



Public Health
England

Protecting and improving the nation's health

Screening Quality Assurance visit report

NHS Antenatal and Newborn Screening
Programmes
North Bristol NHS Trust
Executive Summary

5 November 2019

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG

Tel: 020 7654 8000 www.gov.uk/phe

Twitter: [@PHE_uk](https://twitter.com/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.

www.gov.uk/phe/screening Twitter: [@PHE_Screening](https://twitter.com/PHE_Screening) Blog: phescreening.blog.gov.uk

For queries relating to this document, please contact: phe.screeninghelpdesk@nhs.net



© Crown copyright 2020

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v3.0. To view this licence, visit [OGL](https://www.ogil.io). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Published: January 2020

PHE publications

gateway number: GW-1075

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 visit of the North Bristol NHS Trust screening service held on 5 November 2019.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in antenatal and newborn 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 south regional SQAS as part of the visit process

Local screening service

North Bristol NHS Trust provides maternity services for the population of Bristol, North Somerset and South Gloucestershire. Both consultant and midwifery led services are provided at the trust with a midwifery led unit at Cossham Hospital in Bristol.

Newborn hearing screening is carried out by dedicated screeners. This service is managed by University Hospitals Bristol NHS Foundation Trust and screens babies born at 2 maternity service providers in Bristol. The child health information service is provided by In Health Intelligence. This is a region wide service covering a geographic area from Bristol to Cornwall.

Between April 2018 and March 2019, 6921 women booked for antenatal care with the service and 5,996 babies were born within the same timeframe. This data was reported by the trust on 5 November 2019 at the QA visit. Other data supplied by the service shows that the birth population is characterised as 61% white British.

Local screening services are commissioned by NHS England and NHS Improvement South West.

The scope of this review includes:

- the maternity service
- the sonography service for fetal anomaly screening
- the newborn hearing screening service
- the child health information service

Delivery of the screening service involves interdependencies with other departments or providers for parts of the pathway, which were not included in the scope of this visit:

- analysis and risk calculation of first and second trimester screening samples for Down's syndrome, Edwards' syndrome and Patau's syndrome are performed at the North Bristol NHS Trust and The Newcastle upon Tyne Hospitals NHS Foundation Trust. respectively
- laboratory screening services for sickle cell and thalassaemia, infectious diseases and newborn blood spot are provided by North Bristol NHS Trust

Women requiring enhanced care are referred to fetal medicine services at North Bristol NHS Trust or to University Hospitals Bristol NHS Foundation Trust. There is a neonatal intensive care unit at North Bristol NHS Trust.

Findings

This is the second QA visit to the antenatal and newborn screening services at North Bristol NHS Trust. During the visit there was evidence of a commitment to providing high level services for women and newborn babies through the screening pathways. The local service was aware of some areas for further development and are already planning some enhancements.

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 4 high-priority findings, summarised below as:

- women who have a screen positive result for sickle cell or thalassaemia are not counselled by an appropriately trained clinician within a timeframe that facilitates the offer of prenatal diagnosis by 12⁺⁰ weeks

- the trust does not meet the standard for referring women when a fetal anomaly is suspected or confirmed
- tracking of the eligible cohort for the fetal anomaly screening programme is not timely
- although the majority of screening sonographers hold the minimum qualification required by NHS fetal anomaly screening programme, some do not

Shared learning

The QA visit team identified several areas of practice for sharing, regarding training provided in the organisation for:

- midwives rotating to the community setting
- newborn and infant physical examination practitioners
- stakeholders directly and indirectly involved in the newborn hearing screening service

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 commissioner and the provider should ensure signed contracts are in place with all sub-contractors	Service specification 16	12 months	Standard	Confirmation at the antenatal and newborn screening clinical meeting that contracts are in place
2	Update terms of reference for the Bristol and Weston screening programme board to reflect work on inequalities, feedback from user surveys and audit	Service specification 15 to 21	6 months	Standard	Terms of reference
3	The commissioner and provider should work together to develop and implement a health inequalities strategy	Service specifications 15 to 21 Guidance for NHS Commissioners on equality and health inequality duties 2015	12 months	Standard	Summary of the action plan to be presented at the Bristol and Weston screening programme board

