

ANNUAL REPORT
ANTENATAL AND NEWBORN SCREENING PROGRAMMES

Fiscal Year	1st April 2018 – 31st March 2019
Provider	Bradford Teaching Hospitals NHS Foundation Trust
Author(s)	Vicky Jones
Job Title	Antenatal and Newborn Screening Co-ordinator
Email	Vicky.jones@bthft.nhs.uk
Date of Report	17 th June 2019

NHS Screening Programmes Annual Report template

Names of:	
Local Authority Area(s)	Bradford and Airedale,
CCG(s)	
Sites of Delivery (Including static or mobile)	Bradford Teaching Hospitals Foundation Trust
Programme Lead	Vicky Jones

Programme report	
Annual Programme Update	<p><i>Brief narrative on significant changes to staffing, equipment, facilities over the last 12 months.</i></p> <p>The antenatal and newborn screening team is made up of 1 WTE screening co-ordinator who is supported by a seconded midwife 7.5 hours a week, this was reduced from 15 hours a week in February. We are responsible for the oversight of all the screening programmes, as well as providing care and support to all screen positive women identified through the screening service.</p> <p>In October, 1 WTE failsafe officer joined the team and is responsible for ensuring the screening pathway is complete from offer of screen to receipt of result, whereby maintaining safety and reducing harm.</p> <p>The named person responsible for co-ordination of the Newborn hearing screening programme is Pushpa Mistry. Rob Gardner is Team leader (Consultant Clinical Scientist, Head of audiology Services). The aim of the NHSP is to identify permanent moderate, severe and profound deafness and hearing impairment in newborn babies).</p> <p>The ANNB service was complimented following a Quality Assurance visit in March. The service was found to be patient centred and delivered by a team that is dedicated and committed to providing continuous quality improvements across the screening pathway.</p> <p>The ultrasound service is awaiting imminent replacement of one obstetric ultrasound machine following a serious incident. This machine is on the risk register as in use for growth scans only.</p>

Performance over the last 12 months

- *How successfully are performance issues being managed?*
- *What are the **significant** issues?*
- *Are there any **significant** issues anticipated for next 12 months?*

Activity at BTHFT from 1 st April 18 – 31 st March 19	
Women booked for maternity care	5454
Total births recorded by Trust/unit (including live births / stillbirths)	5370
Babies born including multiple births	5437

Performance data



Annual data submission 18-19.xls



Bradford review of NHSP reports for year

Significant Issues

- Key Performance indicators are consistently achieved with the exception of NB2 (avoidable bloodspot repeats) and ST3 (completion of family origin questionnaire). Strategies and a detailed avoidable bloodspot action plan have been implemented which are showing a steady improvement in the recent quarterly data.
- Current challenge covering Screening co-ordinator planned leave. Formal arrangement to be agreed locally.
- Annual essential and desirable screening audit schedule devised however not all desirable planned screening audits were completed due to capacity.
- Unable to confirm if all women are notified of their screening blood results at their next appointment. Awaiting Medway upgrade which should address this concern.
- Verifying KPI ST3 (completion of family origin questionnaire) data which is reported by the Leeds laboratory has been problematic, resulting in nil submission for quarter 3. A new process was implemented for quarter 4; however our local laboratory is working towards reporting this data in the future.

Health Promotion Activities


Brief narrative about successful activities over the last 12 months and the impact seen

- Assurance that our women and babies complete the screening pathway in a timely manner is in place following the appointment of a failsafe officer in October. This has released screening hours and enabled the screening co-ordinator to provide support in the

	<p>fetal medicine meetings/clinic, enhancing the maternal medicine service.</p> <ul style="list-style-type: none"> • A women's satisfaction survey was produced in April 18 which highlighted an improvement in women's experiences compared with the audit of 2016. It revealed women feel they are being equipped with all the relevant information to make an informed choice about screening and that they are given enough time to do so. • The Screening and Immunisation team have worked with General Practice Surgeries to ensure babies born to hepatitis B mothers are offered subsequent appointments for the hepatitis B vaccination following the birth vaccination. • The screening co-ordinator has close links with the hepatology nurse specialists, HIV consultants and sexual health consultants; this ensures women with a positive screen are provided with quality, safe care. Additionally this has a positive impact on KPI ID2 (timely assessment of women with hepatitis B). • All women with a diagnosis of HIV receive a seamless service throughout the antenatal and often intrapartum period by the screening team. This is a vulnerable group of women and this model has had positive verbal feedback throughout the year.
Client Feedback/Client Involvement	<p><i>Overall trend in numbers of Patient comments/complaints/compliments in the last 12 months (e.g. 12 comments 35 complaints and 72 compliments out of 200 patients screened)</i></p> <p>A patient satisfaction survey was conducted in April. 51 questionnaires were completed relating to all the antenatal screening programmes. It highlighted an improvement in women's experiences compared with the audit completed in 2016 and showed women feel they are equipped with adequate information to make an informed choice about screening and that they are given enough time to do so.</p>
Programme Operational Group	<p><i>How effective are the Programme Operational Groups at managing the Screening /Action Plans/Challenges etc.</i></p> <p>Bradford has 2 separate groups, antenatal screening and newborn screening. 4 antenatal and 2 newborn operational screening group meetings have taken place this year, attended by multi-disciplinary members. The remit of both groups is to assess and review the screening programmes, plan for future developments and work towards provision of evidence based services which are equitable and in line with national recommendations. At all meetings audits and screening incidents are discussed in order to improve the overall quality of the service provided. Minutes of the meetings are widely circulated and issues fed into Maternity core group meetings.</p>

