Public Health England

NHS England

Appendix 3

Lancashire Area Team Screening Performance Review

September 2014

(This report is for discussion at the Screening and Immunisation Oversight group and should not be shared widely as Q4 data is currently unpublished)

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Introduction

This quarterly screening performance report provides an overview of the national screening programmes in operation across Lancashire.

1. Bowel Screening

1.1 Bowel screening uptake (2013/14)

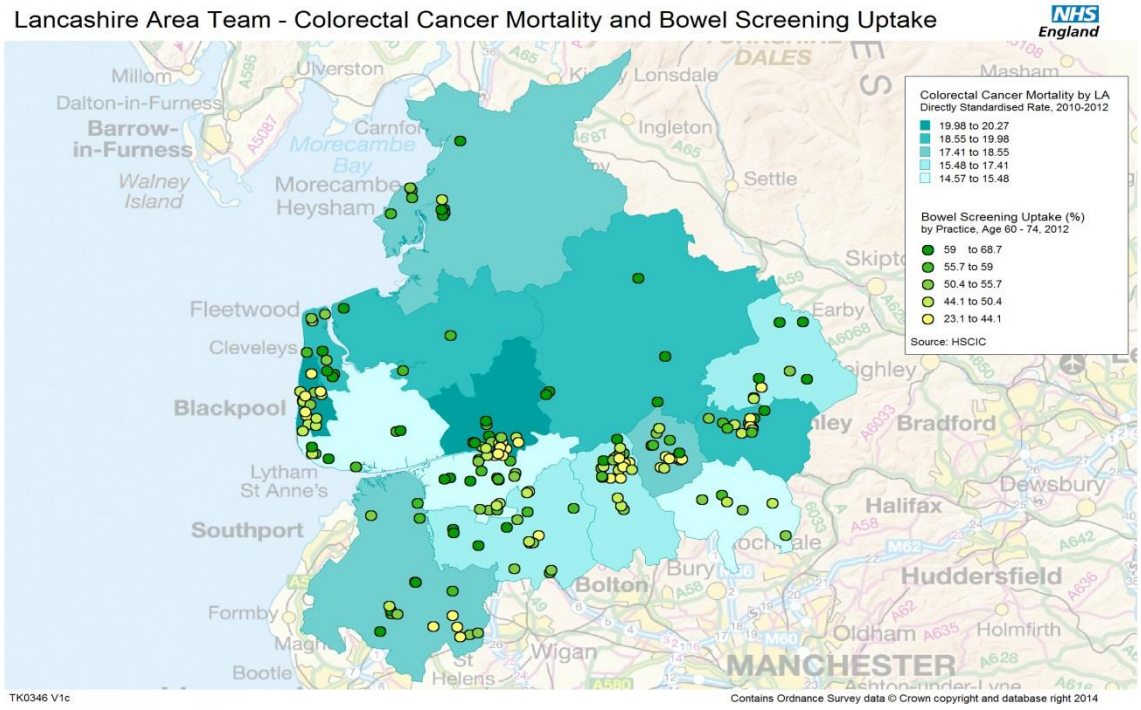
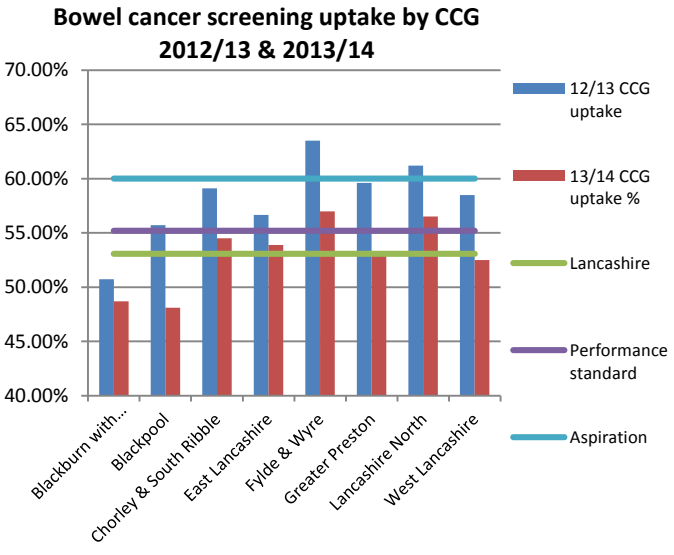


Figure 1 Bowel screening uptake (2012) source national bowel screening systems (OBIEE)



