



Sgrinio Smotyn Gwaed
Newydd-anedig Cymru
Newborn Bloodspot
Screening Wales

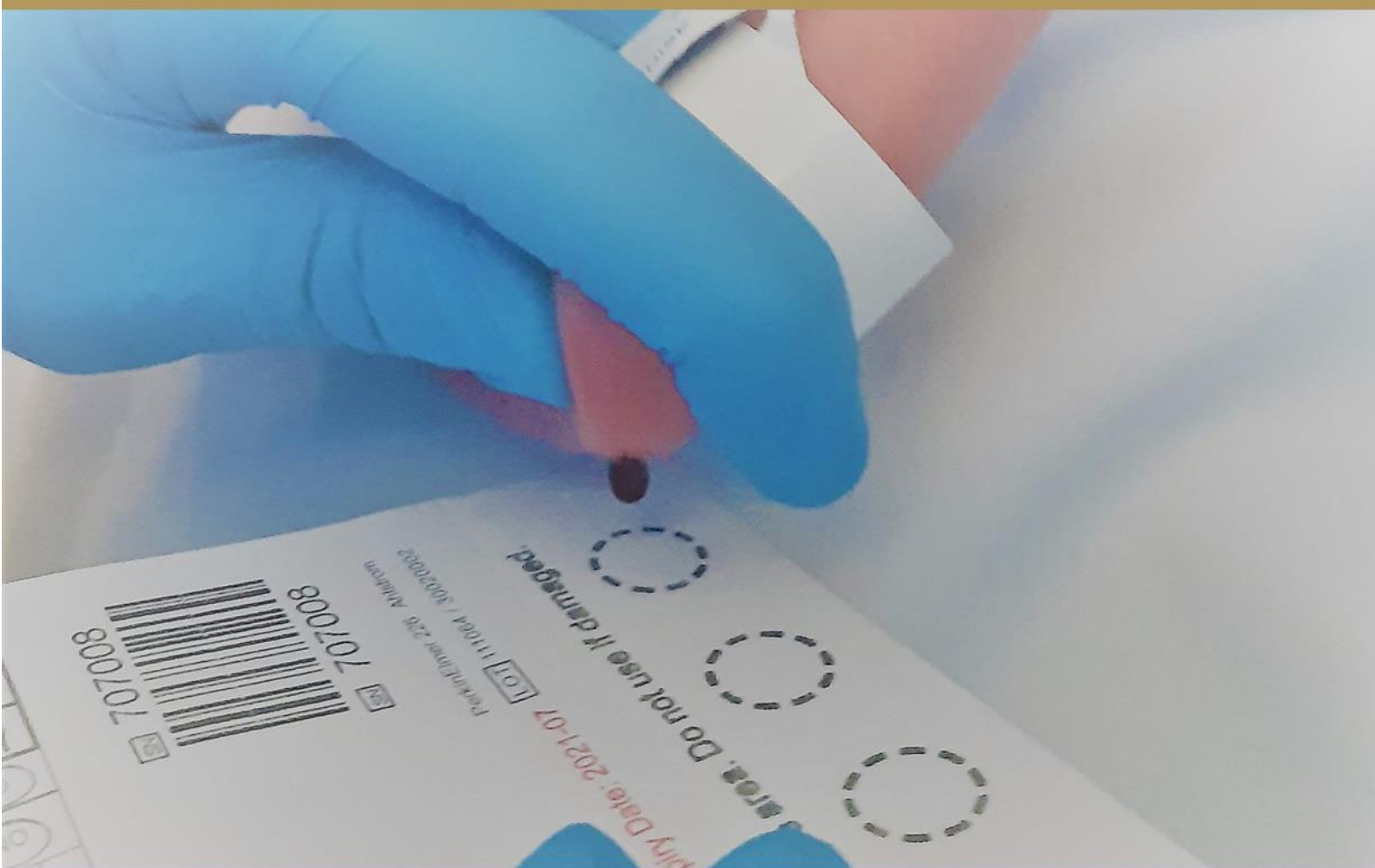


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Newborn Bloodspot Screening Wales Annual Statistical Report 2018-19

November 2019



About us

Public Health Wales exists to protect and improve health and wellbeing and reduce health inequalities for people in Wales.

We are part of the NHS and report to the Minister for Health and Social Services in the Welsh Government.

Our vision is for a healthier, happier and fairer Wales. We work locally, nationally and, with partners, across communities in the following areas:

Health protection – providing information and advice and taking action to protect people from communicable disease and environmental hazards

Primary, community and integrated care – strengthening its public health impact through policy, commissioning, planning and service delivery

Microbiology – providing a network of microbiology services which support the diagnosis and management of infectious diseases

Safeguarding - providing expertise and strategic advice to help safeguard children and vulnerable adults

Screening – providing screening programmes which assist the early detection, prevention and treatment of disease

Health intelligence – providing public health data analysis, evidence finding and knowledge management

NHS quality improvement and patient safety – providing the NHS with information, advice and support to improve patient outcomes

Policy, research and international development – influencing policy, supporting research and contributing to international health development

Health improvement – working across agencies and providing population services to improve health and reduce health inequalities

Further information

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The report is only available electronically from the screening programme and will be available on the website:

www.newbornbloodspotscreening.wales.nhs.uk

This report is a detailed summary of information on work undertaken by Newborn Bloodspot Screening Wales for the financial year from April 2018 to the end of March 2019. Results are reported by health board where screening has been carried out. Further details are available on request.

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg. Byddwn yn ateb gohebiaeth yn Gymraeg heb oedi / We welcome correspondence and phone calls in Welsh. We will respond to correspondence in Welsh without delay.

Quality Assurance Statement

Screening data records are constantly changing. The databases used by Public Health Wales Screening Division are updated on a daily basis when records are added, changed or removed (archived). This might relate to when a person has been identified as needing screening; has had screening results that need to be recorded, or has a change of status and no longer needs screening respectively. Data is received from a large number of different sources with varying levels of accuracy and completeness. The Screening Division checks data for accuracy by comparing datasets, for example GP practice data, and corrects the coding data where possible. It should be noted that there are sometimes delays in data collection, for example a person might not immediately register with their GP. These

delays will therefore affect the completeness of the data depending on individual circumstances. In addition, the reader should be aware that data is constantly updated and there might be slight readjustments in the numbers cited in this document year on year because of data refreshing. When dealing with data from small geographical areas we occasionally suppress numbers lower than five when the data is potentially sensitive.

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This document is also available in Welsh.

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1 Introduction

This is the third annual statistical report published by Newborn Bloodspot Screening Wales (NBSW). This report covers data for babies born between 1 April 2018 and 31 March 2019.

Newborn bloodspot screening is when a small sample of blood is taken from the baby's heel on day five of life (counting day of birth as day zero). The screening test is part of routine postnatal care.

