Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes

North Middlesex University Hospital NHS Trust

27 September 2017

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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 makes sure programmes are safe and effective by checking that national standards are met.

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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 North Middlesex University Hospital NHS Trust screening service held on 27 September 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 make sure 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 the hearing screening provider at the Trust, The Whittington Health on 18 September 2017, Child Health Information Service, North East London Foundation Trust, and Health Services Laboratory pre-review visits on 26 September 2017
- information shared with the London regional SQAS as part of the visit process

Local screening service

North Middlesex University Hospital NHS Trust (NMUH) is situated in North Central London serving a local population of 350,000 in the boroughs of Enfield and Haringey and surrounding areas including Barnet and Waltham Forest. There has been an increase in referrals since the closure of Chase Farm hospital maternity unit in 2013. The Trust provides the full range of antenatal, labour, birth and postnatal care. All ANNB screening programmes are offered.

In the financial year 2016 to 2017, 5,116 women were booked at the Trust with 5,045 babies born. Laboratory services are provided by Health Services Laboratory for infectious diseases in pregnancy screening and sickle cell and thalassaemia screening. Laboratory services for first trimester Down's, Edward's and Patau's syndromes screening and second trimester screening for Down's syndrome are provided by Birmingham Women's and Children's NHS Foundation Trust.

Great Ormond Street Hospital (GOSH) newborn screening laboratory provides the screening service for the newborn blood spot screening programme. Newborn hearing screening is provided by The Whittington Health NHS Trust.

Findings

This was the first QA visit to NMUH.

The maternity service at NMUH has seen significant challenges in the past 3 to 4 years; particularly in senior management stability. The head of midwifery has changed a number of times over this period and currently this is an interim appointment. There have also been recent changes of staff at executive level.

Despite these challenges the service demonstrates an open culture and willingness to learn. The senior team interviewed were clearly able to articulate the vision and strategy for the service.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 14 high priority findings as summarised below:

- define and document roles and responsibilities, including senior accountability and oversight, within the antenatal and newborn screening programmes
- the Health Services Laboratory must be accredited in line with section 7a service specifications
- make sure pathways are in place to allow equitable and early access to screening services
- implement a weekly process for tracking each woman through the screening pathway to make sure that screening is offered, tests are performed and results are received

- make sure all women who miscarry or terminate their pregnancy receive their results and those who screen positive are referred directly to specialist services
- implement a tracking process to make sure all women are identified, referred to and seen by specialist services if they screen positive for any antenatal screening tests
- implement a process for notifying key stakeholders about deceased babies (including updating the baby's status as deceased on the screening IT systems)
- make sure all women have access to interpreting services where required
- report ST2 & ST3 key performance indicators (KPI) in line with the national KPI definitions
- implement the national Family Origin Questionnaire (FOQ) template and make sure the laboratory use the FOQ to interpret all antenatal results
- implement and monitor a plan to meet the acceptable threshold for KPI ID2
- implement and monitor a plan to meet the acceptable threshold for KPI NH2
- implement the national electronic NIPE SMaRT system to make sure accurate cohort identification and effective failsafe pathways for newborn infant physical examination (NIPE) are in place
- report NP1 & NP2 KPI's in line with definitions
- implement and monitor a plan to meet the acceptable threshold for KPI NB2

Shared learning

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

- a 'message of the week' pops up on the maternity system when staff log in and this is used to provide information to all staff - for example it has been used to highlight themes from ANNB incidents
- all new midwives who start with the Trust spend a day shadowing the screening midwives as part of their induction
- George Marsh Centre aim to offer a home visit the same day they contact the parents with a newborn blood spot sickle cell disease affected result
- to improve performance of KPI ID2, Hepatitis B positive women are informed of the date of their appointment with the hepatologist when they are seen by the screening midwife
- the early pregnancy assessment unit refer women directly to the maternity service to improve early access
- the screening and immunisation team has undertaken 2 health equity audits in the past 4 years