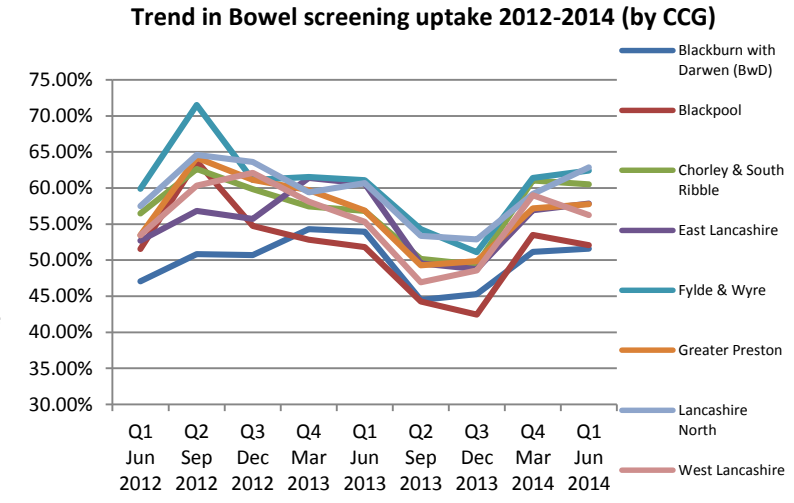


Fig 2: Bowel cancer screening uptake (2013)

Fig 3: Trend in uptake by Quarter 2012-2014

Points to note:

- Uptake has declined in most CCGs comparing 2012/13 with 2013/14.
- The map illustrates a large number of practices reaching 55%+. Many of the lower uptake practices are centered within the more deprived areas.

1.2 Bowel Scope programme

The Lancashire bowel scope programme commenced in December 2013 with the first scopes undertaken in Feb 2014. The data below shows some activity to date. The programme is currently rolling out in Blackpool with a phased roll out across Lancashire which will be completed in 2016.

Programme activity 01.01.2014- 05.09.2014

1.01.14 to 05.09.14	
Subjects	1448
Responded to invitation	514 (response rate 35%)
Rescheduled rate	36.7% (of those that responded)
Attended	322 (22% uptake rate)
Colonoscopies required	20 (17 attended)

Table 1: Programme activity 01.01.2014- 05.09.2014 Data source: Lancashire BCSP

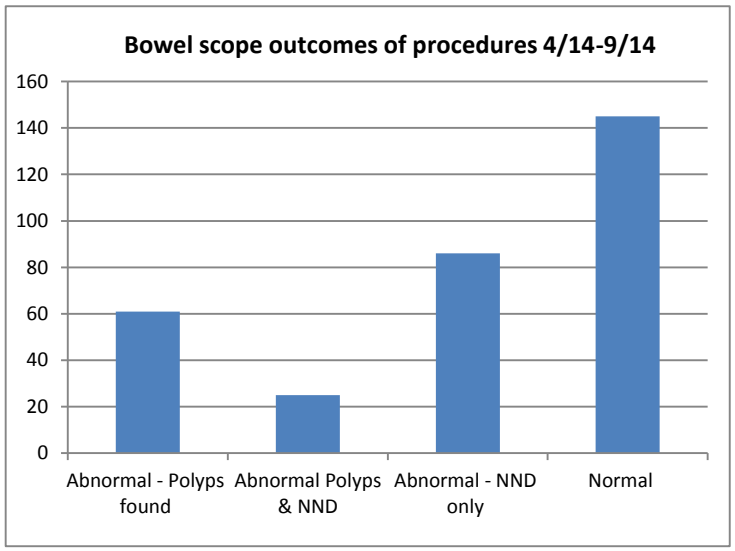


Fig 4: Outcomes of the bowel scope programme 01/14-09/14

The number awaiting histology is <5 therefore not reported in Fig 4

2.0 Breast Screening

2.1 Coverage

The coverage of the screening programme is the proportion of resident eligible women who have had a mammogram with a recorded result at least once in the previous 3 years.

