Public Health England

NHS

# Screening Quality Assurance visit report

## NHS Antenatal and Newborn Screening Programmes

## Harrogate and District Foundation Trust

**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 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 visit of the antenatal and newborn (ANNB) screening service held on 7 February 2018.

## Quality assurance purpose and approach

Quality assurance (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 collected during pre-review visits to NHS England commissioners and PHE Screening and Immunisation team on 17 January 2018
- information shared with the North regional SQAS as part of the visit process

## Local screening service

Harrogate and District Hospital Foundation Trust (HDFT) offers all six NHS antenatal and newborn screening programmes. HDFT provides maternity services within GPs' surgeries, at home and in children's centres over a large geographical area across North Yorkshire.

In 2016 to 2017, 2,200 women booked for maternity care with HDFT, with 1,934 births recorded.

HDFT meets 13 of 16 key performance indicators (KPIs), 7 standards are at the upper level of achievable and 6 at the acceptable threshold. HDFT is unable to meet the threshold for 3 KPIs (NP2, NH2 and NB4).

NHS England North (North Yorkshire and Humber) is the lead commissioner for antenatal and newborn screening programmes and also child health organisations (CHO). NHS Harrogate Clinical Commissioning Group (CCG) is the contract holder for maternity services.

## Findings

This is the second ANNB QA visit to this service. 13 of the 29 recommendations remain outstanding from the visit in 2015. A small team of highly motivated and committed staff support the antenatal and newborn screening programmes. The service relies on manual, person dependent processes to manage failsafe.

### Immediate concerns

The QA visit team identified no immediate concerns.

### High priority

The QA visit team identified 5 high priority findings as summarised below:

- governance arrangements for the screening programmes are not resilient
- limited annual audit to demonstrate failsafes and monitor performance against national programme standards
- national guidance for incident management is not being followed
- use of the newborn infant physical examination screening management and reporting tool (NIPE SMART) does not record outcomes
- business continuity for the child health organisation in the event of an IT failure and service change is not evident

### Shared learning

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

- the local screening co-ordinator (LCO) has direct communication with the Trust Executive Board for scrutiny of KPI monitoring
- 2 peer review audits following successful implementation of additional cardiac views to enhance screening for cardiac conditions
- use of a local newborn blood spot competency training package and mentors to improve performance for the key performance indicator for avoidable repeats (NB2)
- newborn hearing screeners are on an honorary contract which allows more flexibility in service delivery

# Recommendations

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

## Governance and leadership - commissioning

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 1 | NHS England North (North Yorkshire and Humber) commissioner to formalise contract monitoring and escalation process with NHS Harrogate Clinical Commissioning Group (CCG) | 4 to 10 | 6 months | Standard | Formal monitoring supported by new terms of reference and minutes |
| 2 | NHS England North (North Yorkshire and Humber) commissioners to make sure concerns about progression of the provider plan are escalated within the governance process | 4 to 10 | 6 months | Standard | Formal monitoring supported by new terms of reference and minutes |
| 3 | NHS England North (North Yorkshire and Humber) commissioner to include patient engagement in screening service delivery in the CCG contract | 4 to 10 | 12 months | Standard | Revised contract |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 4 | NHS England North (North Yorkshire and Humber) commissioner to include antenatal and newborn screening within their health inequality strategy and local improvement plan | 4 to 10 | 12 months | Standard | Health inequality strategy Local improvement plan |

## Governance and leadership - Trust

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 5 | Make sure clinical lead is identified to have oversight of newborn infant and physical examination (NIPE) in line with national guidance | 10,18,19, | 3 months | High | Identified leads in post |
| 6 | Make sure clinical lead is identified to have oversight of newborn hearing screening programme (NHSP) in line with national guidance | 9,17, | 3 months | High | Identified leads in post |
| 7 | Make sure a process is in place to monitor and review action plan progress within the maternity service governance structure | 4 to 10 | 3 months | High | Meeting minutes demonstrating monitoring of action plans as a standing agenda item |
| 8 | Include antenatal and newborn screening in the business continuity plan in the event of an IT system failure | 4 to 10 | 12 months | Standard | Ratified business continuity plan |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 9 | Make sure that consideration of screening is included in meetings between maternity and radiology | 3,5,6,14,15,23 | 3 months | Standard | Standing agenda<br>Minutes<br>Feedback to ANNB local operation screening meeting |
| 10 | Update maternity risk strategy to make sure that accountability for reporting, investigating and managing screening incidents are explicit and in line with national guidance and that learning is shared | 3 | 6 months | High | Updated maternity risk strategy with reference to NHS England Managing Safety Incidents in NHS Screening Programmes |
| 11 | Review and update the screening policies and guidelines to address the gaps identified and make sure they comply with national guidance including expected failsafe mechanisms | 4 to 10 | 6 months | Standard | Ratified guidelines and SOPs reflect national guidance and failsafe mechanisms |
| 12 | Review and update pathway for women with diabetes and make sure they comply with national guidance including expected failsafe mechanisms | 20,26 | 6 months | Standard | Ratified guidelines and SOPs reflect national guidance and failsafe mechanisms |
| 13 | Implement an annual audit schedule for all screening programmes to demonstrate failsafe processes and evidence that national programme standards are met | 4 to 10 | 3 months | High | Audit presented to governance board |
| 14 | Develop and complete an | 4 to 10 | 12 months | Standard | User survey presented to |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| | annual user satisfaction survey specific to antenatal and newborn screening | | | | ANNB screening oversight group.<br>Action plan to address any identified gaps |