The aim of the Newborn Bloodspot Screening programme in Wales is to offer all eligible babies, at day five of life, quality assured screening for rare but serious diseases that would benefit from early intervention and reduce mortality and/or morbidity from the disease.

In Wales all eligible babies are offered screening for the conditions below which are recommended by the UK National Screening Committee:

- Congenital hypothyroidism (CHT)
- Cystic fibrosis (CF)
- Inherited metabolic disorders (IMDs):
 - Medium-chain acyl-CoA dehydrogenase deficiency (MCADD)
 - Phenylketonuria (PKU)
 - Maple syrup urine disease (MSUD)
 - Isovaleric acidaemia (IVA)
 - Glutaric aciduria type 1 (GA1)
 - Homocystinuria (HCU)
- Sickle cell disorders (SCD)

1.1 Key messages for parents

Information for parents and the general public has been produced and is summarised in the NBSW Key Messages leaflet. The following messages are included:

- Newborn bloodspot screening identifies babies who may have rare but serious conditions
- If your baby is found to have any of the conditions they will receive early specialist care and treatment
- Early treatment can improve your baby's health and prevent severe disability or even death

- Screening is not 100% accurate. If the screening test suggests a problem, your baby will need further tests to confirm that they have the condition
- Newborn bloodspot screening is recommended
- The 'Information for Parents' leaflet, which is available from your midwife, explains the conditions screened for and how the sample is taken

1.2 Programme delivery

The Screening Division of Public Health Wales is responsible for the planning, preparation and delivery of the Newborn Bloodspot Screening Wales (NBSW) programme. NBSW is one of three programmes within Maternal and Child (MAC) Screening, which has an overall Programme Lead. There are two NBSW programme co-ordinators with administration support across the MAC programmes. The other two programmes are Antenatal Screening Wales (ASW) and Newborn Hearing Screening Wales (NBHSW).

The offer of newborn bloodspot screening to eligible babies and the collection of bloodspot samples is undertaken by health professionals within the seven health boards in Wales.

The Wales Newborn Screening Laboratory in Cardiff is responsible for testing the screening samples taken in Wales and for the referral of babies suspected of having conditions. Babies are referred to a network of clinicians and designated medical leads in the health boards. The programme has external Quality Assurance Advisors which include some of the medical leads.

The Newborn Bloodspot Screening Wales System (NBSWS) has been developed to support the management of a safe and sustainable programme across Wales. This system collects and collates information across the programme to monitor the quality of newborn bloodspot screening and provides quality assurance and management reports based on the policies and standards.

NBSWS also identifies babies for whom the programme expects to receive either a bloodspot card or decline for the test(s), and initiates failsafe procedures for possible 'missed' babies. This failsafe system identifies babies in Wales who do not have a newborn bloodspot screening sample in

the Newborn Screening Laboratory by day 14 of life. Every baby identified by the failsafe is followed up by the administration failsafe teams. The three regional teams across Wales are staffed by newborn screening managers and administrative staff who work across both the NBSW and Newborn Hearing Screening Wales (NBSHW) programmes.

In each health board there is a Governance Lead for Antenatal and Newborn Screening. This role, funded by Screening Division, Public Health Wales, is to act as liaison between the health board and NBSW, and to lead the provision of newborn bloodspot screening in the health board to ensure the provision of an effective and efficient service.

1.3 Screening pathway

Babies who are eligible for screening are identified in each health board from midwife birth notifications. Eligible babies up to one year of age who move in to Wales are identified following registration on to the Welsh Child Health System.

The offer of screening and collection of bloodspot samples is carried out by health professionals within the health boards in accordance with the NBSW guidance, standards and policies. The majority of samples are taken in the baby's home by the midwife. Neonatal or paediatric unit staff offer the screening and take samples for those babies who are inpatient in those units at day five of life. Health visitors take responsibility for offering and arranging sample collection for eligible babies who have moved into Wales.

Newborn bloodspot screening samples are sent by prepaid envelopes (first class Royal Mail) to the Wales Newborn Screening Laboratory in Cardiff for testing. The laboratory accepts samples according to the UK bloodspot quality guidelines for screening laboratories that were implemented in April 2015. Babies suspected of having one of the conditions screened for are referred, according to the relevant clinical referral guidelines, to the appropriate specialist clinician for diagnostic tests and treatment. This is within 24 hours of the screening result. The screening threshold for congenital hypothyroidism was decreased from 10mU/L to 8mU/L in April 2018 in line with UK guidance.

An improved results process for parents was introduced from February 2019 with results letters being sent to parents directly from the programme. Bloodspot screening results are sent to the parents within six weeks of the sample being taken. Previous to this the results were sent

from the laboratory via the child health department to the health visitors to discuss with the parents.

For babies who have a suspected result for any of the conditions, the results letter is sent via the baby's health visitor. The programme will contact the health visitor after the baby has been received into clinical care to inform them of the result. The baby's health visitor will then be sent the results letter and information to enable an informed discussion of the results with the parents. The results for each baby are sent to the local Child Health Department and are entered onto the Child Health System.

More information is available at:

www.newbornbloodspotscreening.wales.nhs

2 Headline statistics

April 2018 to March 2019

- The number of eligible births across Wales was 31,219
- The number of babies tested was 31,048 (99.5%)

Screening

Completeness of offer and coverage by day 17 of life (eligible newborns)

- Completeness of offer – 97.0% of babies had a bloodspot card (for screening or decline) received in the laboratory by day 14 of life
- Coverage – 93.2% of babies had conclusive bloodspot screening results by day 17 of life

Timeliness of sample collection

- Timely collection of sample (day five-eight of life) – 97.9%
- Timely collection of sample (day five of life) – 76.2%

Avoidable repeat rate

- Avoidable repeat rate – 8.3%

Improving performance in collecting good quality samples remains a high priority for the programme to avoid delays in the referral of babies with suspected conditions.

NHS number on bloodspot card

- 99.3% bloodspot cards received in the laboratory had a valid NHS number for the baby recorded

Timely receipt of card in laboratory

- 94.5% of bloodspot cards were received within four working days of sample collection

Outcomes

The number of babies who had one of the conditions detected in the year was as follows: phenylketonuria (6), congenital hypothyroidism (31), maple syrup urine disease (1), cystic fibrosis (14) and sickle cell disorders (3).

3 Data

The data tables in this section outline the performance of the programme against the standards that have been set.

Table 1: The number of eligible births in Wales in the period April 2018 to March 2019 and the number of these babies tested.

	Aneurin Bevan	Abertawe Bro Morgannwg	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	Wales
Births	6,097	3,662	6,522	5,259	4,779	3,357	1,154	31,219
Tested	6,078	3,636	6,487	5,209	4,766	3,336	1,147	31,048
%	99.7	99.3	99.5	99.0	99.7	99.4	99.4	99.5

The Wales total includes some babies who do not map to a health board.