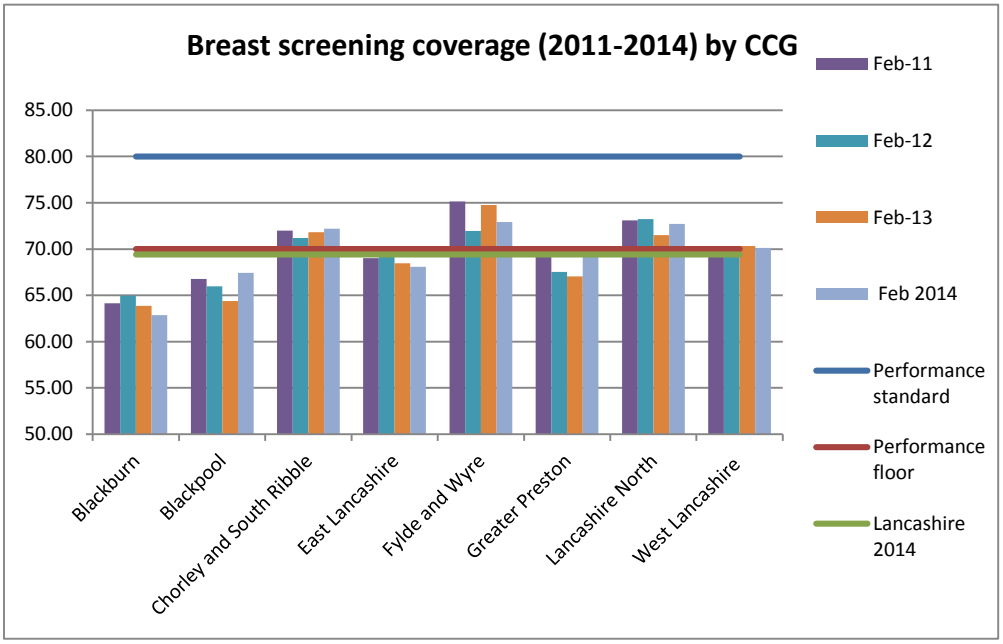


Figure 5 Breast screening coverage (September2013) Source: Primary care support services (PCSS)

Coverage is declining annually in all CCGs. Improving breast screening coverage is a priority for the Lancashire area team and the Screening and Immunisation team will be working with both the breast screening programmes and practices in the lower uptake areas.

2.2 Screen to assessment

All women with abnormal mammograms should be called to assessment within 3 weeks.

Screen to assessment- The percentage of women who attend an assessment centre within three weeks of attendance for their screening mammogram.								
	July to September 2013		**September to Dec 2013**		**Jan- March 2014**			
	≤ 3 weeks	**>3 weeks**	≤ 3 weeks	>3 weeks	≤ 3 weeks	>3 weeks	≤ 3 weeks	> 3 weeks
East Lancashire	99	1	97	3	98	2	95	5
North Lancashire	90	10	86	13	90	9	93	7
South Lancashire	89	10	83	16	79	20	1	99
Northwest	87.5	11.6	87.8	11.5	89.4	11.6	76.8	23.2
Minimum standard –≥ 90% Achievable- 100%								

Table 2: Screen to assessment **Data source: NW QA quarterly report**

Points of note:

- Screen to assessment- All programmes struggle with this KPI, but there has been good progress in East Lancashire and North Lancashire, South Lancashire is the only programme remaining below target. A recovery plan was put in place following the release of the Q4 figures and performance has been improving month and month and is now operating a screen to assessment for all women of 3 weeks or less.

3. Cervical Screening

3.1 Local Coverage

Coverage is the percentage of eligible women (25-64yrs) who have a recorded adequate test result within the last 5 years - national target 80%. The NW has seen a persistent downward trend for several years.

	25-49years (screened over the last 3 years)				50-64years old (screened over that last 5 years)			
	Coverage (%)	Additional screens per year to reach 80% (CCG)	Additional screens per month (CCG)	Estimated additional screens per practice per month	Coverage (%)	Additional screens per year to reach 80% (CCG)	Additional screens per month (CCG)	Estimated additional screens per practice per month
NHS Blackburn with Darwen CCG	60.4	1847	**153**	**6**	73.0	823	**68.5**	**2**
NHS Blackpool CCG	64.4	1372	**114**	**5**	71.4	1193	**94.9**	**4**
NHS Chorley and South Ribble CCG	70.1	954	**79**	**3**	76.9	458	**38**	**1**
NHS East Lancashire CCG	67.2	2529	**210**	**4**	76.5	1031	**86**	**1**
NHS Fylde and Wyre CCG	70.1	700	**59**	**3**	77.5	345	**29**	**1**
NHS Greater Preston CCG	64.4	1766	**147**	**5**	74.8	827	**69**	**2**
NHS Lancashire North CCG	66.5	1045	**87**	**7**	75.1	592	**49**	**4**
NHS West Lancashire CCG	67.9	670	**56**	**3**	75.9	388	**32**	**1**

Table 3: Cervical screening coverage by CCG Data source: PCSS (2014)

