antenatal and newborn screening steering group to oversee all programmes	1 to 7	3 months	High	Terms of reference Agenda and minutes Action plans Screening board incorporated into divisional governance framework
1.4	Update all policies and standard operating procedures related to screening to ensure compliance with national service specifications and national programme guidance	1 to 7 11 to 23	6 months	Standard	Ratified policies and standard operating procedures for each screening programme
1.5	Include screening related audits in maternity audit schedule	1 to 7 11 to 23	6 months	Standard	Maternity audit schedule demonstrating inclusion of screening related audits
1.6	Audit the screening pathways to demonstrate compliance against national service specifications and national programme standards	1 to 7 11 to 23	6 months	Standard	Completed screening audits and action plans
1.7	Ratify the terms of reference for the Dorset antenatal and newborn programme board	1 to 7	6 months	Standard	Ratified terms of reference
1.8	Formalise the infectious diseases in pregnancy screening (IDPS) and perinatal multidisciplinary team (MDT) meetings and the scanning and screening meeting	1 to 3 7	6 months	Standard	Ratified terms of reference Agenda, minutes and action logs

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1.9	Complete a risk assessment of the infectious diseases in pregnancy pathway through the microbiology laboratory	12	6 months	Standard	Risk assessment and action plan
1.10	Develop a process within the sonography department to review and provide feedback on reports obtained by Down's Syndrome Screening Quality Assurance Support Service (DQASS)	2	6 months	Standard	Standard operating procedure/proforma for the review of DQASS reports
1.11	Collate the results of the user survey and formulate an action plan to include shared learning	1 to 7	12 months	Standard	User survey report and action plan Evidence of shared learning

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
2.1	Formalise the role and responsibility of the newborn infant physical examination (NIPE) lead	21	6 months	Standard	Job description
2.2	Revise the service level agreement with Portsmouth Hospitals NHS Trust to ensure that there is a reciprocal arrangement in place for the testing of sickle cell and thalassaemia (SCT) and infectious diseases in pregnancy screening (IDPS) samples in case of service failure	1 4	6 months	Standard	Service level agreement

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
3.1	Maximise the functionality in the maternity information system to ensure the timely identification of cohort	1 to 4	3 months	High	Ratified policy or standard operating procedure

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4.1					

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5.1	Revise the process for testing to ensure that women are screened at the earliest opportunity	1 to 4	3 months	High	Ratified policy or standard operating procedure
5.2	Revise the screening choices form to ensure that there is clear consent or decline recorded for each of the conditions screened	1 to 4	6 months	Standard	Revised screening choices form and inclusion into ratified policy
5.3	Review the needs of vulnerable groups within area in order to target specialist services accordingly	1 to 4	12 months	Standard	Service needs assessment and action plan

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6.1	Implement a process to mitigate the risk of error when manually transcribing High Performance Liquid Chromatography (HPLC) results from the analyser into the laboratory information management system (LIMs)	12	3 months	High	Ratified standard operating procedure detailing new process
6.2	Implement a pathway for known at risk couples to ensure access to prenatal diagnostic services is not delayed by the screening pathway	4	6 months	Standard	Ratified policy detailing pathway
6.3	Implement a process to track samples sent to an external laboratory for deoxyribonucleic acid (DNA) analysis	12	6 months	Standard	Ratified standard operating procedure, detailing timely tracking of samples including confirmation of receipt at the external laboratory Service level agreement with King's College Hospital, London
6.4	Revise the standard operating procedure reflecting the arrangements for testing Royal Bournemouth and Christchurch Hospitals' antenatal samples received at weekends	12	6 months	Standard	Ratified standard operating procedure

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7.1	Revise the blood request form to ensure compliance with the infectious diseases in pregnancy screening (IDPS) programme	14	3 months	High	Antenatal specific blood request form with the ability to: • accept and decline for each condition • remove rubella screening • fast track samples through the laboratory • identify known positives
7.2	Discontinue the practice of authorising and releasing screen positive results prior to confirmation of the result from the reference laboratory	14	3 months	High	Screen positive reports only released following confirmation of result
7.3	Revise the tracking database for screen positive women to ensure all aspects of the pathway are covered	1	6 months	Standard	Screen positive tracker

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8.1	Track the booked cohort in a timely way to ensure that those who accept screening for fetal anomalies complete the pathway	2 3	3 months	High	Ratified policy or standard operating procedure
8.2	Embed process of reporting unexpected abnormalities at birth to the ultrasound department to facilitate the review of images	2 3 7	6 months	Standard	Audit

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9.1	Track the screen positive babies from identification of an abnormality to ensure they enter treatment services in a timely way	7	3 months	High	Screen positive tracker
9.2	Ensure all staff involved in newborn infant physical examination screening are trained in using NIPE Screening Management and Reporting Tool (SMaRT)	7	6 months	Standard	Improvement in key performance indicator NP1
9.3	Input outcomes of screen positive babies into NIPE SMaRT to ensure that the loop is closed in the pathway	7	6 months	Standard	Ratified policy or standard operating procedure

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10.1	Ensure that all babies admitted to the neonatal unit have an admission newborn blood spot sample taken	5	3 months	High	Ratified policy reflecting change in practice
10.2	Reduce the avoidable repeat rate to an acceptable level of less than 2%	5	6 months	Standard	Improvement in key performance indicator data NB2

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 after the report is published. 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.