



Public Health
England

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening
Programmes Hampshire Hospitals NHS
Foundation Trust

4 October 2016

Public Health England leads the NHS Screening Programmes

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Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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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 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 QA visit to the Hampshire Hospitals NHS Foundation Trust antenatal and newborn screening service held on 4 October 2016.

Purpose and approach to quality assurance (QA)

QA 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 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

Description of local screening service

The antenatal and newborn screening service at Hampshire Hospitals NHS Foundation Trust (HHFT) delivers screening to an eligible population of approximately 600,000 people. The local population is characterised as 80.74% white British, 9.46% white other and 2.49% Asian Indian (annual report 2015 – 16).

Local screening services are commissioned by specialised commissioning on behalf of NHS England (Wessex). Services provided at HHFT include laboratory services for sickle cell and thalassaemia and infectious diseases in pregnancy screening, the sonography service for first trimester screening and the 18 to 20+6 week fetal anomaly scan. Delivery of the service involves interdependencies with other providers for parts of the pathway and for laboratory services for Down's syndrome and newborn blood spot screening. The newborn hearing screening programme is a hospital model managed by HHFT and delivered by maternity support workers in community clinics

when the baby is five days old. Child health information services are provided by Southern Health NHS Foundation Trust.

There are identified leads within the provider organisations to coordinate and oversee the screening programmes.

Findings

Immediate concerns

The review team identified no immediate concerns.

High priority

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

- some incidents are not managed in line with the PHE guidance for managing incidents in NHS screening programmes as they are not reported to commissioners or to the screening quality assurance service when identified
- the haematology laboratory does not hold a valid United Kingdom Accreditation Service (UKAS) certificate

Shared learning

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

- the screening and immunisation team/commissioning team is proactive in ensuring that screening programmes are delivered to national specifications while maintaining oversight and mitigating risk
- there are screening champions within the community midwifery teams and the sonography department who take a lead role cascading information relevant to screening, training staff, assessing competency or checking failsafes
- the trust has systems to support communication in the absence of key individuals. These include a generic email account and a database to track samples shared between the haematology laboratory and the screening team
- review of 18 to 20+6 week fetal anomaly scan images identifies areas for improvement and supports quality in the screening programme
- in areas with a high ethnic minority population information in booking packs for pregnant women has been adapted to meet local needs
- there is a process in place in Basingstoke hospital which assures the provider that a blood sample has been sent for each woman who has had a scan as part of first trimester screening for Down's, Edward's and Patau's syndromes

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Timescale	Priority *	Evidence required
1.1	Revise the terms of reference for the Hampshire and Isle of Wight antenatal and newborn programme board to include membership, expectation of attendance, oversight of incidents and escalation of issues	6 months	Standard	Revised terms of reference
1.2	Revise the terms of reference for the provider antenatal and newborn screening group to include frequency of meetings, membership and expectation of attendance	6 months	Standard	Revised terms of reference
1.3	Embed programme specific meetings within the organisation	6 months	Standard	Formalise the terms of reference for the programme specific ANNB meetings Minutes from meetings
1.4	Formalise the terms of reference for the quarterly pathology meeting to include membership, expectation of attendance, oversight of incidents and escalation of issues	6 months	Standard	Terms of reference available with screening as a standing agenda item Minutes from meetings
1.5	Revise the incident management policy for each provider and ensure that NHS England and SQAS are informed of all incidents	3 months	High	Incident management policy implemented which reflects managing incidents in NHS screening programmes guidance

No.	Recommendation	Timescale	Priority *	Evidence required
1.6	Revise all screening pathways and standard operating procedures to ensure that local practice is in line with current national guidance	12 months	Standard	Revised guidelines and standard operating procedures which have been benchmarked against NHS screening programme service specifications and standards
1.7	Establish an annual audit schedule and ensure there is a systematic process for audit of antenatal and newborn screening pathways	12 months	Standard	At least two audits completed with action plans presented at the screening group meeting Screening group minutes
1.8	Ensure laboratory audits required annually are completed in recommended timeframes within the microbiology and hematology laboratories	12 months	Standard	Audits completed detailing findings and action plan presented at the screening group meeting Screening group minutes

Infrastructure

No.	Recommendation	Timescale	Priority *	Evidence required
2.1	Review the staffing resource within the sonography department to ensure the requirements of the NHS screening programmes are fulfilled	6 months	Standard	Documented workforce plan including succession planning
2.2	Strengthen compliance with education and training strategy for staff involved in undertaking first trimester screening within the sonography department	12 months	Standard	Induction and competency assessments available for agency staff Training records for staff who have completed the fetal anomaly e-learning modules