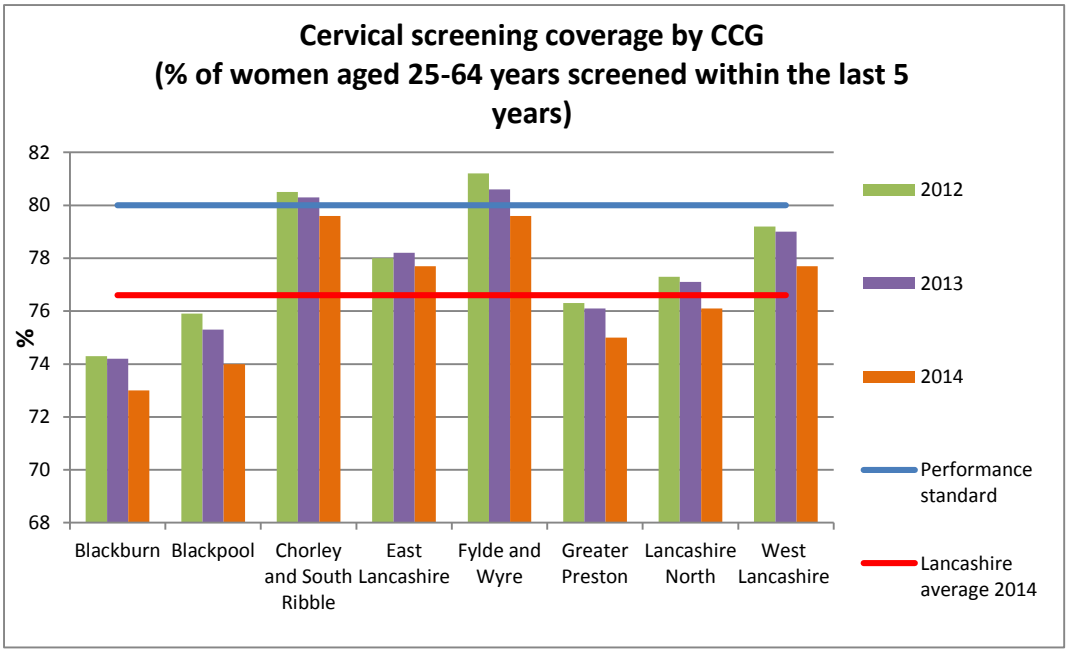


Fig 8: Cervical screening coverage (2014) **Source: Primary care support services (PCSS)**

Points to note:

- Coverage is declining annually in all CCGs and this is a similar picture nationally. Improving cervical screening coverage is another key priority for the Lancashire area team and the Screening and Immunisation team will be working with CCGs and practices to support practices in improving coverage especially in the younger age groups and target population groups.

4.0 Diabetic Eye Screening

4.1 Uptake and issuing of results

Uptake is the percentage of invited patients that attend for an annual screening. The marked variation in uptake between the programmes is likely to be due to issues with the programme software systems which are currently being updated by Digital healthcare.

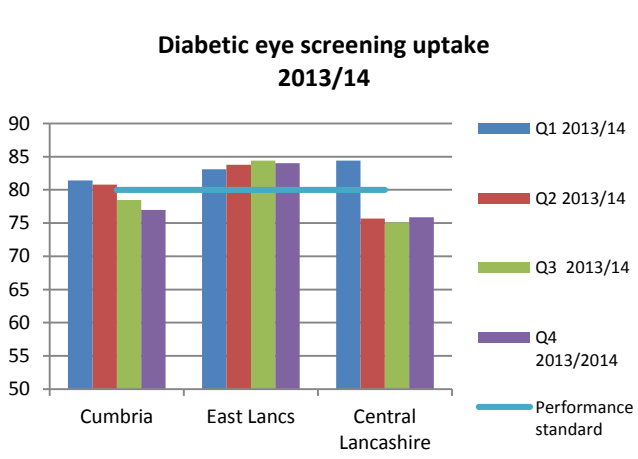


Fig 9: Diabetic eye screening uptake (2013/14)
Source of data- KPI returns

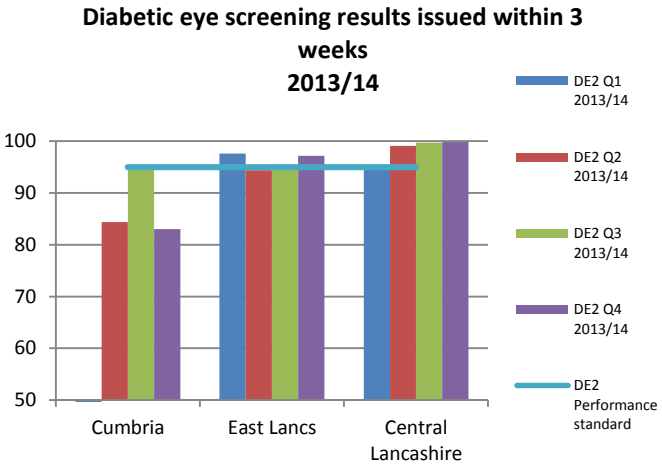


Fig 10: Diabetic eye screening issuing of results (2013/14)

5. Abdominal Aortic Aneurysm (AAA) Screening

5.1 Uptake

The definition of uptake is the percentage of those offered screening who accept the initial offer.

