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Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes
Chelsea and Westminster Hospital NHS Foundation Trust

12 and 13 June 2019

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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 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. PHE advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK NSC recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

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Published November 2019
PHE publications
gateway number: GW-872

PHE supports the UN
Sustainable Development Goals

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 (QA) visit to the Chelsea and Westminster Hospital NHS Foundation Trust screening service held on 12 and 13 June 2019.

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:

- 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 shared with the London SQAS as part of the visit process
- information collected during interviews with: NHS England London on 12 June 2019 and Child Health Information Services (CHIS) north-west London hub on 12 June 2019

Local screening service

Chelsea and Westminster Hospital NHS Foundation Trust (CWHFT) provides acute and specialist services to a population of more than one million people across north-west London at Chelsea and Westminster hospital (CWH) and West Middlesex University Hospital (WMUH).

The trust provides all 6 antenatal and newborn screening programmes at both acute hospital sites. CWH has a tertiary fetal medicine unit.

There is a private maternity unit at the CWH site and the trust also operates several HIV and sexual health clinics across London.

Across both hospitals there were 12,951 women booked for maternity care in the financial year 2018 to 2019 and a total of 11,600 births recorded, making the trust one of the largest maternity services in England.

The maternity services were rated ‘Good’ by the Care Quality Commission (CQC) in April 2018.

There is a regional, level 3 neonatal intensive care unit (NICU) at CWH and a level 1 special care baby unit (SCBU) at WMUH, both of which are part of the north-west London (NWL) Neonatal Operational Delivery Network.

External services used for the ANNB screening programmes at the trust include:

- laboratory services for Down’s syndrome, Edwards’ syndrome and Patau’s syndrome screening – provided by Birmingham Women’s and Children’s NHS Foundation Trust
- laboratory services for infectious diseases in pregnancy screening (IDPS) for both sites and sickle cell and thalassaemia (SCT) screening for CWH – provided in partnership with north-west London pathology hosted by Imperial Healthcare NHS Trust
- child health services are provided by NWL Child Health Information Service (CHIS) hub
- some IDPS samples that require additional or confirmatory testing are sent to the Public Health England reference laboratory at Colindale including:
  - newborn bloodspot screening (NBS) laboratory services for WMUH are provided by Great Ormond Street Hospital (GOSH) newborn screening laboratory
  - NBS laboratory services for CWH are provided by South West Thames Regional Newborn Screening Service at Epsom and St Helier University Hospitals NHS Trust
  - SCT genetic counselling for at risk women and couples at WMUH is provided by Hounslow and Richmond Community Healthcare NHS Trust

Findings

This is the first ANNB QA visit to Chelsea and Westminster Hospital NHS Foundation Trust. The service is delivered by a team of dedicated staff who are committed to quality improvement. There is evidence of good working relationships between staff across the screening programmes.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 6 high priority findings, summarised as:

- screening incidents are not always reported or managed in line with PHE guidance for managing incidents in NHS screening programmes
- there is a lack of dedicated administrative support for the screening pathways
- there are no cohort-tracking failsafe processes for first and second trimester fetal anomaly screening
- there is an ongoing (Down's syndrome Quality Assurance Support Service) DQASS red flag for the Chelsea and Westminster site
- the newborn infant physical examination screening management and reporting tool (SMaRT4NIPE) is not being used to record referrals and outcomes
- babies at risk for developmental dysplasia of the hip (DDH) are not all receiving hip ultrasounds within the correct timeframe

Shared learning

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

- WMUH sonographers attend Antenatal Results and Choices (ARC) study days
- a customised in-house training update for midwives who perform newborn infant physical examination (NIPE)
- a one-stop orthopaedic clinic which includes paediatric orthopaedic physiotherapy practitioners for all hip referrals at CWH
- evidence of extensive ANNB screening audits performed
- a detailed gap analysis and action plan was completed across all screening programmes on both sites benchmarking current arrangements against national standards

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	The commissioners should make sure NHS England London's process for the identification and escalation of concerns and performance issues for KPI ST2 is adhered to	11	12 months	Standard	Confirmation at the trust screening steering group (TSSG) meeting the process for escalation for ST2 KPI
2	Update the terms of reference (ToR) for TSSG meeting to reflect the current governance structure, the process for escalating risks and update the membership to include all stakeholders including NWLP	1-5, 7, 9, 10, 11	6 months	Standard	Revised ToR to be approved at the TSSG
3	Complete a risk assessment for the planned transfer of SCT counselling to maternity services	4	6 months	Standard	Risk assessment and action plan submitted to TSSG
4	Make sure all ANNB programmes are covered at each TSSG so that action plans are monitored in a timely manner	1-7	6 months	Standard	Revised ToR, evidence of quarterly review of action plans in TSSG meeting minutes

No.	Recommendation	Reference	Timescale	Priority	Evidence required
5	Report and manage all screening patient safety incidents and serious incidents in accordance with Managing Safety Incidents in NHS Screening Programmes	9	3 months	High	Confirmation to TSSG that all screening incidents reported on Datix are also being notified to QA and NHSE Screening incidents added to the TSSG agenda
6	North-west London Pathology should achieve UKAS accreditation for all antenatal screening laboratory services	17, 18	12 months	Standard	An action plan presented to the TSSG Confirmation of accreditation
7	Include the screening team on the distribution list for guideline updates	1-7	6 months	Standard	Guideline update added to TSSG agenda
8	Update routine first trimester dating ultrasound guidelines to comply with FASP national guidance	2, 12, 15	6 months	Standard	Updated guidelines presented at the TSSG
9	The SCT laboratories should include a vertical audit of an antenatal sample in the audit schedule	18	12 months	Standard	Confirmation to TSSG that antenatal sample vertical audit has been added to the audit schedule for WMUH SCT lab
10	Complete a user survey to gather views about the antenatal and newborn screening pathways within the trust	1-7	12 months	Standard	Outcome of surveys and actions taken discussed TSSG

