Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Leeds Teaching Hospitals NHS Trust (LTHT)

14 June 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 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 Leeds Teaching Hospitals NHS Trust screening service held on 14 June 2017.

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 interviews with the newborn hearing screening (NHSP) programme manager, community midwifery and neonatal service staff (newborn blood spot pathway) and the partner testing service for sickle cell and thalassaemia (SCT) Leeds Community Healthcare NHS Trust
- information shared with SQAS North as part of the visit process

Local screening service

Leeds Teaching Hospitals NHS Trust (LTHT) provides care for the population of Leeds (766,000) and the wider West Yorkshire region (2,500,000). The Trust is a large and complex organisation providing maternity services across several hospital sites. These include St James University Hospital (SJUH), Leeds General Infirmary (LGI) and Wharfedale Hospital.

In 2015 to 2016, 11,111 women booked for maternity care at LTHT and there were 9552 births.

Leeds Teaching Hospitals NHS Trust (LTHT) provides laboratory services for infectious diseases screening in pregnancy (IDS) and sickle cell and thalassaemia screening (SCT), ultrasonography and audiology. Leeds Community Healthcare NHS Trust (LCHT) provides child health information services.

LTHT provides regional laboratory services for Down's, Edwards' and Patau's syndrome screening and newborn blood spot screening. There are also services for confirmatory testing for sickle cell disease and infectious diseases. These services are outside the remit of this report.

NHS England North (Yorkshire and the Humber) is the lead commissioner for antenatal and newborn screening programmes. Clinical commissioning groups (CCG) NHS Leeds South and East, NHS Leeds North and NHS Leeds West hold the contract for maternity services.

Findings

Antenatal and newborn (ANNB) screening is a well-led, woman-focussed service with a strong ethos for quality improvement. The team are motivated and work well across all disciplines that deliver the service. The commitment to address areas falling short of standards, maintain patient safety and drive programme quality is evident.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 15 high priority findings as summarised below:

- the maternity risk management policy does not demonstrate accountabilities for reporting, investigating and managing ANNB screening incidents
- newborn hearing screening programme is not compliant with national standards for education and training, equipment checks and staff competency assessments
- the Trust is unable to provide electronically matched antenatal data for the cohort of women screened
- failure to improve KPIs
- limited annual audit to demonstrate failsafes and monitor performance against national programme standards
- partner testing service for Leeds Community Healthcare NHS Trust lacks resilience to cover for absence and is unable to provide assurance of relevant failsafe mechanisms

Shared learning

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

- the Haamla team is established to support vulnerable families
- the SHE programme (Strong, HIV-positive, empowered women) is in place to address specific challenges facing women living with HIV
- monthly multidisciplinary team meetings for women who are screen positive for infectious diseases
- staff in the neonatal service are trained to access the newborn blood spot failsafe
- sickle cell and thalassaemia, and infectious disease laboratories have comprehensive and updated systems and processes in place. These include governance, audit, education and training
- community midwives offer a dedicated clinic appointment for newborn blood spot screening for babies who move in under one year old

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Implement a process to ensure that KPIs and related action plans are monitored via the maternity governance structure	13,17,18,23,24, 26	3 months	High	Meeting minutes demonstrating KPIs and monitoring of action plans as a standing agenda item
2	Update maternity risk strategy to ensure accountabilities for reporting, investigating and managing screening incidents are explicit	3	6 months	High	Maternity risk strategy
3	Review and update the screening policies and guidelines to address the gaps identified and ensure compliance with current national guidance and expected failsafe mechanisms	4-25	6 months	High	Ratified guidelines and standard operating procedures reflect national guidance and failsafe mechanisms
4	Implement an annual audit schedule for all screening programmes to demonstrate failsafe processes and that national programme standards are met	11-15, 17, 18, 19,21, 23 24	12 months	High	Audit presented to governance board. Action plan to address any identified gaps
5	Make sure ultrasonographers receive timely feedback of monthly image review	14, 15	6 months	Standard	Three monthly feedback of image reviews

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	Develop a multidisciplinary group to review outcomes from abnormalities detected at ultrasound scan. Include the review of cases detected following delivery	14, 15,16	12 months	High	Minutes of meetings to demonstrate review of cases
7	Develop and complete an annual user satisfaction survey specific to antenatal and newborn screening	4-10	12 months	Standard	User survey presented to ANNB screening oversight group. Action plan to address any identified gaps