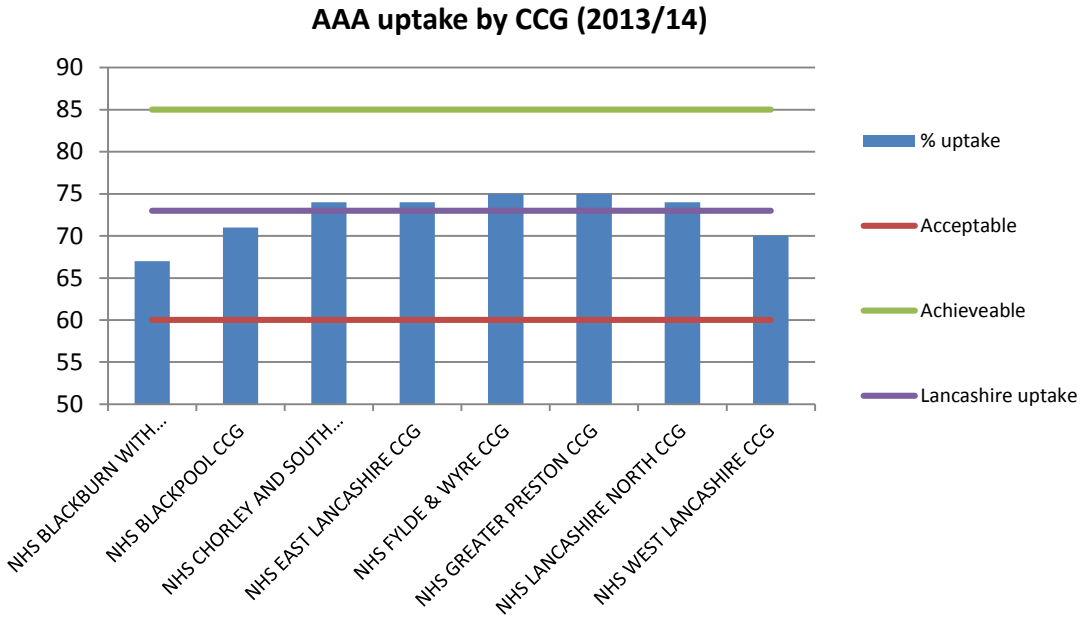


Fig 11: AAA Uptake by CCG (2013-14) Source- Screening programme data

Points to note:

- The programme has now been established for a full year, the acceptance rate is already over 60% in all CCGs.

5.2 Self referrals

	13/14	To date 14/15
Number of referrals	**389**	**455** June 166 July 86 August 48 (A publicity campaign took place in June)