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 3				
11	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	High	Confirmation to the TSSG that administration support for all ANNB programmes is in place
12	Implement a weekly process for tracking each woman through the FASP screening pathway to make sure screening is offered, tests performed, and results are received	2, 3, 12, 15	6 months	High	Work instruction for managing the tracking process with roles and responsibilities clearly outlined Submission of KPI data for FA2, FA3 with all women accounted for
13	Make sure all midwives complete the ANNB screening national e-learning modules	1- 5, 7	12 months	Standard	The training log, training needs analysis and related action plan to be presented to the TSSG

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 12				
14	Make sure all women who miscarry or terminate their pregnancy receive their screening results	1, 4	3 months	Standard	Confirmation at TSSG and amended guideline to reflect practice

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	No recommendations				

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Make sure pathways are in place to allow equitable and early access to antenatal screening services	4	6 months	Standard	Action plan for ST2 agreed and monitored by the TSSG Meeting the acceptable threshold for ST2 for both sites
16	Implement a process for women whose SCT positive or carrier status is on the booking referral to be referred directly for counselling	4	6 months	Standard	Pathway demonstrating direct referral process presented to the TSSG

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 3				
	See recommendation 9				

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 14				
	See recommendation 16				
17	Address printer label issues affecting the electronic request of antenatal SCT screening at WMUH	4	6 months	Standard	Confirmation to the TSSG that SCT labels are being printed correctly
18	WMUH on-site SCT screening laboratory should implement a weekly failsafe list of all positive antenatal and father results and repeat requests and send to the screening team and nurse counsellor	4, 18	6 months	Standard	Confirmation to the TSSG that a documented process is in place. Updated laboratory standard operating procedure (SOP)

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 14				
19	Electronic requesting of IDPS screening should provide the option to accept or decline each condition individually	1, 16, 17	6 months	Standard	Laboratory action plan and amended laboratory SOP presented to TSSG
20	Implement a process to notify the screening teams when women are screened on labour ward or postnatally	1, 16	6 months	Standard	Guideline or SOP submitted to TSSG

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 8				
	See recommendation 12				
21	Implement a tracking process for samples transferred to Birmingham Women's and Children's biochemistry laboratory	2, 13	6 months	Standard	Guideline or SOP submitted to TSSG
22	Implement an action plan, in accordance with the programme handbook to address the ongoing DQASS red flag	2, 14, 15	3 months	High	DQASS added as a standing agenda item. Minutes of TSSG meeting,

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	All NHSP policies, SOP, pathways and guidelines should be ratified	6	6 months	Standard	Ratified documents submitted to TSSG

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 11			Choose a priority	
24	Identify deputies for NIPE leads to support monitoring of the failsafe system and follow up referral outcome	7, 21	6 months	Standard	Confirmation to TSSG that deputisation/cover arrangements are in place
25	Make sure that referrals and outcomes for positive NIPE screens are monitored	7, 21	3 months	High	NIPE guideline is updated and disseminated with roles and responsibilities defined
26	Make sure a pathway is in place for hip ultrasounds to be completed in the correct timeframe	7, 21	3 months	High	Pathway in place presented and approved at the TSSG Trust data presented to the TSSG for KPI NP2 and NIPE Standard 4

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
27	Identify leads within the neonatal team of both hospitals so there is an appropriate level of responsibility, accountability and overall oversight for the NBS programme on NICU/SCBU	5, 20	6 months	Standard	Updated NBS guidelines describing roles and responsibilities submitted to TSSG
28	Develop NBS training for the nurses working on the neonatal unit utilising the national NBS e-Learning modules	5, 20	6 months	Standard	Training log for staff to be submitted to TSSG
29	Make sure staff in the neonatal unit have access to the national newborn bloodspot failsafe system and there is cover each day	5, 20	6 months	Standard	Confirmation to TSSG that a sufficient number of staff in each neonatal unit have access to Northgate

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 and 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 number 17: NHS Fetal Anomaly Screening Programme: 18^{+0} to 20^{+6} week fetal anomaly scan (2018 to 2019) https://www.england.nhs.uk/wp-content/uploads/2017/04/Gateway-ref-07838-180913-Service-specification-No.-17-NHS-FASP-Fetal-anomaly-scan.pdf

4. Service specification number 18: NHS Sickle Cell and Thalassaemia Screening Programme (2018 to 2019) https://www.england.nhs.uk/wp-content/uploads/2017/04/Gateway-ref-07839-180913-Service-specification-No.-18-NHS-Sickle-cell-and-thalassaemia-screening.pdf

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9. Managing Safety Incidents in NHS Screening Programmes (August 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachme

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13. NHS Screening Programmes: Fetal anomaly screening programme laboratory handbook (August 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749746/Fetal_anomaly_screening_programme_laboratory_handbook_revised_FINAL_12.10.18.pdf

14. NHS Fetal Anomaly Screening Programme: Laboratory Quality Assurance Evidence Requirements (July 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796767/FASP_laboratory_quality_assurance_evidence_requirements__April_2019_.pdf

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