Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes
Bridgewater Community Healthcare NHS Foundation Trust

17 April 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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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 Bridgewater Community Healthcare NHS Foundation Trust screening service held on 17 April 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 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 shared with the North West regional SQAS as part of the visit process

Local screening service

Bridgewater Community Healthcare NHS Foundation Trust (BFT) provides community-based healthcare to more than 1 million people living in Bolton, Halton, Oldham, St Helens, Warrington and Wigan. The community trust offers midwifery care to women who live in the borough of Halton which includes the towns of Widnes and Runcorn. Antenatal, intrapartum care for home births and postnatal services including antenatal and newborn screening is provided. Women accessing midwifery care at BFT access acute midwifery and obstetric services at Warrington and Halton Hospitals NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust, Liverpool Women's NHS Foundation Trust (LWH) or Countess of Chester Hospital NHS Foundation Trust (COCH).

Between 1 April 2017 and 31 March 2018, 1,488 women booked for maternity care with the trust. 9 homebirths and 16 babies born before the arrival of a midwife have been recorded in the last financial year.

NHS Halton Clinical Commissioning Group (CCG) is the lead commissioner for the maternity services within BFT. NHS England and NHS Improvement North West (Cheshire and Merseyside) commission antenatal and newborn screening.

Bridgewater child health information services (CHIS) are provided by BFT. There are 2 separate CHIS's that work together to cover the 0 to 19-years-old population. The St Helens and Knowsley CHIS includes the 0 to 19-years-old population for Halton and St Helens and Knowsley areas. This CHIS is based at and managed through a service level agreement (SLA) with St Helens and Knowsley Teaching Hospitals NHS Trust. The other CHIS cover the Warrington 0 to 19-years-old population is in BFT' Spenser House community office, which is based in Warrington. Clear processes are in place to manage and report each child resident population for example Halton, St Helens, Knowsley and Warrington separately.

Quality assurance of the CHIS provided by Bridgewater Community Trust is included in this report.

Findings

This is the second quality assurance visit to the Trust. The first took place on 30 September 2015. All recommendations from the visit were completed with demonstrable improvements in screening. This visit focuses on antenatal and newborn screening services provided by BFT.

The service at BFT is patient centred and delivered by a team that is dedicated and committed to provide continuous quality improvements across the screening pathway. Midwifery leadership is evident and effective governance structures and escalation processes within the trust were demonstrated. Screening has a high profile within the maternity leadership and governance structure.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 1 high-priority finding:

- there is no senior-level oversight or joint governance in BFT midwifery with the ultrasound scan service that is provided by another organisation

Shared learning

The QA visit team identified several areas of areas of practice for shared learning summarised below:

- a detailed antenatal cohort tracking database of the end-to-end screening pathway for all women which includes effective data cleansing to prevent double counting across the screening pathway
- effective links and communication channels with trusts that women book with for birth
- ‘early bird’ clinics held prior to booking, where general midwifery information is shared that includes screening
- child health information services have comprehensive standard operating procedures and vaccination scheduling flow charts for hepatitis B notification

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Child Health Information Service to work with NHS England to complete child health records validation and implement child movement	1,2	3-6 months	Standard	Confirmation from NHS England of completion
2	Make sure there are governance arrangements and clear lines of accountability for the sonography service provided under SLA so that the head of midwifery can have clinical oversight and account for risks.	1,2,4,6,10,11	6 months	High	Documentation of process with Public Health England (PHE) Commissioning
3	Update relevant local policies to include reference to managing screening incidents in all NHS Screening programmes in accordance with ‘Managing Safety Incidents in NHS Screening Programmes’	4,5,6	6 months	Standard	Standard operating procedures/flow charts to be ratified and presented at ANNB local screening board

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Update local guidelines to meet national guidance and standards and to include communication flow(s) charts with neighboring acute trusts	1 to 15	12 months	Standard	Standard operating procedures/flow charts to be ratified and presented at ANNB local screening board
5	Complete a user survey to gather views about the antenatal and newborn screening pathways	1,2	12 months	Standard	Outcome of survey and action plan monitored ANNB local screening board
6	Revise public facing trust website to include current national guidance and links to national information about antenatal and newborn screening programmes	1 to 14	12 months	Standard	Confirmation of update at ANNB local screening board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
7	Develop a process to evidence professional competency for practitioners undertaking newborn infant and physical examinations	1,2,6,14	6 months	Standard	Process ratified and presented to ANNB local screening board
8	Recruit to staffing vacancy within the child health information service	1	6 months	Standard	Completed recruitment process

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9	St Helens and Knowsley Child Health Information Service Organisation to streamline processes and reduce duplication resulting from data entry in 2 child health information IT services	1,5,6	6 to 12 months	Standards	Confirmation of process to be confirmed at PHE ANNB Quality and operational group meetings

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Standardise the deceased baby notification process in all Bridgewater Community Health Care NHS Foundation Trust child health information services	1,6,13,14	3-6 months	Standard	Confirmation of implementation of single Standard operating procedure

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Make sure that the process in place for women who miscarry or end the pregnancy to be notified of their results is documented in the local guideline/standard operating procedure	1,6,9	6 months	Standard	Revised standard operating procedures/flow charts to be ratified and presented at ANNB local screening board
12	Update the infectious diseases local guidelines and standard operating procedure to include checking infectious diseases screening results for women who have homebirths (or babies born before the arrival of a health professional), and include a process to offer timely screening and results reporting in the care pathway for when results are not available	1,6,9	6 months	Standard	Revised standard operating procedures/flow charts to be ratified and presented at ANNB local screening board
13	Update the local guideline and standard operating procedure to make sure the process for women who decline the initial offer of infectious diseases screening (HIV, hepatitis B and/or syphilis) are tracked and reoffered screening by 20 weeks of pregnancy	1,6,9	6 months	Standard	Revised standard operating procedures /flow charts to be ratified and presented at ANNB local screening board

Newborn hearing screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
14	Child health information services to make sure that there is full import of NHSP screening outcomes consistently across the Bridgewater footprint	1,2,5,6	12 months	Standard	Standard operating procedures/flow charts to be ratified and presented at ANNB local screening board

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Put in place an agreed system for recording 6 to 8 week NIPE exam onto child health information system across the Bridgewater child health information services footprint	1,2,14	6 months	Standard	Standard operating procedures/flow charts to be ratified and presented at PHE ANNB local screening board Quality and operational group meetings
16	Develop a process with acute trusts to make sure that outcomes from referral for the 4 NIPE conditions are tracked and recorded on SMaRT4NIPE	1,2,5,6	6 months	Standard	Standard operating procedures/flow charts to be ratified and presented at ANNB local screening board

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.