Public Health England

NHS

Screening Quality Assurance Visit Report

NHS Antenatal and Newborn Screening Programmes Ashford and St Peter's Hospitals NHS Foundation Trust

10 May 2016

Public Health England leads the NHS Screening Programme

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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

The findings in this report relate to the quality assurance (QA) review of the Ashford and St Peter's Hospitals NHS Foundation Trust antenatal and newborn screening programmes held on 10 May 2016.

1. Purpose and approach to quality assurance (QA)

The aim of quality assurance (QA) in NHS screening programmes is to maintain minimum 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 is derived from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations as appropriate
- evidence submitted by the provider(s), commissioner and external organisations as appropriate
- information collected during pre-review visits
- information shared with the south regional QA service as part of the visit process

2. Description of local programme

Ashford and St Peter's Hospitals NHS Foundation Trust provides hospital and community services to a local population of approximately 380,000. The maternity service booked over 4360 women for pregnancy care during 2014 to 2015 and 4130 babies were born. This population is characterised by: 83.5% white British, with a further 6.9% stated as white. Indian was the next largest ethnic group with 1.8%. The average age of women booked was 32.

Ashford and St Peter's Hospitals NHS Foundation Trust provides the following services:

- maternity service at the acute and community sites
- ultrasound service for first trimester Down's, Edwards' and Patau's syndrome screening and the 18-20+6 week scan

- newborn hearing screening service (hospital model provided through a contract with Virgin Care Services Limited)

Delivery of this screening service involves interdependencies with other departments and providers to form parts of the pathway:

- analysis of blood samples for the fetal anomaly screening programme (FASP) is provided by the Wolfson Institute of Preventive Medicine, Barts and The London School of Medicine and Dentistry
- analysis of newborn blood spot samples is performed at South West Thames Newborn Blood Spot Screening Laboratory at Epsom and St. Helier University Hospitals NHS Trust
- laboratory services for sickle cell and thalassaemia and infectious disease screening are provided by Surrey Pathology Services hosted by Frimley Health NHS Foundation Trust
- child health records department is provided by Virgin Care Services Limited

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

3. Key findings

The overall impression is of a committed team delivering a screening service to women and their families in Surrey. The team had an open, honest approach to this review and a real desire to ensure improvements to service provision are implemented.

Planned changes have been introduced to the management and delivery of the screening programme since autumn 2015 and the foundation trust welcomed the QA visit as a catalyst for identification of any gaps in the antenatal and newborn screening service. Key issues, which the QA visit team identified, include:

- identification of cohort
- early booking
- governance arrangements

Identification and tracking of an accurate cohort of pregnant women is hampered by a lack of IT systems. The screening service does have a range of failsafes in place to ensure that all pregnant women are managed appropriately. However, the failsafes are heavily dependent on paper-based systems.

NHS screening programme standards recommend that women are booked before ten weeks gestation. The key performance indicators for 2015/16 report that 41% of women had blood tests before ten weeks. Referral pathways are convoluted. Simplification could encourage early booking and ensure that the eligible population is accurately identified.

The QA visit team recognised that there had been considerable developmental work undertaken within the previous nine months. At the time of the visit, revised governance arrangements were in place for antenatal and newborn screening programmes. These need to be clarified further to ensure that there is a structured pathway from provision of the screening service through to the foundation trust board. In particular, escalation processes need to be clarified.

High priority issues are summarised below as well as areas of good practice. For a complete list of recommendations, please refer to the related section within the full report, or to the list of all recommendations.

3.1 Shared learning

- communication links and partnership working between all stakeholders and, in particular, the maternity unit, screening and immunisation team and screening quality assurance team
- there is a caseload midwifery team for women at Bronzefield Prison to ensure continuity of care. Newborn hearing screeners also visit the prison to provide screening on site
- the maternity department has been proactive in seeking support, including from external organisations to review and identify risks within the screening pathway
- recent transition for newborn hearing screening provision from a community to hospital model was well managed with key performance indicators remaining above the acceptable level

3.2 Immediate concerns for improvement

The review team identified no immediate concerns.

3.3 High priority Issues

The review team identified seven high priority issues as grouped below. Please see section 3.4 for related recommendations:

- identify and inform population. The eligible population needs to be accurately identified, and the ability to track women through referral and booking pathways needs development, to encourage early booking
- test – failsafes are required to ensure timely receipt of repeat blood samples by the laboratory
- governance – there are a number of governance issues which need to be addressed so that assurance regarding the quality and safety of the trust screening programmes can be provided. These include reviewing the governance structure to ensure that escalation lines are clear and the inclusion of screening within the audit schedule

3.4. Key recommendations

A number of recommendations were made related to the high-level issues identified above. These are summarised in the table below:

Level	Theme	Description of recommendation
High	Identify and inform population	Revise referral and booking pathways to ensure cohort identification and no appointment delays
High	Identify and inform population	Develop strategies to improve the number of women booked before ten weeks gestation
High	Identify and inform population	Document the process of notification of child death to all relevant stakeholders and audit to ensure compliance
High	Test	Implement a failsafe for closing the loop on rejected sickle cell and thalassaemia and infectious diseases samples
High	Test	Introduce a system to track newborn bloodspot repeat requests
High	Governance	Revise the maternity governance chart to ensure all groups are identified with clear lines of escalation to the trust board
High	Governance	Ensure directorate audit schedule includes all aspects of screening pathway
High	Governance	Ensure adequate time for the screening support sonographer to undertake the role

4. Next steps

Ashford and St Peter's Hospitals NHS Foundation Trust is responsible for developing an action plan to ensure completion of recommendations contained within this report.

NHS England South (South East) will be responsible for monitoring progress against the action plan and ensuring all recommendations are implemented.

The Screening QA Service South will support this process and the ongoing monitoring of progress.