Public Health England

NHS

# Screening Quality Assurance visit report

## NHS Antenatal and Newborn Screening Programmes

## Bolton NHS Foundation Trust

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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 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 4 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.

www.gov.uk/phe/screening
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk
Prepared by: Screening QA Service (North)
For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net



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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 Bolton NHS Foundation Trust screening service held on 14 and 15 May 2018.

## 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 collected during pre-review visits to commissioners on 8 March and 11 May 2018 and discussion with the interim Screening Support Sonographer and leads for NIPE and NBS at the Royal Bolton Hospital 15 May 2018
- information shared with the North West regional SQAS as part of the visit process

## Local screening service

Bolton NHS Foundation Trust (BFT) provides services to approximately 280,000 people who live in Bolton, areas of Wigan, Bury and Salford. It serves populations from areas of high socio-economic deprivation and diverse ethnicity. The main hospital site, the Royal Bolton Hospital (RBH), is located in Farnworth, approximately 4 miles south of Bolton town centre.

BFT provides primary and secondary level (low-risk to high-risk) maternity care. The delivery unit is on the main hospital site at the Royal Bolton Hospital (RBH). To improve access, outreach antenatal services (antenatal care and ultrasound) are provided at Bolton One and Walkden Gateway. The trust also provides antenatal midwifery care at Fairfield Hospital, and there is a stand-alone birth centre at Ingleside (Salford).

Between 1 April 2016 and 31 March 2017, 6,318 women booked for maternity care at the Royal Bolton Hospital, and there were 5,970 births.

Local screening services are commissioned by Bolton Clinical Commissioning Group (CCG) and the Greater Manchester Health and Social Care Partnership (GMHSCP).

There are separate identified leads to coordinate the antenatal and newborn screening programmes, but responsibility for oversight of all antenatal and newborn screening programmes is not clear.

## Findings

This is the second quality assurance visit to this trust; the first was in October 2014. The service is patient centred and delivered by a team that is dedicated and committed.

The Head of Midwifery (HOM) role has been vacant since 2017 with 2 interim HOM's fulfilling the role up to the visit. The newly appointed HOM will be in post from June 2018.

Strategic leadership provided by the new HOM will help to drive quality improvement and provide assurance that the screening programmes can be safely delivered.

### Immediate concerns

The QA visit team identified no immediate concerns

### High priority

The QA visit team identified 16 high priority findings which are:

- a lack of resilience of staff cover in important roles, particularly in relation to oversight of failsafe systems and initiatives to lead quality improvements
- no coordination of the antenatal and newborn screening programmes and no interface between the programme leads
- responsibility for the oversight of all antenatal and newborn screening programmes not being clear
- governance processes for screening not being clearly defined with no clear escalation processes
- some lead members of the screening team attending by invitation only, although the local programme board is in place
- screening incidents not being managed in line with national guidance

- guidelines and standard operating procedures not reflecting current national guidance
- responsibility for the follow up of women who do not attend for the $18^{+0}$ – $20^{+6}$ anomaly scan not being clear
- data submitted for the antenatal population not matching cohort

## Shared learning

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

- ARC study day funded for the obstetric ultrasound department with a winning award received for their participation in the Twins and Multiple Births Association (TAMBA) research
- antenatal and newborn ’trigger‘ being added to the Safecare Incident Management System to notify the screening team of all reported screening incidents

# Recommendations

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

## Governance and leadership

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 1 | Complete a gap analysis of the end to end pathways and failsafes to assure safety of all the screening programmes | 13,14,17,18, 19,20,21 | 6 months | High | Action plan in place to be monitored through local operational group |
| 2 | Formalise the organisational accountability structure for the antenatal and newborn screening service | | 3 months | High | Organogram with clearly defined structure and escalation routes for risk and performance issues in place |
| 3 | Rewrite guidelines and SOP's for all antenatal and newborn screening programmes to make sure the pathways are in line with current standards and service specifications. | 13,14,17,18, 19,20,21 | 6 months | High | Guidelines reflecting current national standards and specifications ratified through trust processes and presented at operational group |
| 4 | Update relevant local policies to include reference to managing screening incidents in accordance with "Managing Safety Incidents in NHS Screening Programmes" | 3 | 6 months | High | Revised policy ratified at programme board |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 5 | Demonstrate that all staff are aware of and follow 'Managing Safety Incidents in NHS Screening Programmes' | 3 | 6 months | High | Agenda and minutes from local operational group which show evidence of incidents managed using guidance and appropriately reported to QA and SIT |
| 6 | Revise terms of reference (TOR) for the local screening operational group to make sure that there is representation from all 6 antenatal and newborn screening programmes | 4,5,6,7,8,9,10 | 3 months | High | Ratified TOR<br>Agendas and minutes which show evidence of attendance by representation from all 6 programmes including programme leads |
| 7 | Implement a process to scrutinise and ratify data and before submission | Service specifications, PHE screening KPI definitions and submission document | 6 months | High | Standard operating procedure for sign off of data<br><br>Data submitted on time |
| 8 | Implement and monitor a plan to make sure that key performance indicators (KPIs) consistently meet the acceptable threshold | Service specifications, PHE screening KPI definitions and submission document | 6 months | Standard | Submission of KPI data<br><br>Action plan that is monitored by the programme board |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 9 | Implement and monitor a plan to progress KPIs meeting the acceptable threshold to the achievable threshold | Service specifications, PHE screening KPI definitions and submission document | 12 months | Standard | Submission of KPI data<br><br>Action plan that is monitored by the programme board |