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Define and document roles and responsibilities, including senior accountability and oversight, within the antenatal and newborn screening programmes	1-5, 7	3 months	High	Document/s to be presented to the Trust Screening Steering Group (TSSG) with confirmation of circulation to key staff and stakeholders
2	Identify lead/s for newborn screening programmes within the neonatal unit	5, 7	3 months	Standard	The lead/s to be identified and attend the TSSG
3	Review membership of TSSG to make sure all screening programme leads are invited to attend	1-7	3 months	Standard	Updated terms of reference presented and agreed at the TSSG
4	Update relevant local policies to include reference to managing screening incidents in accordance with ‘Managing Safety Incidents in NHS Screening Programmes’	8	6 months	Standard	Updated policies ratified with the guidelines review team and presented at the TSSG
5	Make sure programme standard operating procedures (SOP) are developed and approved in accordance with the Trust quality management system or equivalent	1-2	12 months	Standard	Updated SOP ratified with the guidelines review team and presented at the TSSG
6	Update antenatal and newborn screening guidelines in line with national guidance	1-7, 11-23	6 months	Standard	Updated guidelines ratified with the guidelines review team and presented at the TSSG
7	Health Services Laboratory must make sure that all processes specific to the ANNB	1, 4, 12, 13	6 months	Standard	Work instruction ratified with Health Services Laboratory and NMUH and

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	screening services provided for NMUH are documented				presented at the TSSG
8	Include screening audits in the maternity audit schedule	1-7	12 months	Standard	Completed audits, with actions followed up in line with Trust audit management policy. Audit findings and actions presented at TSSG
9	Antenatal screening laboratories to schedule regular audits specific to the screening pathways. This should include vertical audits	1, 4, 12, 13	12 months	Standard	Audit reports and action plans presented at the TSSG
10	Complete a user survey to gather views about the antenatal and newborn screening pathways	1-7	12 months	Standard	User feedback survey completed and action plans developed via TSSG
11	The Health Services Laboratory must be accredited in line with section 7a service specifications	1, 4	12 months	High	Confirmation of accreditation submitted to the TSSG

Infrastructure

No.	Recommendation	Reference	Times	Priority	Evidence required
12	Review current provision of administrative support for the screening pathways and make sure this is in line with the national service specifications	1-5, 7	6 months	Standard	Confirmation to the TSSG that administration support for all ANNB programmes is in place

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Make sure pathways are in place to allow equitable and early access to screening services	1-4	6 months	High	Pathway demonstrating equitable and early access Action plans from any audits re: late bookings presented to TSSG
14	Implement a weekly process for tracking each woman through the screening pathway to make sure screening is offered, tests are performed and results are received	1-4	6 months	High	Submission of KPI data – ID1, ST1, ST2, ST3, FA1, FA2 Work instruction for managing the tracking process with roles and responsibilities clearly outlined
15	Make sure all women who miscarry or terminate their pregnancy receive their results and those who screen positive are referred directly to specialist services	1, 4	3 months	High	Confirmation at TSSG and amended guideline to reflect practice
16	Implement a tracking process to make sure all women are identified, referred to and seen by specialist services if they screen positive for any antenatal screening tests	1-4, 10, 11,15,19	3 months	High	Work instruction for managing the tracking process with roles and responsibilities clearly outlined

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
17	Implement a daily auditable process to identify and track each baby through the NIPE and Newborn Blood Spot (NBS) screening pathways to referral	5 & 7	6 months	Standard	Work instruction for the tracking of babies in the NIPE & NBS screening programme
18	Implement a process for notifying key stakeholders about deceased babies	4-7	3 months	High	Work instruction for the notification of deceased babies with roles and

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	(including updating the baby's status as deceased on the screening IT systems)				responsibilities clearly outlined
19	Implement a documented process to inform the newborn screening programmes of birth notification errors so that relevant failsafe systems are updated	5-7	12 months	Standard	Work instruction for the notification of birth notification errors with roles and responsibilities clearly outlined

