Public Health England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes Barking, Havering and Redbridge University Trust

12 and 13 February 2020

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Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

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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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 or families with screen-positive results), or the completion of the screening pathway.

The findings in this report relate to the quality assurance visit to the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) screening service held on 12 and 13 February 2020.

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 Public Health England (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 NHS England and NHS Improvement London (SIT) and North East London Child Health Information Services (CHIS) on 11 February 2020
- information shared with the London regional SQAS as part of the visit process

Local screening service

Barking, Havering and Redbridge University Hospitals NHS Trust serves a population of approximately 750,000 people and provides hospital and community services to the people of Barking, Dagenham, Havering and Redbridge as well as the surrounding Essex areas. It is the largest single site provider of maternity services in East London. The Trust has two main hospital sites King George Hospital in Goodmayes and Queen’s Hospital in Romford.

Antenatal and newborn screening services are provided at both sites and in the community setting. All women deliver at Queen's Hospital site which also has an Emergency Department, Local Neonatal Unit and Children's Services.

The Trust serves a population with a diverse demographic and socio-economic profile. Maternity services at both sites are consultant and midwifery led. For the reporting period of 2017 to 2018 9,500 women were booked for care at the Trust and there were 7,861 babies delivered.

Antenatal and newborn screening services are commissioned by and on behalf of NHS England London. Barking Havering and Redbridge University Hospitals NHS Trust provides the laboratory testing for:

- infectious diseases in pregnancy screening
- sickle cell and thalassaemia screening
- Down's syndrome, Edwards' syndrome and Patau's syndrome screening

The United Kingdom Accreditation Service (UKAS) assesses both ISO 15189:2012 requirements and the screening QA requirements as an integrated process. The interfaces between the laboratory and the Trust were included in the QA visit day discussions and will be included in this report.

Great Ormond Street Hospital for Children NHS Foundation Trust provide the laboratory services for the analysis of newborn blood spot screening samples

The King George Hospital biochemistry screening laboratory offers first trimester Down's syndrome, Edwards' syndrome and Patau's syndrome screening (combined test) and quadruple screening to women booked at BHRUT. The King George laboratories also provide first and second trimester screening to several other maternity service providers.

Newborn Hearing Screening programme (NHSP) and child health information services are provided by North East London NHS Foundation Trust (NELFT).

Findings

The QA visit team identified:

- no immediate concerns
- 9 high priority findings
- 22 Standard priority findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 9 high priority findings as summarised below:

1. screening incidents are not managed in accordance with the national guidance on Managing Safety Incidents in NHS Screening Programmes.
2. the cross-directorate governance structures of the directorates involved in the ANNB screening pathways are not clear.
3. There is a risk of errors when manually entering screening results onto the maternity IT system. Although the screening team manually check each result to try and reduce this risk an automated upload of results into the system is the only way to be certain that errors do not occur.
4. The antenatal cohort may not be accurately identified due to the possibility of recording a new pregnancy against a past pregnancy episode that has not been closed.
5. There is no weekly tracking process in place for the FASP pathways.
6. The screening team are not routinely notified of unbooked women who present in labour which means that they are not always able to follow up and action antenatal screening results in a timely manner. Although the screening team will be notified of screen positives by the laboratories they will not be aware of those with incomplete or missed screens.
7. There is no case-by-case notification of all screen positive results to the counselling and screening teams in addition to the weekly failsafe list.
8. The throughput for second trimester quadruple screening tests is currently below the FASP requirement of 8,000 samples per year.
9. There is a risk of errors when support workers are manually entering sonographer's measurements onto the ultrasound system.

