Public Health England

NHS

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening Programmes

Bradford Teaching Hospitals NHS Foundation Trust

7 March 2019

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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/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 Bradford Teaching Hospitals NHS Foundation Trust screening service held on 7 March 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 collected during pre-review teleconferences to commissioners on 6 March 2019 and the child health information service on 25 February 2019
- information shared with the North regional SQAS as part of the visit process

Local screening service

Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) provides acute hospital services for a population of 500,000 people at Bradford Royal Infirmary (BRI).

The Trust offers all NHS antenatal and newborn screening programmes.
Between 1 April 2017 and 31 March 2018, there were 6,125 women booked for maternity care and 5,536 births (5,610 babies including multiple births) at Bradford Royal Infirmary.

Local antenatal and newborn screening services are commissioned by NHS England North (Yorkshire and the Humber) with maternity services commissioned by Bradford Clinical Commissioning Group (CCG).

Findings

This is the second quality assurance visit to the Trust, the first one took place on 30 September 2015. All recommendations from this visit are actioned. There are 6 recommendations that are ongoing and monitored at screening and immunisation team board level to ensure progress is maintained. This visit focuses on antenatal and newborn screening services provided by Bradford Teaching Hospitals NHS Foundation Trust (BTHFT).

The service at BTHFT is patient centred and delivered by a team that is dedicated and committed to provide continuous quality improvements across the screening pathway. Midwifery leadership has undergone recent staffing changes which has strengthened governance structures and escalation processes within the trust. 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 one high-priority finding as summarised below

- lack of clear cross governance links between Head of Midwifery and radiology

Shared learning

The QA visit team identified several areas of practice for shared learning. Of note is the palliative care pathway established in the fetal anomaly screening programme for families where severe anomalies have been diagnosed at scan with links to a local hospice. This service provides valuable support during both antenatal and postnatal periods.

Other areas of shared learning include:

- dedicated trust wide interpreting service accessible onsite when needed
- hepatitis B pack in place that contains all the relevant information required for management of women and babies
- despite a higher than average referral rate, the achievable standard KPI NH2 is consistently met through established links between the NHSP manager and audiology

Recommendations

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

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Add antenatal and newborn screening to the Women's and Children's core group agendas to evidence effective escalation	1	6 months	Standard	Agendas from core groups discussed at the local antenatal and newborn screening meetings
2	Put in place a mechanism to make sure that the head of midwifery has clinical oversight of cross departmental screening risks including those in radiology	1	6 months	High	Documentation of process confirmed at the local antenatal and newborn screening meetings
3	Make sure 'communication of results' guideline includes clear instruction on informing women of their screening results including those whose pregnancies have ended following screening	1, 8, 9	6 months	Standard	Updated guidelines with ratification evidence presented at the local antenatal and newborn screening meetings
4	Make sure antenatal and newborn screening is included on trust audit schedule. An equity audit should be included	1	12 months	Standard	Audit presented to the local antenatal and newborn screening meetings
5	Update the existing screening specific user satisfaction survey to include newborn screening programmes	1	12 months	Standard	User survey presented to the local antenatal and newborn screening meetings

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	Put in place targeted training to make sure Screening Support Sonographers (or delegated sonographers) have clear understanding of Radiology Information System (RIS) statistics package to assist with accurate data collection	1, 10, 11, 12	6 months	Standard	Documentation of completion of targeted training
7	Risk assess the location of the PACS monitor to make sure monthly image review is not compromised due to accessibility to machine	1, 10	6 months	Standard	Completed risk assessment with action plan to address findings monitored at the local antenatal and newborn screening meetings
8	Update the radiology risk register and capital replacement bid for ultrasound machines to address any identified gaps	1, 10	3 months	Standard	Action plan agreed and monitored by the local antenatal and newborn screening meetings

Identification of cohort – Antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9	Implement and monitor a plan to meet KPI FA1	1, 2, 6	12 months	Standard	Action plan that is agreed and monitored by local antenatal screening meeting

Identification of cohort – Newborn

No.	Recommendation	Referenc	Timescale	Priority	Evidence required
10	Update local processes to include reporting of screen positive outcomes using the functionality from SMART4NIPE screening management and reporting tool	1, 2, 6	12 months	Standard	Agree and monitor implementation plan at local newborn screening meeting
11	Implement and monitor a plan to meet KPI NB1, NB2, NB4 and NP2	1, 2, 6	12 months	Standard	Action plan that is agreed and monitored at local newborn screening meeting

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Review referral process around KPI ST4a and ST4b for known at risk women and couples to make sure there is no delay in referral for pre natal diagnosis and that outcomes from fetal medicine are reported	1, 2, 6	6 months	Standard	Updated referral process agreed at the local antenatal screening meeting

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Maternity to work with IDPS laboratory to audit turnaround times of receipt of results and act to make sure they are in line with national standards	1,8,9	6 months	Standard	Audit and action plan agreed and monitored at the local antenatal screening meetings
14	Maternity to work with IDPS laboratory to update results reporting process to exclude screen negative results in line with national standards	1, 8, 9	6 months	Standard	SOP that describes reporting process in line with national standards.

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Put in place a plan to monitor compliance of timely support and in-house referrals when anomalies are identified on ultrasound scan	1, 2, 6, 11, 12	6 months	Standard	Audit and action plan agreed and monitored at the local antenatal screening meetings

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Work with the child health information service to develop a process to record NIPE examinations on the child health information IT system	1, 2, 14	6 months	Standard	Process confirmed. Outcomes of NIPE recorded on CHIS
17	Develop a process to make sure all newborn examinations and outcomes are recorded on SMART4NIPE	1,12,14	6-12 months	Standard	Action plan agreed and monitored at the local antenatal screening meetings

Next steps

Bradford Teaching Hospitals NHS Foundation Trust 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.