## Infrastructure

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 15 | Make sure the local co-ordinator for screening has sufficient capacity and oversight to strategically manage the screening programmes | 4 to 10 | 3 months | High | Staff in post with appropriate job descriptions |

## Identification of cohort – antenatal

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 16 | Reduce reliance on manual processes for matching the screening cohort to improve efficiency and risk of error | 4 to 10, 26 | 12 months | Standard | Operational Group and the Maternity Risk Management Group minutes |

## Identification of cohort – newborn

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 17 | Make sure child health records are complete with newborn physical examination screening results | 2, 10, 18, 19 | 12 months | Standard | Operational Group and the Maternity Risk Management Group |

## Invitation, access and uptake

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 18 | Make sure the information for patients on the hospital website is up to date and in line with national guidance | 4 to 10 | 3 months | Standard | Updated website and SOP ratified by Trust |

## Sickle cell and thalassaemia screening

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 19 | Audit the pathway for sickle call and thalassemia screening to make sure that samples are received and results available within the expected timeframe | 7, 11, 13, | 6 months | Standard | Audit results reported via governance structure |
| 20 | Implement electronic FOQ | 7, 11, 13 | 12 months | Standard | Electronic FOQ implemented |
| 21 | Laboratory to implement process to confirm that screen positives have been received and actioned, and that father samples are received and reported | 7, 11, 13 | 6 months | Standard | Updated and revised laboratory SOP/guideline |
| 22 | Laboratory to implement and monitor a plan to meet the 3 day turnaround standard | 7, 11, 13 | 6 months | Standard | Audit to evidence compliance reported via the governance structure |

## Infectious diseases in pregnancy screening

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 23 | Identify a clinical lead with responsibility for the infectious diseases in pregnancy screening programme | 4, 12, 21, 22 | 3 months | Standard | Ratified updated organisational chart |

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 24 | Update the Centaur (analyser) standard operating procedure and remove reference to rubella screening | 4, 12, 21, 22 | 3 months | Standard | Ratified updated standard operating procedure. |
| 25 | Make sure a failsafe is in place to verify all samples received have a concluded result | 4, 12, 21, 22 | 6 months | Standard | Updated and revised laboratory risk assessment |

## Fetal anomaly screening

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 26 | Clarify patient pathway, contract arrangements and failsafe for women booked at Harrogate who attend FASP screening at Wharfdale | 5, 6, 14, 15, 16, 23 | 3 months | High | Present patient pathway to ANNB programme board |
| 27 | Make sure that the national screening pathway is followed for women who present late for Quad testing | 5, 6, 14, 15, 16, 23 | 3 months | Standard | Ratified updated SOP |
| 28 | Make sure a process is in place to collect anomaly information to inform the national congenital anomaly and rare disease registration service (NCARDRS) | 5, 6, 14, 15, 16, 23 | 12 months | Standard | Present audit findings |
| 29 | Make sure KPI FA2 data is accurate and accounts for all completed screens | 26 | 12 months | Standard | KPI data reporting |

## Newborn hearing screening

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 30 | Implement and monitor a plan to meet KPI NH2 | 9, 17, 26 | 6 months | Standard | Action plan that is agreed and monitored by programme board<br>Submission of data KPI NH2 |

## Newborn and infant physical examination

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 31 | Make sure all NIPE examination outcomes are recorded on NIPE SMART | 10, 18, 19 | 12 months | Standard | KPIs<br>Audit presented to the local ANNB operational group |
| 32 | Revise the newborn infant physical examination standard operating procedure to include the referral pathways for screen positive babies for all 4 individual referable conditions | 10, 18, 19 | 12 months | Standard | Revised guideline details the referral pathways to meet national programme standards |
| 33 | Make sure that babies with a screen positive result for the 4 referable conditions are seen in treatment services within the time frame to meet national programme standards and outcomes are recorded on the NIPE SMART system | 10, 18,19 | 6 months | Standard | Outcomes on NIPE SMART |
| 34 | Implement and monitor a plan to consistently meet KPI NP2 | 10, 18, 19, 26 | 6 months | Standard | Action plan agreed and monitored by the Programme Board |

## Newborn blood spot screening

| No. | Recommendation | Reference | Timescale | Priority * | Evidence required |
|---|---|---|---|---|---|
| 35 | Implement and monitor a plan to consistently meet KPIs NB2 and NB4 | 8, 24, 25, 26 | 6 months | Standard | Minimum threshold for NB4 met.<br>Action plan monitored through the ANNB Screening Operational Group, Contract Review Group and the Programme Board |

## 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.