Shared learning

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

- there is a midwife based in the Early pregnancy unit (EPU) who is responsible for making sure that all women with a viable pregnancy are referred to maternity services
- the screening team track all referrals from the EPU to make sure that the women receive and attend a booking appointment
- a dedicated member of the North East London CHIS team actively monitors the completion of the vaccination schedule for babies at risk of hepatitis B

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1.	Update the terms of reference (ToR) for Trust screening steering group (TSSG)	1 and 2	6 months	Standard	ToR that reflect the current chair and members' job titles, governance structure, process for risk escalation across the different directorates and oversight of screening related data agreed and signed off by the TSSG
2.	Report and manage all screening patient safety incidents and serious incidents in accordance with 'Managing Safety Incidents in NHS Screening Programmes	4	3 months	High	Confirmation to TSSG that all screening incidents reported on Safeguard are also being notified to SQAS and NHS England and NHS Improvement London Review and management of screening incidents added to the ToR and TSSG agenda New or revised guidelines/standard operating procedure (SOP) submitted to TSSG
3.	Make sure there are processes in place for the screening team to be notified of all ANNB screening incidents	4	6 months	Standard	Confirmation at TSSG that there is a documented process for notifying the screening team of all screening related incidents across the Trust

No.	Recommendation	Reference	Timescale	Priority	Evidence required
					Explore the possibility of being able to notify the screening team directly from the Safeguard system New or revised guidelines/SOPs submitted to the TSSG
4.	Clarify governance processes between all directorates involved in ANNB screening programmes with an established process for escalation, oversight and monitoring of all Trust-wide ANNB screening-related risks	1	6 months	High	Updated Organogram, ToR and risk management guidance that reflects cross directorate governance structures presented at the TSSG
5.	Make sure all screening guidelines and standard operating procedures (SOPs) are in line with national guidance and reflect current Trust processes	1-14	12 months	Standard	Ratified guidelines for all screening programmes New or revised guidelines/SOPs submitted to TSSG
6.	Make sure the departmental audit schedule includes audits in all ANNB screening programmes	1	12 months	Standard	Audit schedule presented at TSSG Audit findings and action plans to address any identified gaps presented and monitored at TSSG
7.	Develop user satisfaction surveys within ANNB screening programmes and use the findings to improve the screening pathways	1	12 months	Standard	Outcome of surveys and action plans for each pathway to be presented and monitored at the TSSG

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
8.	Make sure that the job descriptions for the screening support sonographer and deputy include their screening roles and responsibilities	10,11,12	12 months	Standard	Confirmation at the TSSG that the job descriptions have been updated
9.	Risk assess the process of manually entering screening results onto the Euroking IT system and consider adding this to the women's and children's divisional risk register	1, 2	3 months	High	Findings and action log from the risk assessment presented at the TSSG Confirmation at the TSSG that the risk has been considered for addition to the risk register
10.	Make sure the new maternity IT system delivers the functionality required for tracking and oversight of the antenatal screening pathways	1	12 months	Standard	Confirmation at the TSSG that the functional requirements for ANNB screening have been included in the specification for the new system

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See recommendation 9				
11.	Make sure the identified antenatal cohort captures all women eligible for screening	1, 2	6 months	High	Confirmation at the TSSG that the antenatal cohort is accurate and there are no new pregnancies being booked within a previous pregnancy encounter
12.	Implement a weekly process for tracking each woman through the FASP screening	1, 2	3 months	High	Documented weekly process of tracking eligible cohort to be presented at TSSG

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	pathway to make sure that screening is offered, screening tests are performed, and results are received				New or revised guidelines/SOPs submitted to TSSG

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	No recommendations				

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13.	Amend antenatal referral forms to identify SCT carrier women at the point of referral and fast-track counselling for known carrier women and at-risk couples	7	6 months	Standard	Confirmation at TSSG that the online referral has been amended and allows fast tracking to SCT counsellors
14.	Make sure the screening team are notified of all un-booked women who present in labour	1,2, 7-14	6 months	High	Documented process presented at TSSG and communicated to staff New or revised guidelines/SOPs submitted to TSSG