	<p>Updates from the Regional Laboratory meeting, Regional screening meeting and Screening and Immunisation meetings are fed into both the local operational and core group meetings.</p>
QA Action Plan	<p><i>Consider the outstanding actions on the QA action plan for the next 12 months and how they will be prioritised</i></p> <p>On the 7TH March 19 we had our second formal Quality assurance (QA) inspection of the NHS Antenatal and newborn screening service. The visit was carried out by a team of trained professional and clinical advisors, representing key disciplines involved in the delivery of the screening programmes. Quality assurance aims to maintain national standards and promote continuous improvement in antenatal and newborn screening to ensure that all eligible individuals have access to a consistent high quality service wherever they live.</p> <p>The service at BTHFT was found to be patient centred and delivered by a team that is dedicated and committed to provide continuous quality improvements across the screening pathway. Screening was identified as having a high profile within the maternity leadership and governance structure. No major concerns were found in any of our screening programmes. Areas of practice for shared learning and recommendations were identified, as detailed below.</p> <p>AREAS OF PRACTICE FOR SHARED LEARNING</p> <ul style="list-style-type: none"> • The palliative care pathway established in the fetal anomaly screening programme (FASP) for families where severe anomalies have been diagnosed at scan with links to a local hospice. This service provides valuable support during both the antenatal and the postnatal period. • 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 by the NHSP manager directly into audiology. <p>RECOMMENDATIONS</p> <p>High priority (6 months)</p> <ul style="list-style-type: none"> • 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

	<p>Standard priority (3 months)</p> <ul style="list-style-type: none"> • Update the radiology risk register and capital replacement bid for ultrasound machines to address any identified gaps <p>Standard priority (6 months)</p> <ul style="list-style-type: none"> • Add antenatal and newborn screening to the Women's and Children's core group agendas to evidence escalation. • Make sure 'communication of results' guideline includes clear instruction on informing women of their screening results including those whose pregnancies have ended following screening • Put in place targeted training to make sure Screening Support Sonographers (or delegated sonographers) have clear understanding of Radiology Information Systems (RIS) statistics package to assist with accurate data collection • Risk assess the location of the PACS monitor to make sure monthly image review is not compromised due to accessibility to machine • Review referral process around KPI ST4a and b for known at risk women and couples to make sure there is no delay in referral for prenatal diagnosis and that outcomes from fetal medicine are reported • 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 • Maternity to work with IDPS laboratory to update results reporting process to exclude screen negative results in line with national standards • Put in place a plan to monitor compliance of timely support and in-house referrals when anomalies are identified on scan • Work with child health information service to develop a process to record NIPE examinations on the child health information IT system <p>Standard priority (12 months)</p> <ul style="list-style-type: none"> • Make sure antenatal and newborn screening is included on trust audit schedule. An equity audit should be included • Update the existing screening specific user satisfaction survey to include newborn screening programmes • Implement and monitor a plan to meet KPI FA1 • Update local processes to include reporting of screen positive outcomes using the functionality from SMART4NIPE screening management and reporting tool • Implement and monitor a plan to meet KPI NB1, NB2, NB4 and NP2 • Develop a process to make sure all newborn examinations and outcomes are recorded on SMART4NIPE
--	---

	<p>An action plan has been produced locally identifying these recommendations and they will be discussed/reviewed/completed through the local governance meetings. The Quality assurance team will work with the commissioners to monitor activity and progress for a period of 12 months.</p> <p>The full report can be found using the link below:</p> <p></p> <p>Final_ VD_ANNB_QA_Visit_F</p>
Next Steps/Service Developments or Expansion Plans	<p><i>Are there any significant service developments underway or planned for the next 12 months?</i></p> <ul style="list-style-type: none"> Plans to implement non-invasive prenatal screening test (NIPT) into the national FASP screening programme. Awaiting national development of the hepatitis B pathway. A new project is starting in July 19 led by the Leeds bloodspot laboratory to implement the electronic messaging of the full expanded bloodspot screening conditions from Leeds Lab (via Perkin Elmer) into the SystmOne pathology inbox (where they can be bulk filed onto the babies records by CHRD). These are currently only messaged by MCADD as proxy.
Incidents	<p><i>What is the overall trend of incidents over the last 12 months (e.g. have incidents in/de/creased in number, are they generally less/more serious than the previous 12 months?)</i></p> <p>Screening incidents are a standing agenda item on both antenatal and newborn screening governance board meetings. Incidents are discussed, minutes widely circulated and issues fed into the maternity core group meetings.</p> <p>6 screening incidents were reported this year, 1 was a serious incident. 3 of these incidents were reported to the Screening Quality Assurance Service. All the investigations including actions and recommendations have been completed.</p>
Risks & Issues	<p><i>What were the most significant risks/issues affecting the programme over the last 12 months</i></p> <ul style="list-style-type: none"> The palliative care pathway, established within the FASP is not a commissioned service. There is a need to find funds/resources to make this pathway sustainable in the future. Annual essential and desirable screening audit schedule devised however not all desirable planned audits were completed due to capacity.

