Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Northumbria Healthcare NHS Foundation Trust (NHCT)

9 February 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 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 Northumbria Healthcare NHS Foundation Trust antenatal and newborn screening service held on 9 February 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 collected during pre-review visits to Berwick Community Hospital on 16 January 2017
- information shared with SQAS North as part of the visit process

Description of local screening service

Northumbria Healthcare NHS Foundation Trust (NHCT) provides care for the population of Northumberland (316,000) and North Tyneside (203,000). The Trust borders Newcastle, Cumbria and Scotland and is responsible for providing antenatal, intrapartum and postnatal care. In 2015 to 2016, 5,800 women booked for maternity care at NHCT and there were 3132 births. Care is provided at six hospital sites.

Northumbria Healthcare NHS Foundation Trust (NHCT) provides laboratory services for infectious diseases screening in pregnancy (IDS) and sickle cell and thalassaemia screening (SCT), ultrasonography, audiology and child health services. Newcastle Upon Tyne Hospitals NHS Foundation Trust (NUTH) provides laboratory services for Down's, Edwards' and Patau's syndrome screening and newborn blood spot screening.

NHCT has met eight of the 13 key performance indicators (KPIs), with two at the upper level of achievement and six at the acceptable threshold. NHCT is unable to provide matched cohort data for two KPIs (ID1 and ST1).

NHS England North (Cumbria and the North East) (CaNE) is the lead commissioner for antenatal and newborn screening programmes. NHS Northumberland and NHS North Tyneside clinical commissioning groups (CCG) are the contract holders for maternity services.

In March 2015, NHCT was chosen as a 'vanguard' site by NHS England.

Findings

Antenatal and newborn screening in NHCT is a well led woman focussed service with a strong ethos for quality improvement. It is delivered by a team which is motivated and works well across all disciplines. The commitment to address areas falling short of standards, maintain patient safety and drive programme quality is clearly evident.

Immediate concerns

The QA visit team identified no immediate concerns

High priority

The QA visit team identified 12 high priority findings as summarised below:

- unable to provide robust cohort data to assure the antenatal screening programmes
- failure to meet the acceptable threshold for KPI's NB2 and FA1
- limited annual audit to demonstrate failsafes and monitor performance against national programme standards and key performance indicators
- from the evidence submitted, the screening steering group has limited attendance by programme leads
- screening failsafes are not monitored in the event that the screening midwives are absent
- the maternity risk management policy does not reflect accountabilities for reporting, investigating, and managing ANNB screening incidents, and there is no reference to national guidance
- NHCT has developed an in house NIPE training programme which is not university accredited
- the pathway for women booking late for antenatal care does not reflect the need for urgent screening for infectious diseases

Shared learning

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

- identified screening link midwives are based at each hospital site to enable the dissemination of information
- screening incidents are reported in the ‘safety brief’ to ensure timely cascade to all staff
- failsafes implemented for newborn screening to identify the cohort of babies born in Scotland to ensure timely and concluded screening results
- CHRD have secured funding for a data comparison tool to support the electronic matching of data on GP and CHRD systems

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Revise the terms of reference for the screening steering group to include membership and quoracy	3, 4, 10	6 months	High	Terms of reference, agendas, action plans, performance monitoring and meeting notes
2	Ensure that cross cover arrangements are in place for ANNB screening when the screening midwife is absent	1	3 months	High	Documentation of cross cover arrangements SOP for failsafe processes
3	Update the maternity risk strategy and laboratory risk guidance to ensure accountabilities for reporting, investigating and managing screening incidents are explicit and reference national guidance	1	6 months	High	Updated and revised risk strategy
4	Review standardised operating procedures to meet national screening standards and guidance	2, 3, 4, 6	6 months	Standard	Updated and revised SOPs
5	Implement an annual audit schedule for all screening programmes to demonstrate failsafe processes and that national programme standards are met	2-11	12 months	High	Audit presented to governance board. Action plan to address any identified gaps

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6	Ensure that the results of the current user survey are used for service improvement	2-8	12 months	Standard	User survey presented to SSG. Action plan to address any identified gaps

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
7	Amend screening support sonographer and deputy job descriptions to reflect the roles and responsibility of the posts with protected time to drive quality improvement	3,4,11	3 months	High	Revised job description. Job plan
8	Review and update the job descriptions for child health record department staff to reflect accountabilities, roles and responsibilities in relation to screening	6	3 months	High	Job description
9	Ensure requirements to replace NHSP equipment is escalated through the ANNB screening governance structures. Review the financial arrangements to ensure there is clarity regarding responsibilities	7	3 months	High	Minutes of meetings reflect financial arrangements
10	Apply for accreditation for the NIPE training programme currently delivered in house	8, 15	12 months	High	Monitor progress via the OGOG

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
11	Provide matched cohort data for KPI ID1 and ST1	14	12 months	High	Updated action plan of progress monitored through the OGOG
12	Implement a failsafe process for women booked by NHCT for delivery at Borders General Hospital to ensure timely follow up of antenatal screening results	2,3,4,5	6 months	High	Working failsafe implemented and monitored by the SSG

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
13	Review the process for timely collection of the NBS for movements in from abroad	6, 14	12 months	Standard	Updated process and accurate data submitted for NB4. Outcome monitored via the SSG
14	Audit the failsafes for the three newborn screening programmes for babies born at Borders General Hospital	6,7,8	12 months	Standard	Audit findings reported to the SSG

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
15	Provide links to the NHS Choices website from the ANNB screening information on the NHCT website	16	6 months	Standard	Evidence of updated links

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
16	Review the process for all women booking for antenatal care at all maternity sites to ensure early and timely access to ANNB screening	5	12 months	Standard	Review outcomes monitored via the SSG
17	Investigate the variance in uptake of combined and quadruple testing across all sites	2-8	12 months	Standard	Report findings via the SSG

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
18	Provide monthly feedback to the screening midwife on samples which arrive in the laboratory with an incorrect FOQ. Analyse themes to improve practice	5,13	3 months	Standard	Data analysed and discussed at the SSG
19	Implement an electronic FOQ	5,13	12 months	Standard	Action plan and progress reported through SSG

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20	Review and update the IDS guidance to meet national standards	2	6 months	Standard	Updated guideline agreed by SSG

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
21	Review the pathway and guidance to ensure women who book after 26 weeks of pregnancy have samples tested as a matter of urgency	2, 10	3 months	High	Pathway review and guideline updated monitored by the SSG
22	Ensure all babies born to hepatitis B positive women receive vaccination/immunoglobulin by maternity service as required	2	6 months	Standard	Monthly data returns demonstrate coverage and detail of action/concluded outcome. Reported via SSG and CaNE Programme board

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
23	Implement a failsafe for the monitoring of quad samples sent to Borders General Hospital to ensure timely receipt of sample and results	3	6 months	Standard	Implementation of failsafe monitored by the SSG
24	Review the process for notification of anomalies before and after birth to provide complete data on the 11 auditable conditions	4	12 months	Standard	Quarterly data monitored via the SSG
25	Review the pathway for women who have a fetal anomaly detected to ensure that they are referred and seen to meet national standards	4, 11, 9	6 months	High	Review monitored via the OGOG

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
26	Meet the acceptable threshold for key performance indicator NB2	6,14	6 months	Standard	Consistently met acceptable level for key performance indicator NB2 with progress to meeting the achievable threshold. Action plan monitored via the SSG

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.