There were 171 babies that were not tested in this period. Parents declined screening in 46 newborns and 58 babies that moved into Wales from outside the UK. Sadly there were 19 deaths after day 5. A suspended status was recorded for 48 babies. These were movements into Wales from outside the UK that, at the time of reporting, the programme had been unable to contact the parents or the health visitor to obtain a definitive answer regarding consent for screening.

3.1 Standards

This table outlines the standards set by the screening programme to monitor performance.

Table 2: Programme performance standards

NBSW standards – screening programme					
	Objective	Criteria	Minimum Standard	Actual Value	Variance from 2017-18
1A	Completeness of offer (Newborns)	The percentage of eligible newborn babies who have a notification of receipt of the bloodspot card in the laboratory by day 14 of life	99%	97.0%	+0.5

	Objective	Criteria	Minimum Standard	Actual Value	Variance from 2017-18
1B	Completeness of Offer (All)	Eligible babies (up to one year of age) who have a notification of receipt of the bloodspot card in the laboratory within 18 days of registration	99%	98.9%	+1.8
1C	Coverage (Newborns)	Eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	93.2%	-0.6
1D	Coverage (All)	Eligible babies (up to one year of age) who have a conclusive bloodspot screening result within 21 days of registration	95%	96.5%	+1.7
3A	Timely Collection of Sample (Day Five-Eight of Life)	The first bloodspot sample should be taken between day five and day eight of life (counting day of birth as day zero)	95%	97.9%	No change
3B	Timely Collection of Avoidable Repeat Samples	Repeat testing for insufficient/poor quality samples or incomplete/incorrect card information should be conducted within three calendar days of the request	95%	73.6%	+9.2
3C	Timely CHT Second Sample Collection for Pre-Term Babies	Pre-term babies with a second bloodspot card received in the laboratory which was taken at day 28 of life or on day of discharge	95%	2018-19 data not available	-
3D	Timely Second Sample Collection for Borderline TSH (thyroid stimulating hormone)	Babies with a borderline TSH result who have a second bloodspot card for TSH received in the laboratory which was collected between 7 and 10 days after the initial borderline sample	95%	70.9%	-4.1
4A	Avoidable Repeat Rate	Repeat cards that are required because of poor quality bloodspots or incomplete/incorrect information recorded	<=2%	8.3%	+3.6 (drop in performance)

	Objective	Criteria	Minimum Standard	Actual Value	Variance from 2017-18
4B	Poor Quality Repeat Rate	Repeat cards that are required because of poor quality bloodspots	$\leq 2\%$	7.2%	+4.0 (drop in performance)
4C	NHS Number on Bloodspot Card	Bloodspot cards received in the laboratory that have a valid NHS number for the baby recorded	100%	99.3%	+0.2
5	Timely Receipt of Card in Laboratory	Bloodspot cards received within four working days	99%	94.5%	+0.6
6A	Timely Processing of IMD and CHT Positive Samples	Clinical referral for IMD/CHT screen positive results initiated within three working days of sample receipt	100%	100%	no change
6B	Timely Processing of CF Positive Samples	Clinical referral for CF screen positive results initiated within 25 days of sample receipt	95%	100%	no change
6C	Timely Processing of SCD Positive Samples	Clinical referral for SCD screen positive results initiated within 42 days of sample receipt	95%	100%	no change
7A	Timely Clinical Care Receipt of IMD Positive Babies	First clinical appointment attendance for IMD screen positive results by day 14 of life	100%	100%	no change
7B	Timely Clinical Care Receipt of CHT Positive Babies	First clinical appointment attendance for CHT screen positive results by day 14 of life or initial borderline results followed by a positive by day 21	100%	82.8%	-17.2
7C	Timely Clinical Care Receipt of CF Positive Babies	First clinical appointment attendance for CF screen positive results by day 28 of life	95%	81.0%	-7
7D	Timely Clinical Care Receipt of SCD Positive Babies	First clinical appointment attendance for SCD screen positive results by day 90 of life	90%	100%	no change

3.2 Completeness of offer and coverage

Standard 1A: 99% of newborn babies are offered screening - notification of receipt of the bloodspot card in the laboratory by day 14 of life

Standard 1B: 99% of all babies are offered screening - notification of receipt of the bloodspot card in the laboratory within 18 days of registration

Standard 1C: 95% of newborn babies complete screening - a conclusive bloodspot screening result by day 17 of life (coverage)

Standard 1D: 95% of all babies complete screening - a conclusive bloodspot screening result within 21 days of registration (coverage)

Table 3: Babies offered and completing newborn bloodspot screening

Health Board	% Offered (Newborn)	% Offered (All)	% Coverage (Newborn)	% Coverage (All)
Abertawe Bro Morgannwg UHB	96.1	98.9	93.4	96.8
Aneurin Bevan UHB	97.7	99.1	92.6	96.5
Betsi Cadwaladr UHB	96.3	98.9	92.9	96.3
Cardiff and Vale UHB	96.4	98.4	93.5	96.4
Cwm Taf UHB	97.9	99.3	93.3	97.0
Hywel Dda UHB	97.5	99.1	94.0	96.6
Powys Teaching Health Board	97.6	99.1	93.8	96.6
All Wales	97.0	98.9	93.2	96.5

The All Wales figures show that the standards for offer of screening have not been met, although there is an increase of 0.5% (newborns) and 1.8% (all babies) compared with the previous year. Work to improve timeliness of sample collection and dispatch is continuing.

The standards for coverage for newborns have not been met this year. Across Wales, 93.2% of newborn babies had screening completed in the specified timeframe which is a decrease of 0.6% compared with the

previous year. The high avoidable repeat rate and timeliness issues in collecting repeat samples have an impact on performance in coverage and addressing these problems continues to be a high priority for the programme.