	<ul style="list-style-type: none"> • Current challenge covering Screening co-ordinator planned leave. Formal arrangement to be agreed locally. • A great improvement in the number of avoidable blood spot repeats performed however the Trust needs to continue driving the recent strategies enforced until the target of <2% is consistently achieved. • Unable to confirm if all women are notified of their screening blood results at their next appointment. Awaiting Medway upgrade which should address this concern. • The validation of ST3 (completion of family origin questionnaire) data from the Leeds laboratory has been problematic. Discussions are taking place to move the haemoglobinopathy service from Leeds to our local laboratory which will help with TAT's, reduced the risk of missing samples and improve the accuracy of the KPI ST3 data. • Capacity for fetal anomaly scanning has been affected as one obstetric ultrasound machine is used for growth scans only.
Achievements	<p><i>Any good news/achievements/proud to share events/staff awards/over the last 12 months?</i></p> <p>Generic</p> <ul style="list-style-type: none"> • We had a quality assurance visit in March which found the service to be patient centred and delivered by a team that is dedicated and committed to continuous quality improvements. • We have a have a robust failsafe in place to ensure the screening pathway is complete and a missed screening is identified and escalated in a timely manner whereby reducing the risk of incident recurrence and harm. • Overall improvement in women's experiences of the antenatal screening programmes compared with the previous year, highlighted in a locally conducted audit. • KPI data for ID1 (HIV coverage) ID3 (hepatitis B coverage), ID4 (syphilis coverage), ST1 (sickle cell and thalassaemia coverage) and FA2 (fetal anatomy coverage) consistently meets the performance thresholds. • Charitable funds have been raised to create a suitable environment for women with a diagnosis of a life limiting condition of their baby. <p>Fetal anomaly</p> <ul style="list-style-type: none"> • Improvement in the Fetal Anomaly Screening Programme (FASP) Standard 8a data. 100% of women referred locally were seen within the timeframe (suspected/confirmed fetal anomalies seen locally within 3 working days. • Screening co-ordinator has commenced attending weekly multidisciplinary team (MDT) meeting/clinic for discussion of fetal

	<p>abnormalities. This provides a link between all the relevant internal and external disciplines and continuity of care for those women who have poor outcomes.</p> <ul style="list-style-type: none"> • Commenced reporting data for KPI FA3. No threshold has been set for this KPI as yet. • Commenced recording trisomy screening results from Leeds laboratory into the woman's maternity record. <p>Infectious Diseases</p> <ul style="list-style-type: none"> • Women diagnosed with HIV receive an exemplary service with antenatal and often intrapartum care is provided by the screening coordinator to maximise continuity of care • Robust clear Hepatitis B pathway with 100% Hepatitis B vaccination coverage for babies born to Hepatitis B positive mothers. <p>Hearing screening</p> <ul style="list-style-type: none"> • The service has been named by Public Health England as one of only a handful of sites nationally that have consistently met and exceeded the KPI standard for NH2 (time taken to see a hearing specialist from the audiology service after referral from the screen). https://www.bradfordhospitals.nhs.uk/2018/03/05/newborn-hearing-programme-among-nations-best/ • Consistently meet NH1 (proportion of babies eligible for screening whom the screening process is complete by 4 weeks of age. • The Child Health Records Department (CHRD) informs the NHSP screeners of all babies identified with no concluded result including movers in.
<p>Future vision/horizon planning</p>	<p><i>Over the next 12 months</i></p> <ul style="list-style-type: none"> • To monitor the formulated action plan which addresses the recommendations made in the Quality Assurance report. The actions will be reviewed at the local screening governance and core group meetings. • Formalise a plan for deputy cover when the screening co-ordinator is on annual leave so standards are consistently met. • Devise and complete an essential and desirable screening audit schedule for 19-20. • Discuss and implement a process to ensure newborn outcomes are recorded on SMART4NIPE. • To conduct a training needs analysis in order to address staff training needs in relation to screening. • To continue monitoring the avoidable blood spot repeat rate (KPI NB2) and ensure the strategies implemented are consistently enforced, until threshold reached. • CHRD to explore inputting NIPE results onto SystmOne records.

	<ul style="list-style-type: none"> • Awaiting replacement of one ultrasound machine which will improve the capacity for fetal anomaly scanning. • To explore means of commissioning the palliative care service within the FASP
--	---

DRAFT