No.	Recommendation	Timescale	Priority *	Evidence required
2.3	Implement a strategy to strengthen liaison between the hearing screening management team and the screeners	12 months	Standard	Minutes of meetings Document processes for mentoring, training and input into personal development plans for hearing screeners
2.4	Strengthen education and training strategy for laboratory staff involved in local screening programmes	12 months	Standard	Training plan in place and completion monitored for all relevant laboratory staff
2.5	Develop IT solutions to reduce the reliance on manual processes for data transfer and collection	12 months	Standard	IT links between all relevant stakeholders ie maternity and antenatal screening laboratories or CHRD and newborn blood spot laboratory

Identification of cohort – antenatal

No.	Recommendation	Timescale	Priority *	Evidence required
3.1	Implement a system to track the booking cohort and ensure that all women who accept the offer, complete antenatal screening within nationally recommended timescales	6 months	Standard	System implemented Failsafe processes defined and documented to include identification of the eligible population, offer, acceptance or decline, results and onward referral if appropriate

Identification of cohort – newborn

No.	Recommendation	Timescale	Priority *	Evidence required
4.1	Develop failsafe systems between the child health records department and the hearing screening service to ensure accurate identification of the cohort including babies moving in and out of area	6 months	Standard	System implemented Failsafe processes defined and documented to include identification of the eligible population, offer, acceptance or decline, results and onward referral if appropriate
4.2	Document processes to ensure transfer of care for babies who transfer in and out of the area but who may not have completed newborn physical examination screening	6 months	Standard	Failsafe processes defined and documented to include identification of the eligible population, transfer of care process, results and onward referral if appropriate
4.3	Ensure all stakeholders document the process for notification of child death across departments	12 months	Standard	Processes documented in a standard operating procedure

Invitation, access and uptake

No.	Recommendation	Timescale	Priority *	Evidence required
5.1	Amend the electronic request form for infectious diseases screening to reflect the agreed format and terminology recommended in the NHS screening programme laboratory handbook	6 months	Standard	Revised request form

No.	Recommendation	Timescale	Priority *	Evidence required
5.2	Amend the request form (family origin questionnaire) for sickle cell and thalassaemia screening to reflect the agreed format and terminology recommended in the NHS screening programme laboratory handbook	6 months	Standard	Revised request form
5.3	Implement a system so women receive results of all screening tests if screening is performed before a miscarriage or termination of pregnancy	6 months	Standard	System implemented Process documented in a standard operating procedure
5.4	Revise the local policy for the re-offer of infectious disease screening for women who decline screening at booking	3 months	Standard	Revised policy in place Process documented in a standard operating procedure

Sickle cell and thalassaemia screening

No.	Recommendation	Timescale	Priority *	Evidence required
6.1	Ensure the application for UKAS accreditation for the sickle cell and thalassaemia screening laboratory is achieved	6 months	High	UKAS accreditation certificate
6.2	Amend the reports for sickle cell and thalassaemia screening to reflect the agreed format and terminology recommended in the NHS screening programme laboratory handbook	6 months	Standard	Revised report format

Infectious diseases in pregnancy screening

No.	Recommendation	Timescale	Priority *	Evidence required
7.1	Implement a timely tracking process for samples that are sent to the external laboratories	6 months	Standard	Documented process for tracking of samples
7.2	Document process for notifying women of screen positive results	6 months	Standard	Process documented in a standard operating procedure

Fetal anomaly screening

No.	Recommendation	Timescale	Priority *	Evidence required
8.1	Ensure a consistent approach to departmental review of first trimester scan images	6 months	Standard	Image review records for each individual involved in first trimester screening
8.2	Ensure women with suspected fetal anomalies are referred in line with fetal anomaly screening programme recommended timescales	3 months	Standard	Fetal anomaly screening programme annual data submission

Newborn blood spot screening

No.	Recommendation	Timescale	Priority *	Evidence required
9.1	Ensure a process is in place to give parents results of carrier conditions and for the other conditions where a baby has one screen positive result for newborn blood spot screening	6 months	Standard	Documented process for ensuring parents receive results for all newborn blood spot screening

Next steps

The screening service providers are responsible for developing an action plan to ensure completion of recommendations contained within this report.

SQAS will work with commissioners to monitor activity and progress in response to the recommendations made for a period of 12 months following the issuing of the final report to allow time for at least one response to all recommendations to be made.