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 9				
	See Recommendation 10				
	See Recommendation 12				
	See Recommendation 13				
15.	Make sure the Trust accurately reports KPI ST3 data in line with national KPI definitions	3	6 months	Standard	Confirmation at TSSG that accurate data has been submitted Submission of Quarterly KPI data
16.	Implement a system for case by case notification of all screen positive results to the counselling and screening teams in addition to the weekly failsafe list	1, 2, 7-9	6 months	High	Confirmation at TSSG that there is a lab daily notification process for all screen positives and this is in use and accurate New or revised guidelines/SOPs submitted to TSSG
17.	Review the SCT pathway and remove any extra steps in the process which may cause delays	7	6 months	Standard	Outcome of pathway review presented at TSSG Revised guidelines/SOPs submitted to TSSG

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 9				
	See Recommendation 10				
	See Recommendation 12				
	See Recommendation 14				
	See Recommendation 16				
18.	Review the pathway for urgent testing and identify ways to increase compliance with the process	1, 2,	6 months	Standard	Audit against compliance with the current policy presented to TSSG Action plan from audit findings presented and monitored at TSSG New or revised guidelines/SOPs submitted to TSSG
19.	Implement a laboratory out of hours urgent testing service for all three IDPS conditions	1, 2, 8	12 months	Standard	Confirmation at the TSSG that testing for all three conditions is in place New or revised guidelines/SOPs submitted to TSSG
20.	Update the paper request form for IDPS screening to include options for accept and decline	1,2 8	6 months	Standard	Confirmation at the TSSG that the blood request form has been amended to include accept and decline options Copy of new request form to be presented at TSSG

No.	Recommendation	Reference	Timescale	Priority	Evidence required
					New or revised guidelines/SOPs submitted to TSSG
21.	Implement a process to notify the screening team of all babies born to hepatitis B positive women	2,9	6 months	Standard	Confirmation at the TSSG that a notification process has been implemented New or revised guidelines/SOPs submitted to TSSG

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 5				
	See Recommendation 9				
	See Recommendation 10				
	See Recommendation 12				
22.	Make sure the laboratory is part of a managed network for quadruple testing by April 2020	1, 10	3 months	High	Evidence of contracts in place with laboratories in the network with clear governance and reporting structures presented to the TSSG
23.	Make sure sonography capacity is sufficient to provide effective screening pathways	1, 2	6 months	Standard	Findings of the review from both sites presented at the TSSG with action plans if required

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24.	Risk assess the process of support workers manually entering measurements into Viewpoint and consider adding this to the divisional risk register	1, 2	3 months	High	Findings and action log from the risk assessment presented at the TSSG. Confirmation at the TSSG that the risk has been considered for addition to the risk register

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
25.	Develop guidelines for all service operational pathways	1,2	12 months	Standard	Ratified guidelines circulated to the TSSG
26.	Make sure essential service information is sent to generic email accounts and not only to individual staff members		6 months	Standard	Confirmation at TSSG that generic emails are in place for notification of deceased babies and that all staff have been informed
27.	NHSP to liaise with Midwifery, NICU / SCBU and child health to develop processes for exception reporting	13	6 months	Standard	Confirmation at TSSG that exception reports are in place for notification of movers in/out and incomplete screening

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 5				
	See Recommendation 6				
	See Recommendation 7				

No.	Recommendation	Reference	Timescale	Priority	Evidence required
28.	Implement and monitor a plan to meet NP2 standard	1,2	6 months	Standard	Action plan submitted to and monitored by the TSSG
29.	Make sure the screening team has access to the radiology information system to access reports for newborn hip ultrasounds	14	6 months	Standard	Confirmation at the TSSG that access has been granted and that the screening team access reports
30.	Make sure the newly implemented (January 2020) process for tracking all screen positive referrals on the newborn infant physical examination (NIPE) and completing the outcomes on S4N is clearly documented and audited	1, 2, 15	6 months	Standard	Confirmation at the TSSG that the new tracking process is fully implemented and that outcomes for all screen positive referrals are entered onto S4N New or revised guidelines/SOPs and completed audits submitted to TSSG

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
	See Recommendation 5				
31.	Implement an action plan to meet NBS standards 3, 4 and 6	2	6 months	Standard	Action plan to be presented 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 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.