3.3 Timeliness of testing

Standard 3A: 95% of samples are taken between day five-eight of life

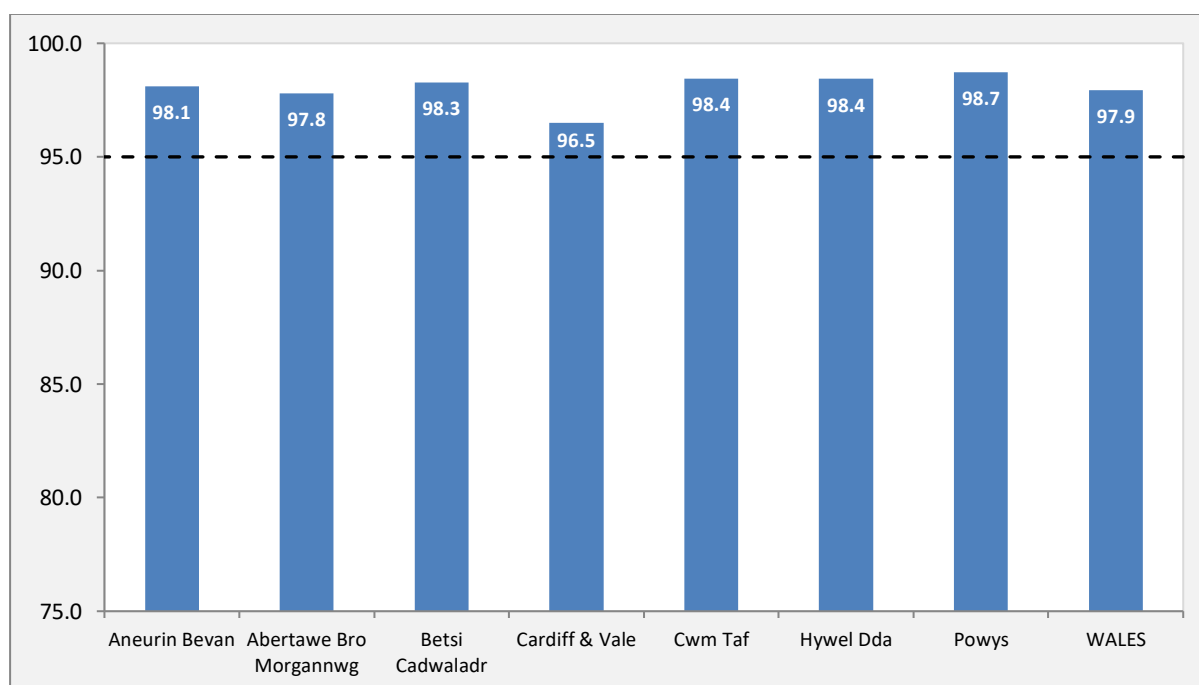
Standard 3B: 95% of avoidable repeat samples are taken within three calendar days of request

Standard 3C: 95% of CHT repeat samples for pre-terms babies are taken at day 28 of life or date of discharge

Standard 3D: 95% timely second sample collection for borderline TSH collected between seven and ten days after initial borderline sample

Standard 3A

Graph 1: Timely collection of samples (day five–eight of life)



This standard has been met in all of the health boards. Across Wales, 97.9% of samples were taken between day five and day eight of life. The programme is working with the health boards to improve timeliness of sample collection, with the emphasis on taking the sample on day five to enable earlier identification and referral of screen positive babies.

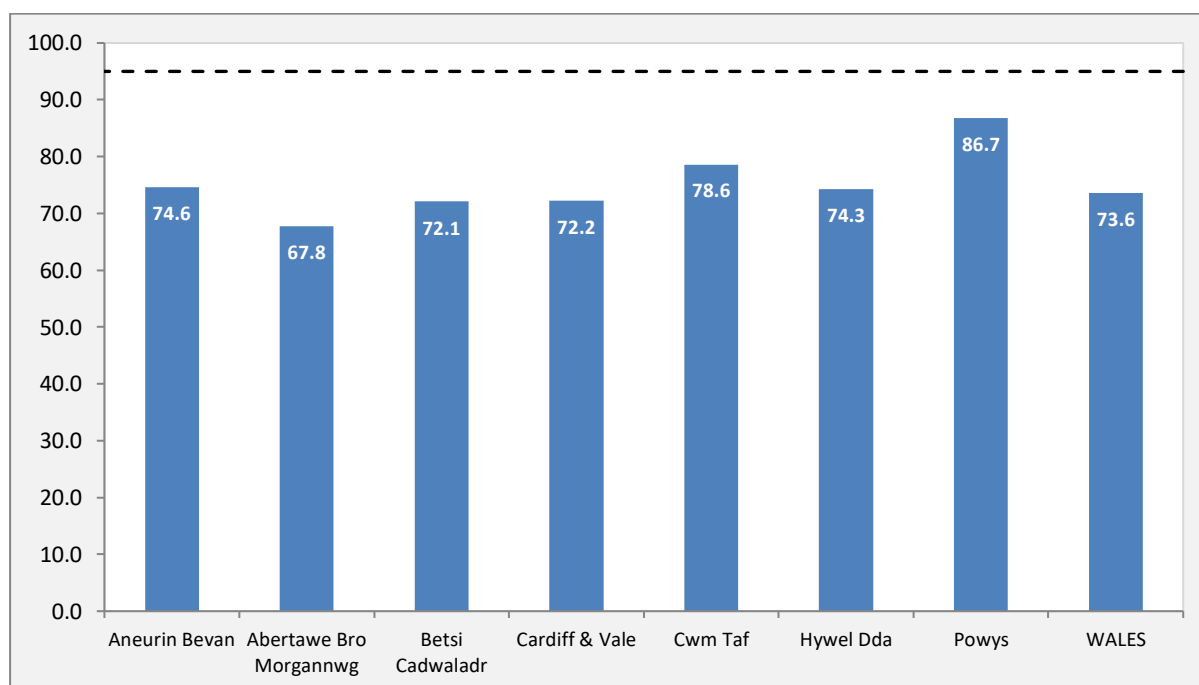
To monitor performance in timely collection of samples more closely, data is collected for sample collection at day five of life. Improving performance in this is a high priority for the programme to enable timely referral of screen positive babies to clinical care.

Across Wales, 76.2% of samples were taken at day five of life which is a drop of 2.2% compared with the previous year. This decline has been in four of the seven health boards.

Performance data for sample collection timeliness is fed back quarterly to the health board governance leads and Heads of Midwifery. The programme continues to work with the health boards to improve performance and this has included the education of sample takers of the importance of taking samples on day five. The programme is aware that competing demands on maternity services have an impact on this figure.

Standard 3B

Graph 2: Timely collection of avoidable repeat samples



Across Wales, 73.6% of avoidable repeat samples were taken within three calendar days of the request. The standard has not been met but there is an improvement of 9.2% on the previous year.

All requests for repeat samples are emailed to designated generic email addresses in the maternity and neonatal units. Although the process was implemented in June 2017, regular reviews have further improved the process. This includes ensuring the laboratory email out to the health boards by 3pm daily and that the health boards have robust systems set up to access these email addresses daily. The programme continues to work closely with the Newborn Screening Laboratory to identify any factors that may result in delays in the timely receipt of requests in the health board.

Work continues with the health boards to improve the timeliness of repeat samples and this has included the education of sample takers of the importance of timely collection of repeat samples.

The importance of taking a repeat sample for borderline TSH samples has also been emphasised during training sessions in health boards.

Standard 3C

Timely CHT second sample collection for pre-term babies.

Pre-term babies should have a second sample taken for CHT testing on day 28 of life or earlier if they are to be discharged home.

Table 4: The actual day of testing for the total number of pre-term babies in the year.

Day of life second CHT sample taken										
<28*	28	29	30	31	32	33	34	35	>35	Total
26	87	31	14	10	6	6	7	7	23	217

* Performance by health board and all Wales has not been given for this standard as the IT systems were not able to capture all the required data during 2018-19.