No.	Recommendation	Reference	Timescale	Priority	Evidence required
		NHS accessible Information standard and specification			
4	Make sure there is regular attendance by senior members of the midwifery team at the antenatal and newborn screening clinical meeting	Service specification 15 to 19 and 21	12 months	Standard	Minutes from antenatal and newborn screening clinical meeting
5	Implement a process within the trust to share learning from screening incidents	Managing safety incidents in NHS screening programmes	12 months	Standard	Documented process to share learning across the trust from screening incidents
6	Document the process for monitoring identified risks relating to the screening service and escalating them to the trust board if required	Service specification 15 to 21	6 months	Standard	Documented process
7	Revise screening guidelines to make sure that current documents reflect local practice and national screening guidance	Service specification 15 to 19 and 21	6 months	Standard	Revised guidelines
8	Work with adjacent maternity providers to clarify and simplify referral pathways for screen positive women and babies for community midwives	Service specification 15 to 19 and 21	12 months	Standard	Agreed process presented at the Bristol and Weston screening programme board
9	Develop a suite of standard operating procedures to describe processes for managing babies through the hearing screening pathway	Service specification 20	6 months	Standard	Standard operating procedures

No.	Recommendation	Reference	Timescale	Priority	Evidence required
10	Agree with commissioners how often diabetic eye screening in pregnancy will be on the antenatal and newborn screening clinical meeting agenda	Service specification 22	6 months	Standard	Minutes from antenatal and newborn screening clinical meeting
11	Agree a schedule of audits for the newborn hearing screening service	Service specification 20	12 months	Standard	Audits completed, and recommendations and action plans presented at Bristol and Weston screening programme board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Make sure all staff involved in undertaking first trimester screening within the sonography department complete the e-learning modules and individualised feedback is documented in line with the fetal anomaly screening programme recommendations	Service specification 16 and 17 Handbook for ultrasound practitioners	6 months	Standard	Training records for staff
13	Make sure that staff undertaking an ultrasound scan on a pregnant woman for the purpose of screening hold the minimum qualification	Service specification 16 and 17	6 months	High	Confirmation of a training plan
14	Document a process for notifying key stakeholders when changes are made to records on the national newborn failsafe IT systems	Service specifications 19 to 21	6 months	Standard	Guideline or standard operating procedure

Identification of cohort – antenatal

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Implement a timely process for tracking each woman through the fetal anomaly screening pathway to ensure that screening is offered, screening tests are performed and results are received	Service specification 16 and 17	6 months	High	Standard operating procedure

Identification of cohort – newborn

No.	Recommendation	Reference	Timescale	Priority	Evidence required
16	Develop a process within North Bristol NHS Trust for notifying stakeholders about deceased babies, that includes updating the baby's status as deceased on the national screening IT systems	Service specification 19 and 21	6 months	Standard	Guideline or standard operating procedure
17	Document the process for the follow up of babies who are not brought to an appointment for the newborn infant physical examination or newborn blood spot screening	Service specification 19 and 21	6 months	Standard	Guideline or standard operating procedure

Invitation, access and uptake

There are no recommendations in this section.

Sickle cell and thalassaemia screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
18	Complete a review of roles and responsibilities for the referral pathway of screen positive women for sickle cell and thalassaemia	Service specification 18	6 months	High	Action plan and changes to guidelines making sure that counselling is provided by appropriately trained professionals

Infectious diseases in pregnancy screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
19	Ensure each 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	Service specification 15 IDPS programme handbook	3 months	Standard	Database to demonstrate tracking Annual audit of declines and action plan presented to the antenatal and newborn screening clinical meeting
20	Make sure that confirmed screen positive results for infectious diseases screening are communicated within required timescales	Service specification 15 IDPS standard 5	12 months	Standard	Submission of data for IDPS standard 5 Submission of data to the antenatal and newborn national audit protocol 2019 to 2022

Fetal anomaly screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
21	Make sure women are seen within the required timeframe when an anomaly is suspected or confirmed	Service specification 17 FASP standard 8	6 months	High	Submission of data for FASP standard 8

Newborn hearing screening

There are no recommendations in this section.

Newborn and infant physical examination

No.	Recommendation	Reference	Timescale	Priority	Evidence required
22	Make sure that babies are assessed by ultrasound within the required timeframe for suspected developmental dysplasia of the hip	Service specification 21 NIPE standard 3/ KPI NP2	12 months	Standard	Submission of data for KPI NP2

Newborn blood spot screening

No.	Recommendation	Reference	Timescale	Priority	Evidence required
23	Make sure that samples taken for newborn blood spot screening are of a standard which can be tested and a result reported first time	Service specification 19 NBS standard 6/KPI NB2	12 months	Standard	Completion of current action plan Submission of data for KPI NB2

No.	Recommendation	Reference	Timescale	Priority	Evidence required
24	Make sure that blood spot cards received by the laboratory have a barcoded label containing the baby's NHS number	Service specification 19 NBS standard S03	12 months	Standard	Submission of data for NBS standard 3

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.