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This is a National Statistics Publication

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics Registration Service Act 2007 and signifying compliance with the Code of Practice for Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Find out more about the Code of Practice for Statistics at: https://www.statisticsauthority.gov.uk/code-of-practice/

The statistics in this report are used to inform policy and to monitor the quality and effectiveness of screening services.

They are derived from information that is routinely collected by Public Health England (PHE) for the operation of the screening programme, including quality assurance and performance management purposes.

We would like to acknowledge the key contributions made by members in PHE Screening who provided a significant contribution to the collection and interpretation of data, as well as acting as subject matter experts informing the production of this report.
Introduction

This document is designed to accompany the main publication report, available on the publication homepage via the following link:

https://digital.nhs.uk/pubs/cervical1819

This document includes all of the appendices which are referenced throughout the report, but is presented separately with the aim of keeping the main publication as succinct as possible.

The publication Quality Statement, also published as a separate document, presents information to aid understanding and presentation of the data.

The appendices included are;
- Appendix A – Background
- Appendix B – Definitions
- Appendix C – Types of invitation
- Appendix D – Cytology test result categories
- Appendix E – Outcomes of gynaecological referral
- Appendix F – Data validation and data quality
- Appendix G – Uses of statistics by known users
- Appendix H – Feedback from users
- Appendix I – Related publications and useful web links
- Appendix J – Impact of HPV primary screening

References related to the publication are also listed at the end of the document.
Appendix A – Background

Data Sources

The statistics presented in this publication are derived from information that is routinely collected by PHE for the operation of the cervical screening programme.

Information is collected on the following NHS Digital Korner Collection (KC) returns:

- **KC53** – Information from the call and recall system, collected for all Upper Tier Local Authorities (LAs). (Data reported for 2018-19 is based on LA geography as at 1 April 2019, 151 LAs).

- **KC61** – Information on screening samples examined by pathology laboratories, collected from all 48 laboratories carrying out cervical screening in 2018-19.

- **KC65** – Information on referrals to colposcopy, subsequent treatment and outcomes, collected from 193 clinics providing colposcopy services in 2018-19.

The full KC forms are available via the main publication page: https://digital.nhs.uk/pubs/cervical1819

In addition to the KC returns, the following data is also collected:

- **VSA15** – Data on time from screening to receipt of results, collected for all LAs. (Data reported for 2018-19 is based on LA geography as at 31 March 2019, 152 LAs).

- **PHOF** – Data on age appropriate coverage, collected for all LAs. (Data reported for 2018-19 is based on LA geography as at 1 April 2019, 151 LAs).

NB. There was a change to the LA boundaries on 1 April 2019. Data for the KC53, PHOF and VSA15 datasets in 2018-19 was collected as at 31 March 2019. However, due to system changes, the KC53 and PHOF datasets are aggregated to LA level using the new LA boundaries (151 as of 1 April 2019).

Further information on the underlying sources of information can be found in the separate Quality Statement and in NHS Digital’s List of Administrative Sources:


1. PHOF outcome figures may show small variances year-on-year as updates are made to historic figures after the data are published.
Appendix A – Background
Cervical screening process – call and recall programme

Women between the ages of 25 and 64 are invited for regular cervical screening under the NHS Cervical Screening Programme (the programme).

The cervical screening programme is intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer.

A first invitation for screening is sent to a woman when she is 24.5 years old.

Subsequent invites are sent every three or five years depending on a woman's age.

Women aged 65 or over can still be invited for screening if a recent or previous cervical cytology sample is abnormal. (Additionally, women may also be screened if they have not had a cervical screening test since 50 years of age and they request one.)

Call

A call invite is an invitation sent to previously unscreened women.

Recall

A recall invite is an invitation for subsequent screens.

For a more detailed overview of the programme see: https://www.nhs.uk/conditions/cervical-screening/
Appendix A – Background
Cervical Screening Process (HPV Triage) – Cervical Cytology

Screening samples are sent to pathology laboratories for slide preparation and screening by a cytologist/screener.