Across Wales, 12% of second CHT samples were taken before day 28 of life, the same as the previous year. This data does not currently show if the samples were correctly taken from babies who were discharged before day 28 of life, or taken too early resulting in a request for a repeat sample. However, laboratory monthly feedback of avoidable repeat samples includes CHT second samples that have been taken too early. This showed

a reduction in the number of these samples that were taken too early this year.

The programme continues to work closely with the neonatal units across Wales to improve performance so that CHT second samples are taken at the correct time.

In July 2018, the programme produced a short film 'Newborn bloodspot screening in neonatal units' for sample takers working in these units. It looks at aspects of newborn bloodspot screening for babies who are being cared for in neonatal units and the additional requirements needed for screening these babies. The film is available on the website and has been used during educational sessions on the units.

3.4 Poor quality repeat samples required

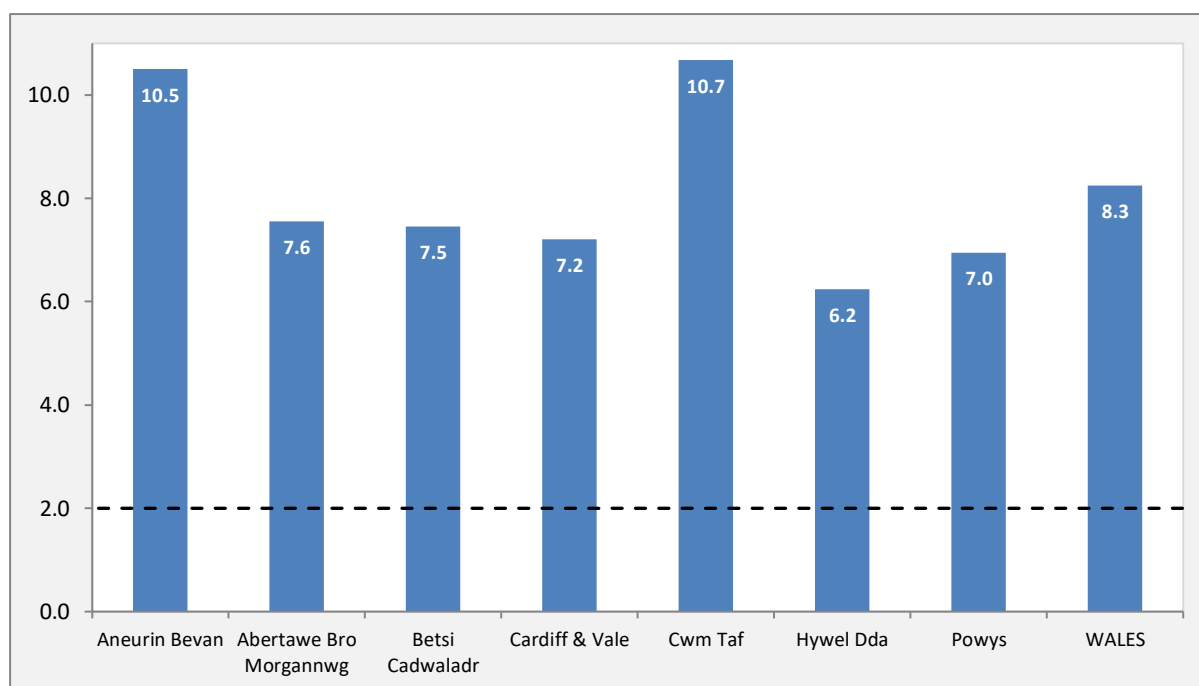
Standard 4A: *avoidable repeat rates - $\leq 2\%$ repeat cards required because of poor quality bloodspots or incomplete/incorrect information recorded*

Standard 4B: *poor quality repeat rate - $\leq 2\%$ repeat cards required because of poor quality bloodspots*

Standard 4C: *NHS number on bloodspot card - 100% of bloodspot cards received in the laboratory have a valid NHS number for the baby recorded*

Standard 4A

Graph 3: Avoidable repeat rate



The avoidable repeat rate in Wales is 8.3%, a considerable increase of 3.6 percentage points compared with the previous year. Achieving the standard of $\leq 2\%$ remains a high priority for the programme to avoid delays in the referral of babies and to avoid the other costs associated with repeating samples.

Due to the significant increase in the avoidable repeat rate the programme have established an improving sample quality task and finish group. The first monthly meeting was held in January 2019. The group consists of all members of the programme and representatives from the laboratory, failsafe teams, informatics, neonatal network, governance leads, health visiting, 1000 Lives and Heads of Midwifery. The group is tasked with improving the quality of the samples being received in the laboratory.

A pilot is being undertaken in one health board to reduce the avoidable repeat rate through having NBS champions who commenced practice in April 2019.

The programme has worked closely with the governance leads to support them in updating and training all sample takers in their health boards. The training films that are available on the website have been an important part of these training sessions. The laboratory film 'Good quality newborn

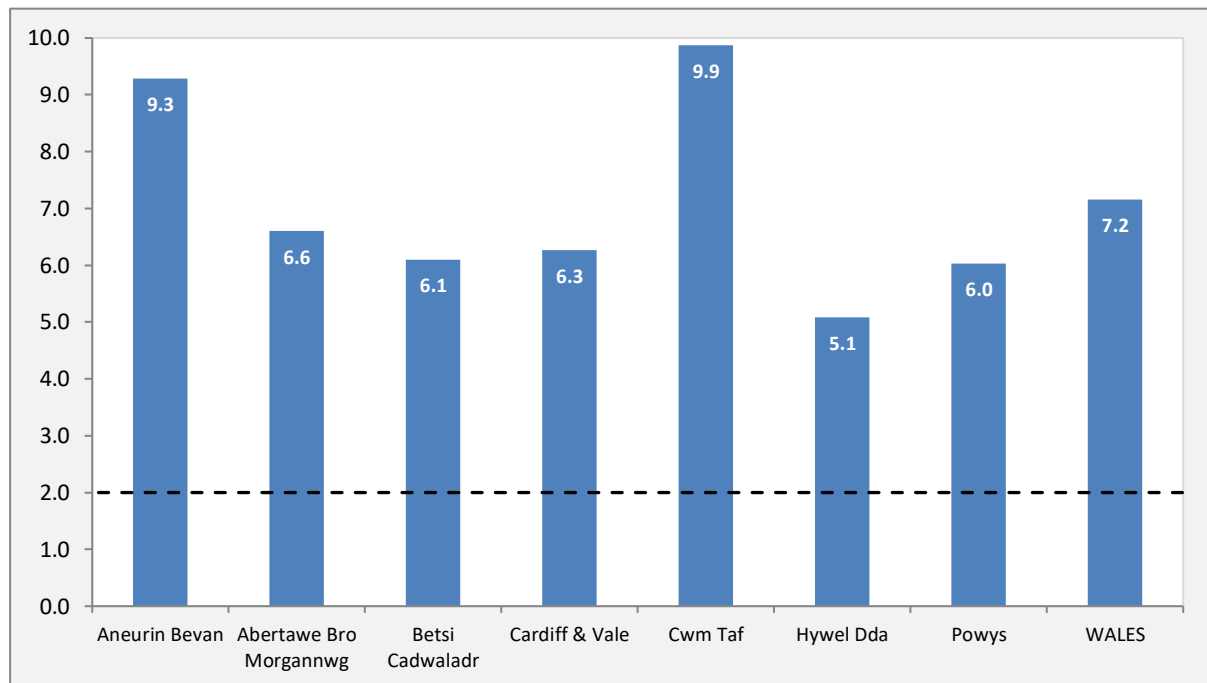
bloodspot screening samples – understanding laboratory requirements and processes’ illustrates the process of testing a screening sample once it is received in the laboratory. It highlights why good quality samples are important and provides examples of poor quality samples and why they are unsuitable for testing.

