

Cervical Screening Results:

Basic Information	
1. What is being measured?	The % of women screened whose result is negative, borderline/mild dyskaryosis or moderate/severe dyskaryosis.
2. Why is it being measured?	Measuring the results of women's screening informs policy and monitors the quality and effectiveness of the cervical screening programme.
3. How is the indicator defined?	The proportion of eligible women with an adequate test screening that had a result of negative, borderline/mild dyskaryosis or moderate/severe dyskaryosis.
4. Who does it measure?	The proportion of eligible women aged: • 25-64 years old with an adequate test whose result was negative • 25-64 years old with an adequate test whose result was borderline/mild • 25-64 years old with an adequate test whose result was moderate/severe Women ineligible for screening and therefore not included in the numerator or denominator of the coverage calculation, are those whose recall has been ceased for clinical reasons (most commonly due to hysterectomy) Women whose screening produced an inadequate result are also not included in the denominator.
5. When does it measure it?	The data for the results is from 2002/03 to 2012/13 The result values are all as at the 31st March for that financial year
6. Does it measure absolute numbers, proportions or rates?	Proportion of eligible women – numerator is number of eligible women who have been screened, denominator is number of eligible women whose screening produced an adequate result
7. Where does the data come from?	The data is published by the Health and Social Care Information Centre (HSCIC) The information is collected on the following return: • KC53 – parts A2-D – information from the call and recall system, collected on all 151 Primary Care Organisations.

8. How accurate and complete are the data?	The NHS Cervical Screening Programme includes regional Quality Assurance (QA), Reference Centres (QARCs) which are responsible for quality assuring the screening programme including KC53. Data are quality assured by the QARCs on an annual basis. Aggregated data is provided to the HSCIC in a defined format. Further validation and quality assurance checks are carried out at the HSCIC as part of the publication process. These are established collections based on 100 per cent data, i.e. not a sample. Submissions have been made for all PCOs and by all pathology laboratories and colposcopy clinics. Please see the annual cervical screening programme bulletins published by the HSCIC for specific quality assurance and validation processes for each year http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-screening
9. Are there any caveats/ problems/ weaknesses?	See link in note 8, above
10. What methods are used to test the meaning of the data and variation? (Interpretation)	Count: The 'count' is the number of women screened with that result in that year Lower and Upper Confidence Limits (LCL and UCL): Confidence intervals have not been calculated for these indicators. Area Profile: Spine Chart: The area profile presents a spine chart which allows a comparison of the local value (represented by a circle) against the national average (represented by a red line in the middle of the chart) and regional average (where available, represented by a diamond), but also where the local area lies in relation to the range of values for all the other local areas. The darker grey shading of the bar represents the 25th to 75th percentile of the range of values. Map: In the map, the range of values for results is split into five groups (quintiles), and not according to statistical significance. Example interpretation: The symbol in the spine chart is always white as statistical significance has not been calculated. Funnel Plot: The screening result rate has not been included in the funnel plot

	Double map: Scatter Plot: The double map option displays a scatter plot of the association between the two chosen rates e.g. cervical cancer coverage and screening result. The correlation coefficient (r) statistic displayed at the top of the scatter plot is Pearson's correlation coefficient, often called the correlation. It measures the degree of 'straight-line' association between the two indicators and can take any value between -1 (perfect negative correlation) and 1 (perfect positive correlation). A value of zero indicates no correlation. Map: In the map, the range of values for screening result is split into five groups (quintiles), and not according to statistical significance. Interpretation: If all the points lie very close to the straight line on a slope indicating, that as one variable increases (or decreases) the other increases (or decreases), then it can be said that there is a strong association between the two indicators. If the points are more scattered, but still in a straight line, would indicate that there is a weaker relationship. Interpretation of the relationship between two indicators should be made carefully; it does not mean there is a 'causal' relationship between the two indicators. Single map: Map: In the map, the range of values for screening result is split into five groups (quintiles), and not according to statistical significance. Time Series: The time series animation allows the user to view how the map changes for each indicator that has time series data.
11. Geography provided in this toolkit	Primary Care Trusts (PCTs) manage the provision of primary care services in a specific area. These include services provided by doctor's surgeries, dental practices, opticians and pharmacies. NHS walk-in centres and the NHS Direct phone service are also managed by the local PCT. There are about 151 Primary Care Trusts in England, each one covering a separate local area. NHS Strategic Health Authorities (SHA) are one branch of the National Health Service in England. Each SHA area contains a range of NHS trusts which either run or commission local NHS services. The SHA is responsible for the strategic supervision of these services.

	Since April 2013, these organisations and the geographical boundaries they represent no longer exist due to the changes to the NHS commissioning structure. New organisations, such as Clinical Commissioning Groups (CCGs) Local Area Teams and Strategic Clinical Networks, with different boundaries have been created. However, in the absence of established boundaries and data for these new organisations we have only been able to present sub-national data for the old organisations.
12. Further data availability	• Coverage and timeliness of results data is also available in the profiles • Other screening metrics can be found on the HSCIC website at the link in note 8
13. Frequency/ timeliness of data updates	The screening data is published annually in the October/November of the same year.
14. Disclosure control	No rates have been suppressed as the smallest geography at which cervical cancer incidence rates are available is PCT level.
15. Rationale for inclusion	Cervical screening aims to detect and treat cervical cells that may, if left untreated, develop into cervical cancer. Looking at trends and variation in the results of screening gives an indication of service use and effectiveness of the screening service. It may also help to understand trends and variation in the incidence of cervical cancer.