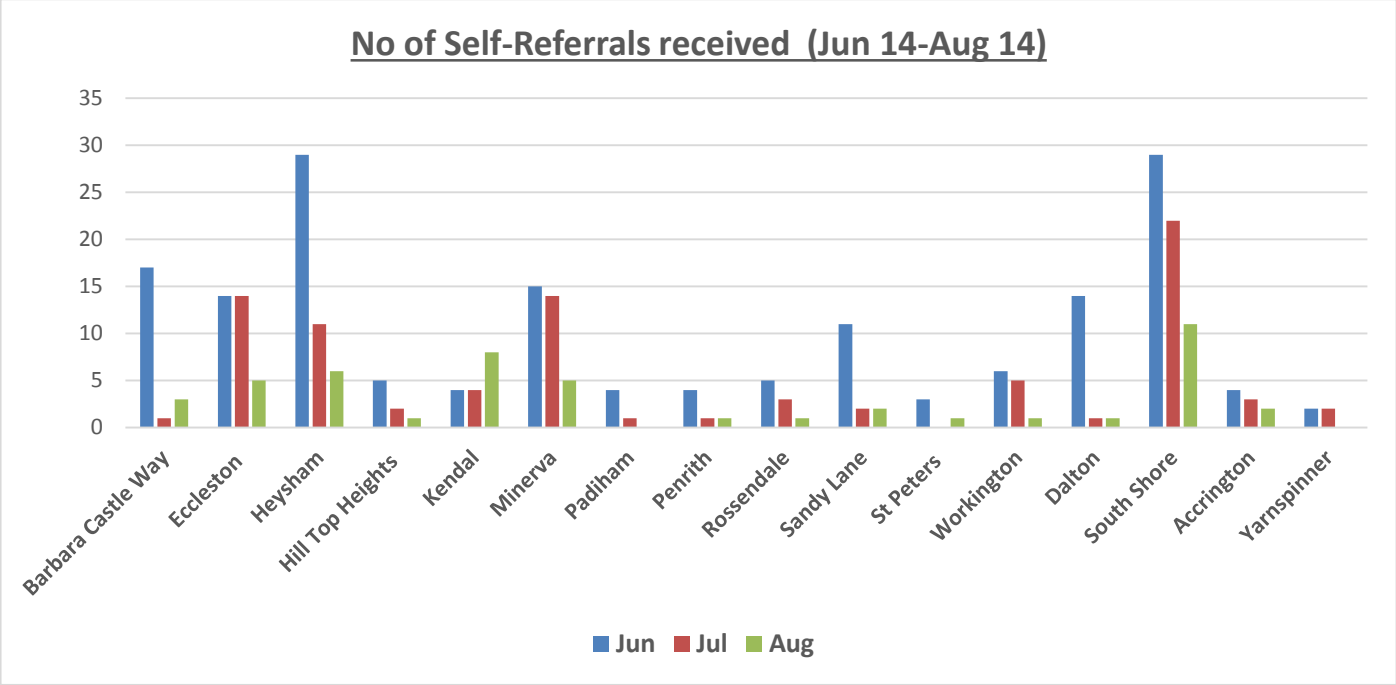


Fig. 12: Self referrals by site

5.3 Uptake within the local prison population

No of Self Referrals / No of men screened Dec 13 to Aug 14				
Clinics	**Self-Referrals**	**In Cohort**	**Consented for Scan**	**No of Clinics**
HMP Kirkham	6	0	6	2
HMP Wymott	13	7	20	2
HMP Garth	18	3	21	3
Total	**37**	**10**	**47**	**7**

5. Antenatal & Newborn Screening

6.1 Infectious Diseases in Pregnancy, Fetal anomaly and Down's syndrome, Sickle Cell and Thalassemia and Newborn blood spot and Newborn infant physical examination programmes

		ID1 ≥ 95%	ID2 (below standard ≤ 70%, acceptable between 70-89.9%, achievable ≥ 90%)	FA1 (below standard less than 97%, acceptable between 97% and 99.9%. Achievable 100%)	STI (below standard less than 95%, acceptable 95% and 98.9%. Achievable 99% and over)	ST2 (below standard less than 50%, acceptable 50-74%, achievable over 74%)	ST3 (below standard less than 90%, acceptable 90-94.9%, achievable over 95)	NB2 (below standard more than 2.0, acceptable 2.0-0.5, achievable less than 0.5) - also reported in some areas by PCT	NP1 (Below standard <95%, acceptable 95-99%, achievable 100%)	NP2 (Below standard <95%, acceptable 95-99%, achievable 100%)
Blackpool	Q1 13/14	96	100	100	95	60.2	98.6	1.6		
	Q2 13/14									
	Q3 13/14	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data		
	Q4 13/14	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**		
East Lancashire	Q1 13/14	96.6	66.7	95	95.5	59.1	100	1		
	Q2 13/14	96.9	66.7	95	97	63	100	0.8		
	Q3 13/14	**96.9**	**50**	**97.5**	**97.3**	**67.8**	**100**	**0.5**		
	Q4 13/14	**96.9**	**60**	**95**	**97.6**	**60**	**100**	**0.9**	**96.1**	
Lancashire Teaching Hospital	Q1 13/14	**99.2**	**no cases**	**98.4**	**99.1**	**56.9**	**99.2**	**0.8**		
	Q2 13/14	98.9		99.3	99.1	54.5	99	1.5		
	Q3 13/14	**98.9**	**100**	**98.8**	**98.9**	**50.3**	**99.3**	**2.1**	**90.3**	
	Q4 13/14	**99.4**	**50**	**99.7**	**99.5**	**40.5**	**97.7**	**2.2**	**91.7 (97 in well babies)**	**66.7**
Southport and Ormskirk	Q1 13/14	**97**	**no cases**	**100**	**96.30%**	**28.2**	**97.6**	**2.7**		
	Q2 13/14	99.4		96.7	98.5	15	97.2	2.4		
	Q3 13/14	**98.5**		**94.6**	**98.5**		**99**	**2.9**	**97.8**	**100%**
	Q4 13/14	**98.1**		**98.9**	**97.6**	**32**	**94.6**	**2.4**		
University Hospital of Morecambe Bay	Q1 13/14	99.4		84	100		100	3.0		
	Q2 13/14	100		94.2	100		99.3	2.3		
	Q3 13/14	**99.9**		**91.7**	**100**	**48.7**	**100**	1.2		
	Q4 13/14	**100**		**94.5**	**98**	**47.8**	**98**	2.1		