The governance leads are kept up to date with avoidable repeats within their health boards as they are copied into all emails requesting repeat testing. This has enabled the timely feedback of poor quality samples to specific sample takers so that training can be undertaken.

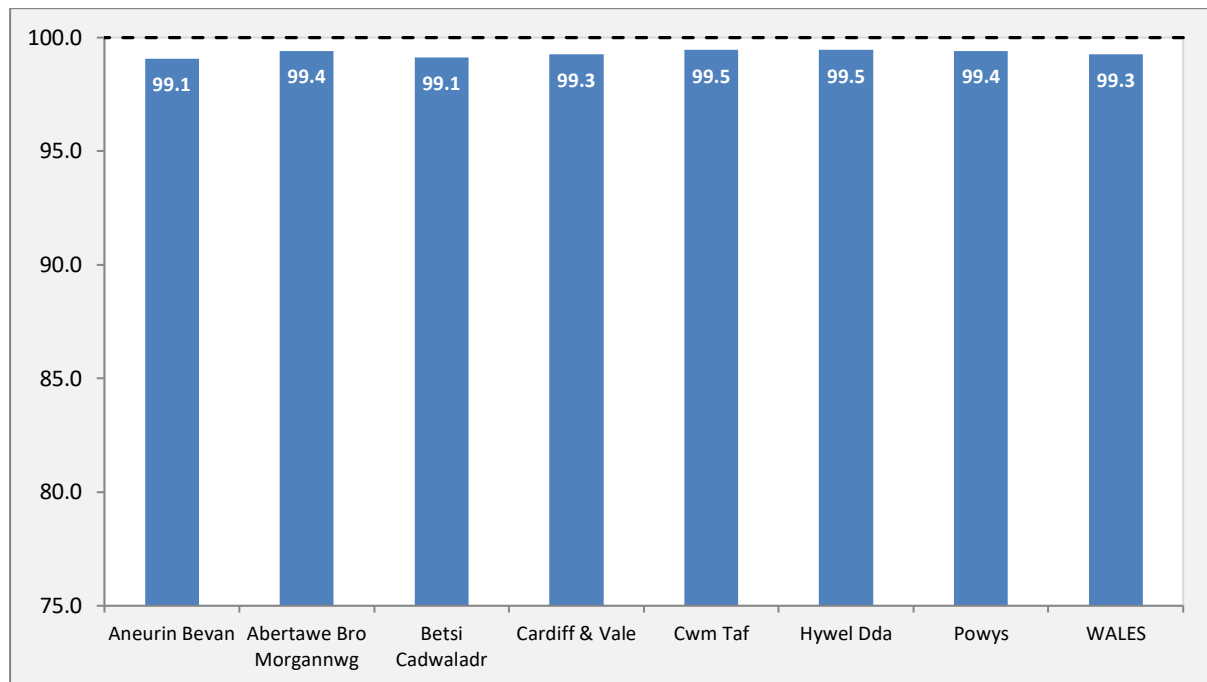
Each month the governance leads and Heads of Midwifery are also sent a monthly sample quality performance report to enable monitoring and appropriate action to be taken within the health boards.

All health boards have invested in appropriate arc shaped lancets which have been developed for newborn bloodspot screening. These lancets are able to provide a suitable flow of blood required for a good quality sample.

Samples taken on expired cards also contribute to the avoidable repeat rate and the importance of checking the expiry date has been highlighted to sample takers. To minimise the use of expired cards, the redesigned bloodspot card now has the expiry date printed in red on the front so it is clearly visible. This new card was sent out to the health boards in April 2018.

Standard 4B**Graph 4:** Poor quality repeat rate

Across Wales, 7.2% of samples required repeating due to poor quality bloodspots, which is a worsening of performance of 4.0 percentage points compared with the previous year. Reducing the poor quality rate further to achieve the standard of $\leq 2\%$ is a high priority for the programme.

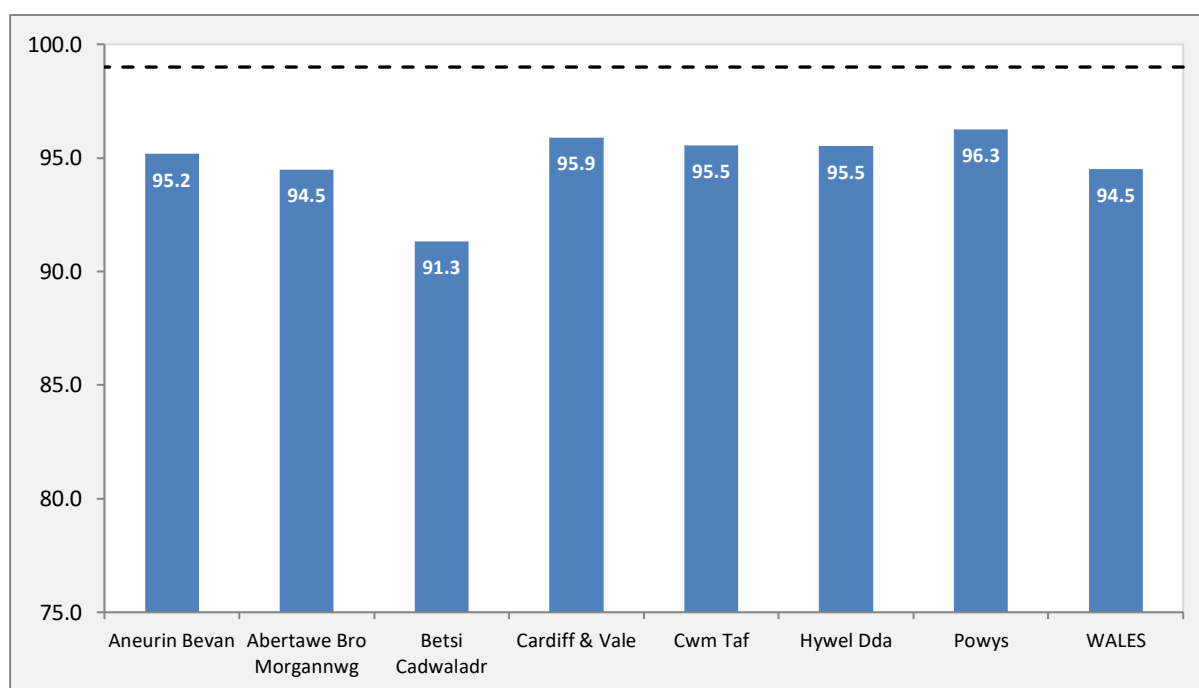
Standard 4C**Graph 5:** NHS number on bloodspot card

A valid NHS number for the baby was recorded on 99.3% bloodspot cards received in the laboratory, a slight improvement from the previous year. Illegibility of NHS numbers, inaccuracy or mixing up the numbers with another baby are the main reasons for non compliance. Work continues with the health boards to improve performance in this standard. Consideration of asking the parent to double check the completed card to reduce the documentation errors has been asked.