The results of each test are returned to the call/recall department and the woman’s GP or the sample taker (if not the GP).

Women should be notified of their test results in writing within two weeks.

Most women receive a normal result and are recalled for another routine test in three or five years dependent on their age.

A cytology result of high grade dyskaryosis (or worse) results in a referral to colposcopy.

Where a test result shows borderline change or low-grade dyskaryosis (abnormal cell changes), the sample is then tested for infection with high-risk HPV (Human Papillomavirus).

HPV is a common virus which, although harmless in most women, is linked to the development of abnormal cervical cells.

If left untreated, these abnormal cells can develop into cervical cancer. Women whose samples test positive for HPV are referred to colposcopy. Where the HPV test is negative women are recalled for screening in three or five years as usual.

HPV testing as triage (sorting) for women with borderline and low-grade dyskaryosis results was rolled out from March 2012.

In a small proportion of cases the pathology laboratory is unable to assess the cells on the cytology slide to give a result and the test is considered inadequate. In such cases women are asked to return for a repeat test three months later.

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4. Where HPV Primary Screening is being piloted, women are first tested for HPV. If the sample is found to be positive, it is then examined by the cytologist for any abnormal cells.
Appendix A – Background
Cervical screening process (HPV Primary) – cervical cytology

HPV primary testing as routine began implementation as a pilot in 2013 and full rollout is expected by December 2019.

Screening samples are sent to pathology laboratories for Human papillomavirus (HPV) testing.

HPV is a common virus which, although harmless in most women, is linked to the development of abnormal cervical cells. If left untreated, these abnormal cells can develop into cervical cancer.

A sample is first tested for HPV and where the test result is positive, a cytology screen is then performed.

The results of each test are returned to the call/recall department and the woman’s GP or the sample taker (if not the GP).

Women should be notified of their test results in writing within two weeks of the sample being taken.

Most women receive a normal result and are recalled for another routine test in three or five years dependent on their age.

HPV result

• **Negative**
  Woman is returned to routine recall screening (see page 20 in main report).

• **Positive**
  Sample is sent for cytology screening for abnormalities.

Cytology result following HPV positive

• **Negative**
  Woman is assigned a repeat recall status and is re-screened within 12 months.

• **Positive**
  Woman is referred to colposcopy.

In a small proportion of cases the pathology laboratory is unable to get a valid HPV result or assess the cells on the cytology slide. In such cases, the test is considered inadequate and women are asked to return for a repeat test three months later.
Appendix A – Background
Cervical screening process – colposcopy

Women referred for colposcopy\(^5\) attend a colposcopy clinic where a colposcope (a lighted, low-powered microscope) is used to closely examine the cervix to determine appropriate treatment, if any.

A woman may be referred for a colposcopy following her cervical screening if:

- some of the cells in her screening sample are abnormal
- the nurse or doctor who carried out the screening test thought her cervix didn't look as healthy as it should
- it wasn't possible to give her a clear result after several screening tests
- After persistent HPV-positive tests (under HPV primary screening)

A colposcopy can also be used to find out the cause of problems such as unusual vaginal bleeding (for example, bleeding after sex).

A biopsy may be taken from the cervix for diagnosis and/or the cervix may be treated.

Colposcopy and/or biopsy result

- **Normal**
  About 4 out of 10 women have no abnormal cells and are advised to continue attending cervical screening as usual.

- **Abnormal**
  About 6 out of 10 women have abnormal cells in their cervix and may need treatment to remove them.

Women who do not require immediate treatment may be kept under surveillance by repeat cytology tests, with or without repeat colposcopy, at suitable intervals.

5. [https://www.nhs.uk/conditions/colposcopy/](https://www.nhs.uk/conditions/colposcopy/)
**Appendix B – Definitions**

**Coverage**

Coverage is defined as the percentage of women in a population who were eligible for screening at a given point in time (31 March 2019 in this instance) and who were screened adequately within a specified period.

