Public Health England

NHS

Quality Assurance visit report

Antenatal and Newborn Screening Programmes

Observations and recommendations from visit to Croydon Health Services NHS Trust

11 May 2016

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

The findings in this report relate to the quality assurance (QA) review of the Croydon Health Services NHS Trust Antenatal and Newborn Screening Programmes held on 15 and 16 March 2016.

1. Purpose and approach to Quality Assurance

The aim of 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 shared with the Screening Quality Assurance Service (London) as part of the visit process

2. Description of local screening programme

Croydon Health Services NHS Trust (CHS) serves the borough of Croydon in South West London, providing services for a population of over 360,000. Croydon is a large and diverse borough with 75% of the local population being from a non-white British background. Croydon has some of the most deprived areas in London.

The maternity unit is based at Croydon University Hospital with care also being provided in antenatal clinics at Purley War Memorial Hospital and a variety of community settings. The Trust provides inpatient and outpatient care to approximately 4000 women per year. Antenatal sickle cell and thalassaemia (SCT) counselling services are provided by CHS and are based at the Croydon SCT centre.

Since October 2015, antenatal laboratory services for infectious diseases and sickle cell and thalassaemia have been provided by South West London Pathology (SWLP) at the hub based at St George’s Hospital, Tooting.

Prenatal diagnosis for SCT takes place at King's College Hospital NHS Foundation Trust. Fetal anomaly prenatal diagnosis services are provided by St George's University Hospitals NHS Foundation Trust. All antenatal samples for Down's, Edwards' and Patau's syndromes (trisomies 21, 18 and 13) are sent to the Wolfson Institute of Preventive Medicine.

Newborn blood spot screening laboratory services are provided by South West Thames laboratory at Epsom and St Helier University Hospitals NHS Trust.

CHS maternity services are commissioned by Croydon CCG. The commissioners of the antenatal and newborn screening programmes for CHS are the NHS England London Section 7A Public Health commissioning team.

3. Key findings

The Immediate and High priority issues are summarised below as well as areas of good practice.

On the visit day, we met a committed and engaged team who showed a willingness to improve their services and deliver high quality antenatal and newborn screening programmes. We saw a number of examples of strong communication links between departments and evidence of good working relationships within teams.

The screening team consists of a full time screening co-ordinator, a full time infectious diseases midwife and a full time maternity support worker. During the visit, it was reported the screening team structure is currently under review to ensure the whole pathway for every programme is included and to bring more clarity to roles and responsibilities.

The community matron is responsible for the oversight of all antenatal and newborn screening programmes. She is actively involved in the day to day running of the programmes and is the Chair of the Trust's antenatal and newborn screening steering group (SSG).

The lack of effective, timely failsafe systems to track the eligible antenatal cohort for infectious diseases, sickle cell and thalassaemia and fetal anomalies, was an immediate concern identified during the visit. Linked to this concern is the lack of failsafe systems for all antenatal screen positive results, to ensure these are notified to the screening team for appropriate referrals and care plans to be implemented.

Performance for key performance indicator (KPI) ST2 (SCT testing by 10+0 weeks) is consistently below the achievable standard. Recent data shows that self-referrals for

maternity care are as low as 3% and this may be a contributory factor in not achieving this KPI.

It was reported during the visit that since laboratory screening services have been transferred to the SWLP hub there have been several instances of samples being lost between CHS and the SWLP hub. The process for transferring samples from Croydon maternity services to the hub was observed during the visit and a number of risk areas were identified which require assessment and mitigation.