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8	Review and update job descriptions to reflect accountabilities, roles and responsibilities in relation to screening	5, 7, 9, 10	6 months	Standard	Job descriptions
9	Make sure there are adequate numbers of appropriately trained staff in place to deliver the NHSP, NIPE and SCT laboratory screening programmes	7,8,10	12 months	Standard	Staff in post
10	Develop an action plan to meet national standards for turnaround times for sickle cell and thalassemia screening samples	7,11	6 months	High	Minutes from maternity and laboratory governance meetings demonstrating monitoring of action plan
11	Increase the frequency of quality assurance checks on obstetric ultrasound machines	16	6 months	Standard	Standard operating procedures and logs demonstrating equipment checks
12	Formalise the arrangements for the monitoring and checking of equipment for the newborn hearing screening programme	9,17	6 months	High	Standard operating procedures and logs demonstrating equipment checks

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Update Acculink software for newborn hearing screening programme at the Leeds General Infirmary Hospital site	9,17	3 months	High	Updates to equipment monitored through the maternity governance structure
14	Make sure mandatory training sessions for midwifery, nursing and medical staff include updates on the newborn screening programmes	8-10, 17,18,19	6 months	Standard	Mandatory training programmes
15	Implement a process to monitor competency, education and training for newborn hearing screening staff	9,17	3 months	High	Training and education logs

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Develop a mechanism to enable electronic matching of the antenatal screening cohort	26	12 months	High	Defined electronic failsafe processes included in standard operating procedures
17	Make sure women booking from out of area have booking blood samples taken in line with national standards	13	6 months	Standard	Audit demonstrates compliance with national standards
18	Develop a standard operating procedure to ensure the results of antenatal booking blood samples are checked in line with national standards	21	6 months	High	Standard operating procedure

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Make sure there is a process to notify the child health record department of all patient transfers	2	6 months	Standard	Standard operating procedure
20	Implement a process for notifying key stakeholders about deceased babies including updating the baby's status as deceased on screening IT systems	8-10	3 months	High	Standard operating procedure for the notification of deceased babies with roles and responsibilities clearly outlined

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
21	Implement an electronic FOQ	7,11,13	12 months	Standard	Action plan and progress reported through maternity governance structures
22	Review the haemoglobinopathy pathway to make sure it is adequately staffed and there is a clear interface between the sickle cell and thalassemia partner testing service for Leeds Teaching Hospitals NHS Trust and Leeds Community Healthcare NHS Trust	7,13	6 months	Standard	Report outcomes via the maternity governance structure and the NHS England North (Yorkshire and the Humber) programme board meeting
23	Make sure as many partners are offered testing as possible before 11 weeks and six days of pregnancy	7,13	6 months	Standard	Data monitored through the maternity governance structure and NHS England North (Yorkshire and the Humber) programme board meeting

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Make sure there is a process in place to inform the infectious diseases laboratory of samples which require fast track screening	21	3 months	High	Guideline/policy in place communicated to staff

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Implement and monitor a plan to meet FA1 acceptable threshold	23	12 months	Standard	Action plan that is agreed and monitored by programme board. Submission of KPI data-FA1
26	Make sure women with a twin pregnancy are counselled appropriately prior to trisomy screening	23	3 months	High	Guideline/policy

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Implement and monitor a plan to meet NH1 and NH2 acceptable thresholds	17	12 months	Standard	Action plan that is agreed and monitored by programme board Submission of KPI data-NH1 and NH2
28	Put in place secure electronic transfer of newborn hearing screening programme results to the child health records department	17	12 months	Standard	Secure electronic transfer implemented

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Meet the national standard for babies found to have an abnormality on examination of the hips following newborn infant physical examination	10	3 months	High	Meet the acceptable threshold for KPI NP2 consistently

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
30	Make sure child health record department report missing samples by 14 days	2,24	6 months	Standard	Standard operating procedure
31	Investigate the outstanding samples on the newborn blood spot failsafe system	24	6 months	High	Results reported via the maternity governance structure

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.