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
20	Make sure all women have access to the leaflet 'screening tests for you and your baby' in other languages where required	1-7	3 months	Standard	Confirmation at TSSG.
21	Make sure all women have access to interpreting services where required	1-7	3 months	High	Confirmation at TSSG Audit on the use of interpreting service scheduled and presented at TSSG

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Report ST2 & ST3 KPI's in line with the national KPI definitions	10	3 months	High	Confirmation at TSSG and in KPI submission document that KPIs are reported as per definitions
23	Make sure all George Marsh Centre staff who counsel pregnant women are up to date with any changes in service specifications and standards	4, 11	12 months	Standard	Training logs with completion of antenatal Sickle cell and thalassemia screening e-learning included
24	Revise request forms (paper and electronic) to meet minimum data fields specified by the national programme	12	6 months	Standard	Revised request forms compliant with national programme minimum data fields

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25	Implement the national FOQ template and make sure the laboratory use the FOQ to interpret all antenatal results	11, 12	3 months	High	Confirmation via TSSG

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
26	Make sure each woman who declines the initial offer of IDPS screening (HIV, hepatitis B and/or syphilis) is identified, tracked and re-offered screening by 20 weeks of pregnancy	1	3 months	Standard	Database to demonstrate tracking. Submission of coverage KPI data ID1, ID3 and ID4. Annual audit of declines.
27	Implement and monitor a plan to meet the acceptable threshold for KPI ID2	10, 15	3 months	High	Action plan agreed and monitored at TSSG
28	Implement a tracking system for samples sent to Colindale laboratory	10, 15	6 months	Standard	Work instruction submitted to TSSG

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
29	Make sure protected time is given to the Screening Support Sonographer (SSS) to allow image review to be undertaken as per FASP guidelines	17	6 months	Standard	Audit findings shared with TSSG
30	Identify a deputy screening support sonographer	2, 18	12 months	Standard	Confirmation at the TSSG

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required

No.	Recommendation	Reference	Timescale	Priority	Evidence required
31	Implement and monitor a plan to meet the acceptable threshold for KPI NH2	10, 22	3 months	High	Action plan agreed and monitored at TSSG
32	Audit the reasons for high referral rates to audiology services	22	6 months	Standard	Audit findings presented at TSSG

Newborn and infant physical examination

No.	Recommendation	Reference	Times	Priority	Evidence required
33	Implement NIPE SMaRT to make sure accurate cohort identification and effective failsafe pathways are in place	7, 10, 21	12 months	High	Implementation of NIPE SMaRT
34	Report NP1 & NP2 KPI's in line with national definitions	10	3 months	High	Confirmation at TSSG KPI's are reported as per definitions
35	Make sure there is adequate cover within the service to provide an effective failsafe pathway	7	6 months	Standard	Confirmation at TSSG cover arrangements are implemented

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
36	Review the management of the Newborn Blood Spot Failsafe Solution (NBSFS) to provide an effective failsafe pathway	5	6 months	Standard	Documented failsafe processes in a SOP/guideline presented at the TSSG
37	Implement a tracking system for repeat newborn bloodspot sampling	5, 23	3 months	Standard	Confirmation at the TSSG and updated guideline/SOP
38	Implement and monitor a plan to meet the acceptable threshold for KPI NB2	5, 10, 23	3 months	High	Action plan agreed and monitored at TSSG

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.

Appendix A: References

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3. Service specification no.17 - NHS Fetal Anomaly Screening Programme – 18+0-20+6 week fetal anomaly scan (2016/17)
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5. Service specification no.19 - NHS Newborn Blood Spot Screening Programme (2016/17)
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    www.gov.uk/government/uploads/system/uploads/attachment_data/file/523320/PHE_Screening_KPI_definitions_2016_to_17.pdf

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www.gov.uk/government/uploads/system/uploads/attachment_data/file/539835/NHS_Infectious_Diseases_in_Pregnancy_Screening_Programme_Handbook_2016_2017_with_gateway_number.pdf

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