3.1 Shared learning

The review team identified several areas of practice that are worth sharing:

- when using the newborn bloodspot (NBS) national failsafe system, the default parameter settings are changed in order to immediately identify all babies that were born elsewhere and have been transferred into the Croydon area to ensure all babies are screened on day five
- health visitors within Croydon have recently commenced the newborn bloodspot sampling for all babies more than 28 days old. Initial reports from the child health records department (CHRD) suggest that this has resulted in significant improvements in NBS standard 1b, the number of ‘movers in’ who have a conclusive result within 21 calendar days
- the sonography department have implemented a monthly image peer review process. This has been a positively received opportunity for shared learning which may have contributed to the number of green flags increasing and the number of amber flags decreasing in the most recent Down’s Syndrome Screening Quality Assurance Support Service (DQASS) report
- a comprehensive fetal anomaly database has been implemented that tracks women with positive results from initial screen to postnatal outcome. This system is used to ensure that all referrals sent to St George’s fetal medicine department receive an appointment and prenatal diagnosis results are received by CHS

3.2 Immediate concerns for improvement

The review team identified one immediate concern. A letter was sent to the Chief Executive on 24 March 2016, asking that the following item be addressed within seven days:

- lack of failsafe systems to track the eligible antenatal cohort

A response was received and actions have been taken to partially mitigate the immediate risks within the programme. There is ongoing communication between London SQAS and CHS to support full resolution of this concern.

3.3 High priority issues

The review team identified seven high priority issues as grouped below:

- there are no clear processes in place to provide the required re-offer of infectious diseases screening to women that initially decline. This increases the risk of mother to child transmission
- the sample transfer pathway in place from October 2015, where samples are transferred to the SWLP hub, has several areas of potential risk that require assessment and action planning
- SWLP reported that they had been advised by the Trust to perform antenatal screening on samples where the ‘first antenatal bloods’ box has been ticked but the boxes for the individual tests for HIV, hepatitis B, syphilis, sickle cell or thalassaemia on the paper request form have not been ticked. There is a concern that women are being screened without adequate evidence of consent. There is also nowhere on the form to record decline for each of the conditions screened. This does not comply with national standards
- linked to the immediate concern of lack of antenatal failsafe cohort tracking processes: 1. SWLP does not have a facility to electronically identify antenatal samples. 2. Failsafe systems are not in place for antenatal screen positive results and outstanding repeat requests. There is a risk that positive results may not be actioned with a consequent failure to generate the required specialist referrals and appropriate care pathways
- processes for notifying hepatitis B positive women to CHRD are inconsistent. Therefore, there is a risk of babies not completing the vaccination schedule required to reduce their risk of transmission of hepatitis B
- roles and responsibilities for all the screening programmes and the whole of each pathway are not clearly defined within the current structure of the screening team. A restructure process is currently underway to address this.
- there was a lack of documentary evidence to support quality assurance of the SCT pathway. This leaves the quality of the service difficult to ascertain. There is a need to review and document all screening processes

4. Key recommendations

A number of recommendations were made related to the Immediate and High priority issues identified above. These are summarised in the table below.

Priority	Description of recommendation
Immediate	Ensure that an effective and co-ordinated failsafe system is implemented to track the eligible cohort for all antenatal screening programmes
High	Linked to the immediate concern above: Implement systems to enable the electronic identification of all antenatal samples and results
High	Linked to the immediate concern above: Implement a weekly failsafe process for all positive infectious disease screening (IDS) results and SCT results (including all father carrier results for SCT) and outstanding repeat requests
High	Implement documented and auditable processes for the re-offer of IDS by an appropriate specialist for all women who decline IDS
High	Review and risk assess the process of how antenatal screening samples are being sent to the SWLP hub
High	Review all paper forms currently in use for antenatal IDS and SCT screening to ensure they meet national programme standards in relation to family origin questionnaire (FOQ) forms, and consenting/decline to each individual condition
High	Implement revised processes which ensure samples are tested only with evidence of consent
High	Complete the restructuring currently underway for the antenatal and newborn (ANNB) screening team
High	Document and formalise auditable antenatal and newborn processes for notification of hepatitis B status to CHRD
High	Document all SCT antenatal screening processes into a formal clinical guideline
High	Assess the reported sonography staffing issue and, if appropriate, enter onto the risk register with an action plan to address the issues identified

5. Next steps

Croydon Health Services are responsible for developing an action plan to ensure completion of recommendations contained within this report.

NHS England London will be responsible for monitoring progress against the action plan and ensuring all recommendations are implemented.

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