3.5 Timely receipt of card in laboratory

Standard 5: *timely receipt of card in laboratory - 99% of bloodspot cards received within four working days*

Graph 6: Timely receipt of card in laboratory



Across Wales, 94.5% samples were received in the laboratory within four working days. This is an increase of 0.6% compared with the previous year. Improving performance in this standard remains a high priority to enable timely referral of screen positive babies into clinical care.

To monitor performance more closely, additional data is collated for receipt of samples received within three working days of the sample being taken. This performance data is fed back quarterly to the health board governance leads and Heads of Midwifery.

Work continues with the health boards and Royal Mail to minimise delays in samples reaching the laboratory. It has been highlighted to sample takers during educational sessions the importance of posting the sample on the day it is taken, in a Royal Mail post box and not in the internal mail. Internal mail has been associated with delays in receipt of samples.

Delays in sample receipt are significantly increased during the Christmas period and addressing these delays is a priority for the programme.

Information for Royal Mail staff to highlight the importance of timely receipt was designed and distributed prior to Christmas 2018 and will again happen before Christmas 2019.

3.6 Laboratory processing and referral

The current standard for timely processing of samples was met for all conditions. For the inherited metabolic disorders (IMD) a total of six babies with phenylketonuria (PKU) and one baby with maple syrup urine disease (MSUD) were identified. Confirmation on receipt into clinical care was available for all seven babies (100%). Two of the babies with PKU were identified via the family history protocol and were received into care by day four and day six of life. All babies with IMD were received into care by day 14 of life. The average age of timely receipt into clinical care for the routine screening babies with IMD was day 10 of life (range 7-13 days). No babies with medium-chain acyl-CoA dehydrogenase deficiency (MCADD), isovaleric acidaemia (IVA), glutaric aciduria type 1 (GA1) and homocystinuria (HCU) were identified during 2018-19.

For congenital hypothyroidism (CHT) screening 31 babies were referred for follow up, 15 were identified as having a raised TSH ≥ 20 mU/L on the initial sample, 2 were identified as part of the CHT preterm policy and 14 babies were identified with a borderline raised TSH (≥ 8 but < 20 mU/L) on the initial sample with a positive repeat sample. The increase in the number of borderline repeat samples for TSH compared to the previous year is due to the fact that the TSH screening threshold was decreased from 10 mU/L to 8 mU/L in April 2018 in line with UK guidance. All babies identified as having a raised TSH were referred into clinical care in a timely manner.

Confirmation on the first clinic appointment was available for all 31 babies (100%). Of the 15 babies identified with a raised TSH ≥ 20 mU/L on the initial screening sample, 14 (93.3%) were received into care by day 14 of life. The average age at the first clinic appointment was day 12 of life (range 9-15 days). Of the 14 babies identified following an initial borderline test result, 10 (71.4%) babies were received into care by day 21 of life (the average age at the first clinic appointment was day 20 of life, range 17-25 days). The two preterm babies with CHT, where the day 28 samples were elevated, were seen in clinic by 36 day of life.

A total of 89 second samples were collected for borderline TSH results. The timely second sample collection for borderline TSH samples between day 7 and 10 after the initial sample collection was poor at 70.9% (standard =

95%), with 19 (21.3%) samples being collected on or after day 11 (range 11-31 days). Seven samples (7.9%) were collected before day 7.

For cystic fibrosis (CF) screening, a total of 28 babies were referred for follow-up. Confirmation of receipt into clinical care was available for 21 out of the 28 babies (75%). Seventeen (81%) babies were seen at the first clinic appointment by day 28 of life (standard = 95%). The average age at the first clinic appointment was day 25 of life (range 18-37 days). The baby received into clinical care on day 37 was due to late collection of initial screening sample. Of the 28 babies referred for further investigation, 14 babies were confirmed as having CF with one baby having a CF Screen Positive, Inconclusive Diagnosis (SPID).

All three babies with sickle cell disorder (SCD) were referred into clinical care by day 90 of life. These three babies were also identified via the antenatal screening programme.

The collection of timeliness of appointment and diagnostic outcome data remains a concern for the babies with CF. The laboratory is reliant on the clinician that received the screen positive referral, reporting the age at first appointment and the diagnostic results back to the screening laboratory. Feedback as to whether or not babies were commenced on thyroxine for the double borderline CHT results was poor with only 8/14 (57%) of babies being reported.

4 Definitions

Eligible babies (newborn)

- A baby who is resident in Wales at day five-eight of life
- A baby who is resident in Wales at day five-eight of life but is registered with an English GP
- A baby whose usual place of residence is outside Wales if they are under routine midwife care in Wales at day five-eight of life

Babies who have been recorded as having died before the age of five days are not eligible.

Eligible babies (all)

- All babies up to one year of age who are resident in Wales
- A baby whose place of residence is outside Wales if they are under routine midwifery care in Wales at the time the newborn bloodspot test is due

Babies who have been recorded as having died before the age of 5 days are not eligible.

Screen positive result

Screening results are not 100% conclusive. Instead they provide presumptive results. A screen positive result is a result which shows that the child is likely to have the condition for which they are screened. Sometimes people will say that the child is affected. Positive screening results are then confirmed using diagnostic tests. For example, a screen positive result for congenital hypothyroidism (CHT) means that it is highly likely that the child has CHT, but this must be confirmed by further tests. A screen positive result will be reported as 'suspected'.

Screen negative result

Screening results are not 100% conclusive. Instead they provide presumptive results. A screen negative result is a result which suggests that the child does not have the condition for which they are being screened. Sometimes people will say that the result is 'normal'. For example, a screen negative result for cystic fibrosis (CF) means that it is highly likely that the child does NOT have CF. This screen negative result is NOT usually confirmed using further tests, but it is assumed the child is not affected. A screen negative result will be reported as 'not suspected'.

Conclusive result

A conclusive result is any of the following; not suspected, suspected, not suspected other disorder or carrier. This includes any results that were tested by DNA for sickle cell disorders. For babies greater than 8 weeks of age, not tested for CF is also a conclusive result.