## Infrastructure

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 10 | Review capacity of the screening team to make sure that there is resilience to deliver the screening service and provide assurance and safety of all the programmes | 4,5,6,7,8,9,10 | 3 months | High | Outcome of review of screening team completed. Clear pathways for dealing with screening issues in the absence of LCO or key staff |
| 11 | Implement an annual audit schedule for all antenatal and newborn screening programmes to demonstrate failsafe processes, evidence equity of access and that national programme standards are met | 4,5,6,7,8,9,10 | 12 months | Standard | Annual audit schedule<br><br>Audits to be presented at local operational group |
| 12 | Develop and complete an annual user satisfaction survey specific to antenatal and newborn screening | 4,5,6,7,8,9,10 | 12 months | Standard | User satisfaction survey presented at local operational group |

## Identification of cohort – antenatal

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 13 | Implement a process for tracking each woman through the screening pathway to provide cohort data that includes women who miscarry, terminate pregnancy and move out of area | 4,5,6,7, | 6 months | High | Cohort data provided<br><br>Screen shot of tracking (failsafe) system<br><br>Standard operating procedure for managing the tracking process with roles and responsibilities clearly outlined |

## Identification of cohort – newborn

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 14 | Implement an auditable process to identify and track the newborn cohort to make sure all eligible babies are offered screening and have an outcome recorded | 8,9,10 | 6 months | High | Cohort data provided<br><br>Standard operating procedure for managing the tracking process with roles and responsibilities clearly outlined |

## Invitation, access and uptake

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 15 | Make sure pathways are in place to enable women equitable and early access to screening services from GP services and out of area | 4,5,6,7 | 12 months | Standard | Pathway demonstrating equitable and early access<br><br>Action plans from any audits re: late bookings |
| 16 | Make sure there is a clear documented pathway for the follow up of women who do not attend for the 18+0 – 20+6 anomaly scan | 6,22 | 3 months | High | Integrated pathway between Maternity and Ultrasound which clearly outlines who is responsible for the follow up of women who do not attend for scan |

## Sickle cell and thalassaemia screening

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 17 | Implement an electronic FOQ | 11,13 | 12 months | Standard | Electronic FOQ implemented |
| 18 | Implement and monitor a plan to increase the offer of partner testing by 10 weeks of pregnancy | 7,13 | 6 months | High | Revise guideline to reflect standards and present at programme board<br><br>Audit reoffer of declined screening and present at programme board |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 19 | Make sure individuals involved in the screening pathway complete the required training | 7 | 12 months | Standard | Screening Midwife or nominated individual(s) has undertaken accredited Genetic Risk Assessment and Counselling Module |

## Infectious diseases in pregnancy screening

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 20 | Make sure every woman who declines the initial offer of IDPS screening (HIV, hepatitis B and/or syphilis) is identified, tracked and re-offered screening by 20 weeks of pregnancy | 4, 20, 21 | 6 months | High | Revise guideline to reflect standards and present at programme board<br><br>Audit reoffer of declined screening and present at programme board |

## Fetal anomaly screening

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 21 | Put in place an audit process to assure that women who are not eligible for 1st trimester screening have a second trimester (quadruple) screening opportunity and that an outcome is completed | 5, 14 | 6 months | High | Audit in place monitored through local operational group |
| 22 | Develop a policy to reflect Fetal Medicine Unit (FMU) referral pathway that meets national standards | 6 | 6 months | Standard | Agreed pathway in place |
| 23 | Develop a process to be able to provide KPI FA2 data to give assurance that all screens are completed | Service specifications, PHE screening KPI definitions and submission document | 12 months | Standard | KPI FA2 data submitted.<br><br>Acceptable threshold met |

## Newborn hearing screening

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 24 | Follow national protocol for babies with microtia and external ear canal atresia | 17 | 3 months | High | Guideline ratified and presented at local operational group |

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 25 | Perform quality checks on NHSP screening equipment | 17 | 3 months | High | Log of quality checks |

## Newborn and infant physical examination

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 26 | Make sure all NIPE examinations are recorded on NIPE the national screening management and reporting tool (SMART) | 10 | 6 months | Standard | KPI data meets acceptable standard |
| 27 | Provide a local annual update for those who undertake the NIPE examination. | 19 | 12 months | Standard | Training log for all Midwives and Nurses undertaking the NIPE examination |
| 28 | Develop a process for informing the Child Health Organisation of the outcome of NIPE examination | 10 | 12 months | Standard | Evidence of outcome of examination recorded on Child Health System for all babies |
| 29 | Implement a plan to make sure the outcome of referrals from NIPE examinations are recorded on SMART to assure cohort data | 10 | 12 months | Standard | Evidence of outcome of referrals recorded on NIPE SMART |

## Newborn blood spot screening

| No. | Recommendation | Reference | Timescale | Priority | Evidence required |
|---|---|---|---|---|---|
| 30 | Revise the wording in the letter to parents from Child Health Organisation to from result 'normal' to 'not suspected' when a baby is screen negative for all 9 conditions | 23 | 3 months | Standard | Revised letter |

## Next steps

Bolton NHS Foundation Trust is responsible for developing an action plan with the commissioners to complete the recommendations in this report.

SQAS will work with commissioners for 12 months to monitor activity and progress in response to the recommendations following the final report. SQAS will then send a letter to the provider and the commissioners summarising the progress and will outline any further action needed.