Table 4: Antenatal and Newborn screening KPI data submissions Date Source: Trust data

Definitions of the KPIs for all programmes are in appendix 1
Points to note:

- ID2- Timely referral of Hep B positive women- this indicator is affected by the small numbers involved and the fact that many women are already under the care of a consultant.
- FA1- Completion of laboratory request forms- Some trusts have made progress with this. This KPI will be discussed in depth at the next programme board to ascertain reasons from trusts for being unable to achieve the target.
- ST2- Timeliness of the test (less than 10 week's gestation) - to achieve this KPI work needs to be done to encourage women to book early for antenatal care.
- NB2-avoiadable repeats - Most maternity units have shown improvement in previous quarters however no trusts have met the KPIs this quarter. These issues will be raised at the next Antenatal and newborn meeting in October.
- NP1/ NP2- Maternity units are required to have systems in place to record NIPE outcomes by April 2015 all trusts have either implemented or have plans in place to implement SMART later this year.

6.2 Newborn blood spot (NB1)

This KPI measures the performance of the Newborn blood spot programme in testing babies and, where target conditions are detected, implementing treatment within an effective timeframe.

New born blood spot		NB1 (below standard less than 95%, acceptable 95% and 99.8%. Achievable 99.9% and over)	NB3 (acceptable 95% and 97.9%. Achievable 98% and over)
Blackpool PCT	Q1 13/14	99.10	99.7
	Q2 13/14	96.30	98.7
	Q3 13/14	87.90	99.8
	Q4 13/14	95.9	99.5
East Lancashire PCT	Q1 13/14	96.20	99.7
	Q2 13/14	95.20	99.7
	Q3 13/14	94.00	99.4
	Q4 13/14	95	99.9
Central Lancashire PCT	Q1 13/14	94.80	100
	Q2 13/14	96.70	90.5
	Q3 13/14	99.80	99.8
	Q4 13/14	96.7	99.7
Blackburn with Darwen	Q1 13/14	no data	no data
	Q2 13/14	96.60	94.3
	Q3 13/14	94.30	99.6
	Q4 13/14	95.8	99.4
North Lancashire PCT	Q1 13/14	95.40	99.6
	Q2 13/14	95.2	99.9
	Q3 13/14	91.6	100
	Q4 13/14	95.9	99.7

Table 4: Newborn bloodspot screening KPI data submissions Date Source: Trust data