Parent/guardian surveys

Parent/guardian surveys will be carried out to gather views of parents/guardians on their experience of newborn bloodspot screening. These surveys will also be used to monitor the performance of NBSW in the informed consent and information provision standards. The survey will include the views of those who accept screening and also of those who decline screening.

The Conditions

Congenital hypothyroidism (CHT)

Congenital hypothyroidism (CHT) is a condition where the baby's thyroid gland fails to develop or work properly and fails to make the thyroid hormone called thyroxine. Thyroxine is needed for normal growth and development. Without thyroxine, babies do not grow properly and can develop permanent, serious physical problems and learning disabilities.

Babies with CHT can be treated early with thyroxine tablets and this will allow them to develop normally.

CHT has been screened for in Wales since 1981.

Cystic fibrosis (CF)

Cystic fibrosis (CF) is one of the UK's most common inherited life-limiting diseases. CF is a disease in which abnormal movement of salt and water into and out of cells causes a build-up of thick, sticky mucous. This occurs particularly in the lungs and digestive system. Babies with CF may not gain weight well, have frequent chest infections and a limited life span.

If babies with CF are treated early with a high-energy diet, medicines and physiotherapy, they may live longer, healthier lives.

CF has been screened for in Wales since December 1996.

Inherited metabolic disorders (IMDs):

- Medium-chain acyl-CoA dehydrogenase deficiency (MCADD)

MCADD is a rare inherited condition in which there is a deficiency in the enzyme medium-chain acyl-CoA dehydrogenase which is needed for the breakdown of certain stored fats (medium-chain fatty acids). This makes it difficult for the body to break down fatty acids and produce energy, and can cause sudden death in infants. Fatty acids are an important energy reserve during periods of poor calorie intake, prolonged periods between meals or during infections and sickness. In these situations people with MCADD have high levels of partially broken down fatty acids and low blood glucose concentrations which can result in a metabolic crisis. Most of the time children are well, but an infection or relatively long period without food upsets their metabolism causing coma and sometimes death.

Treatment involves ensuring that children do not go for long periods without food and special management if they do get an infection. Periods of not eating can safely get longer as the child grows.

MCADD has been screened for in Wales since June 2012.

- Phenylketonuria (PKU)

Phenylketonuria (PKU) is a rare inherited condition that prevents the breakdown of a building block of protein, the amino acid phenylalanine. For people with PKU, eating normal amounts of protein can cause a harmful build-up of phenylalanine in the blood. The build-up of phenylalanine is neurotoxic and harmful to the brain. Without treatment PKU can cause severe, irreversible mental disability.

If identified early, the child can be put on a restricted-protein diet with supplements and the brain can develop normally.

PKU has been screened for in Wales since 1970.

- Maple syrup urine disease (MSUD)

Maple syrup urine disease (MSUD) is a rare inherited disorder that prevents the breakdown of some of the building blocks of protein, the amino acids leucine, isoleucine and valine in the blood. For people with MSUD, eating normal amounts of protein can cause a harmful build-up of these amino acids in the blood. Many babies with MSUD

become unwell when they are a few days old. Without treatment, this leads to a coma and permanent brain damage. In older children a minor illness, such as a chest infection or a tummy upset, can lead to serious problems. As in babies, this can lead to a coma unless treated correctly.

MSUD can be treated with a protein-restricted diet. A different regime is required when the child is ill, and they may need to be hospitalised. The condition is named maple syrup urine disease because high levels of these amino acids can cause an unusual sweet smell in the urine and sweat.

MSUD has been screened for in Wales since January 2015.

- **Isovaleric acidaemia (IVA)**

Isovaleric acidaemia (IVA) is a rare inherited disorder that prevents the breakdown of a building block of protein, the amino acid leucine. This then causes a harmful build-up of a substance called isovaleric acid in the blood. Children with IVA can become severely unwell. Without treatment, this can lead to a coma and permanent brain damage. Some babies with IVA have problems within a few days of birth; other children become unwell at a few months or years of age, maybe during a minor illness, such as a chest infection or a tummy upset.

IVA can be treated with a protein-restricted diet and carnitine and glycine. A different regimen is required when the child is ill, and they may need to be hospitalised.

IVA has been screened for in Wales since January 2015.

- **Glutaric aciduria type 1 (GA1)**

Glutaric aciduria type 1 (GA1) is a rare inherited disorder that prevents the breakdown of certain building blocks of protein, in particular the amino acids lysine and tryptophan. For people with GA1, eating normal amounts of protein can cause harmful substances to build up in the blood and urine. In children with GA1, a minor illness, such as a chest infection or a tummy upset, can lead to serious problems. Without treatment, the child can go into a coma. Though most children come out of the coma, they usually have brain damage that affects their ability to control their muscles and

movements. This means that they may be unable to sit, walk, talk or swallow.

GA1 can be treated with a protein-restricted diet and carnitine. A different regimen is required when the child is ill, and they may need to be hospitalised.

GA1 has been screened for in Wales since January 2015.

- **Homocystinuria (HCU)**

Homocystinuria (HCU) is a rare inherited disorder that prevents the breakdown of a building block of protein, the amino acid homocysteine. This then causes a harmful build-up of homocysteine in the blood. Without early treatment this can lead to long term health problems including learning difficulties and eye problems, osteoporosis and blood clots or strokes.

HCU can be treated with a protein-restricted diet and extra supplements and medicines.

HCU has been screened for in Wales since January 2015.

Sickle cell disorders (SCD)

Sickle cell disorders (SCD) is a term that describes a group of conditions in which haemoglobin in red blood cells is abnormal in structure. This causes red blood cells to take up a shape like a crescent moon or farmer's sickle when de-oxygenated. Sickled red blood cells are not as flexible as normal red blood cells and can cause blockages within small blood vessels. Babies who have these conditions will need specialist care throughout their lives. People with SCD can have attacks of severe pain, get serious, life threatening infections and are usually anaemic (their bodies have difficulty carrying oxygen).

Babies with SCD can receive early treatment, including immunisations and antibiotics, which, along with support from their parents, will help reduce the chance of serious illness and allow the child to live a healthier life.

SCD has been screened for in Wales since 2013.

5 Production team

The production team for this report are all employed within Public Health Wales and are listed below.

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Guy Stevens	Deputy Informatics and Data Services Manager
Christie Redman	Informatics & Data Analyst
Sarah Jones	Communications Executive
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6 Pre-Release List

These Official Statistics were sent to the people on this pre-release list five working days prior to publication in accordance with the Pre-publication Official Statistics Order Access (Wales) 2009.

Public Health Wales

Jan Williams	Chair
Dr Tracey Cooper	Chief Executive
Dr Quentin Sandifer	Executive Director of Public Health Services and Medical Director
Leah Morantz	Head of Communications

Welsh Government

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Dr Andrew Goodall	Director General - Health and Social Services
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Rebekah Tune	Head of Strategic Communications and Marketing
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