6.3 Newborn hearing

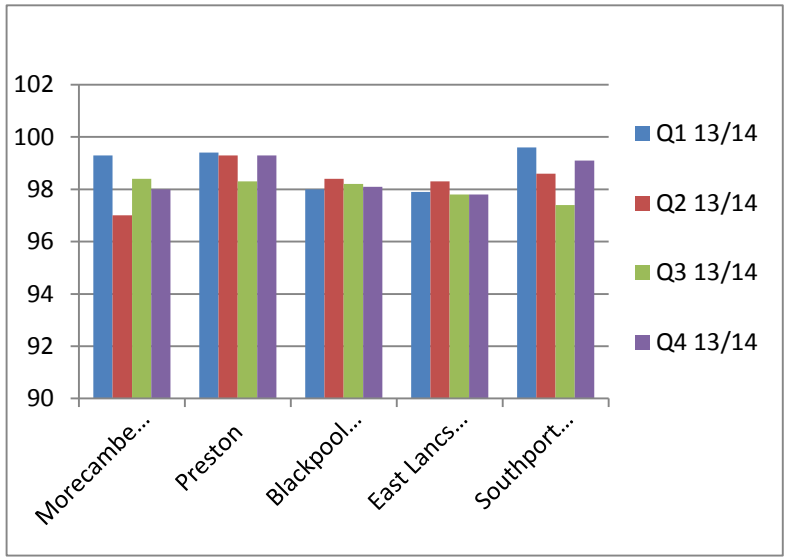


Fig 14: **Screens completed within 4wks (5wks in community) of birth**

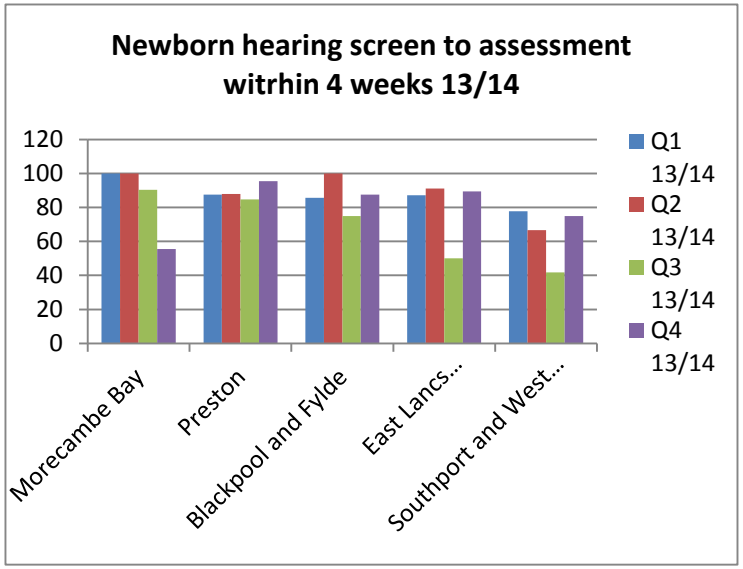


Fig 15: Screen Completion to Attended Assessment within 4 weeks

Data source- KPI submissions

Points to note:

- All centres are continuing to find it difficult to deliver NH2. Newborn hearing will be discussed in depth at the next Antenatal and Newborn meeting programme board to ascertain plans to improve performance. From Q1 2014/15 trusts will be required to report on breaches of NH2. There has been an improvement within some trusts for Q1 14/15 data and trusts are sharing best practice where they have managed to improve. A lot of the best practice involves joint working between maternity and health visitors.

Appendix 1 Antenatal and Newborn Screening KPI definitions

KPI ID1 Antenatal infectious disease screening – HIV coverage
Description: The proportion of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result. Numerator: tested women Denominator: eligible women

KPI ID2 Antenatal infectious disease screening – timely referral of hepatitis B positive women for specialist assessment
Description: The proportion of pregnant women who are hepatitis B positive who are referred and seen by an appropriate specialist within an effective timeframe (6 weeks from identification).
Numerator: women referred for hepatitis B
Denominator: pregnant women with hepatitis B

KPI FA1 Down's syndrome screening – completion of laboratory request forms
Description: The proportion of laboratory request forms including complete data prior to screening analysis, submitted to the laboratory within the recommended timeframe of 10+0 to 20+0 weeks' gestation.
Numerator: completed laboratory request forms Denominator: submitted laboratory request forms

KPI ST1 Antenatal sickle cell and thalassaemia screening – coverage
Description: The proportion of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report. Numerator: tested women
Denominator: eligible women

KPI ST2 Antenatal sickle cell and thalassaemia screening – timeliness of test
Description: The proportion of women having antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available by 10 weeks' gestation.
Numerator: women tested by 10 weeks gestation Denominator: women for whom sample received at laboratory

KPI ST3 Antenatal sickle cell and thalassaemia screening – completion of FOQ
Description: The proportion of antenatal sickle cell and thalassaemia samples submitted to the laboratory which is supported by a completed Family Origin Questionnaire (FOQ).
Numerator: laboratory requests with completed FOQ Denominator: laboratory requests

KPI NB1 Newborn blood spot screening – coverage (PCT responsibility at birth)
Description: The proportion of babies registered within the PCT both at birth and at the time of report who are eligible for newborn blood spot

screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe. For this KPI, PKU is used as a proxy for all tests and the test must be completed by 17 days of age.
Numerator: tested babies Denominator: eligible babies

KPI NB2 Newborn blood spot screening – avoidable repeat tests
Description: The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process.
Numerator: avoidable repeats Denominator: initial blood samples

KPI NB3 Newborn blood spot screening – timeliness of result
Description: The proportion of newborn blood spot screening results which are screen negative for all five conditions, available for communication to parents within six weeks of birth.
Numerator: results available for communication by 6 weeks Denominator: babies screen negative for all 5 conditions

KPI NH1 Newborn Hearing Screening – coverage
Description: The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes-well babies, NICU babies) or by 5 weeks corrected age (community programmes-well babies).
Numerator: complete screens Denominator: eligible babies

KPI NH2 Newborn Hearing Screening – timely assessment for screen referrals
Description: The percentage of referred babies receiving audiological assessment within 4 weeks of the decision that referral for assessment is required or by 44 weeks gestational age.
Numerator: timely assessments
Denominator: assessment referrals indicated

KPI NP1 Newborn and Infant Physical Examination – coverage (newborn)
Description: The proportion of babies eligible for the newborn physical examination who were tested within 72 hours of birth.
Numerator: tested babies Denominator: eligible babies

KPI NP2 Newborn and Infant Physical Examination – timely assessment
Description: The proportion of babies who, as a result of possible abnormality of the hips being detected at the newborn physical examination, undergo assessment by ultrasound within two weeks of birth Numerator: timely assessments
Denominator: number of babies with assessment referrals indication.