Women are identified as eligible for screening if they are:

- registered with a GP (or otherwise known to the NHS)
- in the screening age range (25-64 years)
- not ineligible because their recall has been ceased for clinical reasons (most commonly due to hysterectomy)

As the frequency with which women are invited for screening is dependent on age, coverage is calculated differently for different age groups.

For the total target age group (25-64 years), coverage is presented in this report as 'age-appropriate coverage', which represents the most up to date definition⁶.

This takes into account the frequency with which women of different ages are invited for screening.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Calculation</th>
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| Women aged 25-49 | \[
|                 | \frac{\text{Total number of eligible women aged 25-49 with an adequate screening test in the last 3 ½ years}}{\text{Total eligible population aged 25-49}} \times 100% \]
| Women aged 50-64 | \[
|                 | \frac{\text{Total number of eligible women aged 50-64 with an adequate screening test in the last 5 ½ years}}{\text{Total eligible population aged 50-64}} \times 100% \]
| Women aged 25-64 | \[
|                 | \frac{\text{Total number of eligible women aged 25-49 with an adequate screening test in the last 3 ½ years} + \text{total number of eligible women aged 50-64 with adequate screening test in the last 5 ½ years}}{\text{Total eligible population aged 25-64}} \times 100% \]  

Appendix B – Definitions

Coverage

Coverage statistics in this report are calculated using data from the National Health Application and Infrastructure Services (NHAIS) system via Open Exeter and include all women registered with an NHS GP practice and those who are not registered with a GP practice but who are otherwise known to the NHS.

The total number of women who are not registered with a GP or otherwise known to the NHS is not recorded. It is therefore not possible to estimate how overall coverage rates might be affected by this group.

NHAIS data supports many primary care services including the NHS Cervical Screening Programme’s call and recall system for inviting women for screening.

NHAIS is the only data source that can identify both the eligible population and those women who have been tested in the last three or five years.

Coverage at LA level is based on the eligible LA resident population.

Coverage at Primary Care Organisation (PCO) level, i.e. prior to 2013-14, was based on the eligible PCO responsible population.

For more information on the difference between LA resident and PCO responsible populations see the ‘Impact of NHS reorganisation’ in section ‘Changes in reporting and classification of cervical cytology’ of the Data Quality Statement which accompanies this publication.
Appendix B – Definitions
Achievable standards – PPV for CIN2 or worse

Achievable standards for laboratory reporting in cervical screening are set for key indicators. See the main report for current data relating to these standards.

Positive predictive value (PPV) is the proportion of women referred with high grade abnormalities who have a histological outcome of cervical intraepithelial neoplasia (CIN)2, CIN3, adenocarcinoma in situ/cervical glandular intraepithelial neoplasia (CGIN) or cervical cancer.

PPV is calculated from outcomes of referral for tests with results of high-grade dyskaryosis (moderate) or worse as follows:

\[
\text{PPV} = \frac{\text{Numerator}}{\text{Denominator}} \times 100
\]

**Numerator**
Number of women referred to colposcopy in the previous 12 months with a cytology result of moderate dyskaryosis or worse, whose colposcopic outcome is a histological diagnosis of CIN2, CIN3, adenocarcinoma in situ/CGIN or cervical cancer.

**Denominator**
Number of women referred to colposcopy in the previous 12 months with a cytology result of moderate dyskaryosis or worse, whose colposcopic outcome is No Abnormality Detected (NAD) or a histological diagnosis of normal, HPV, CIN1 or worse*.

*CIN1 or worse is defined as: CIN1, CIN2, CIN3 adenocarcinoma-in-situ/CGIN or cervical cancer.

Appendix B – Definitions
Achievable standards – APV for CIN2 or worse

Abnormal Predictive Value (APV) is the percentage of samples reported as borderline or low grade which lead to a colposcopy referral and where the histological outcome is CIN2, CIN3, adenocarcinoma in situ/CGIN or cervical cancer.

APV is calculated from outcomes of referral for tests with results of borderline or low grade dyskaryosis as follows:

\[
\text{APV} = \left( \frac{\text{Numerator}}{\text{Denominator}} \right) \times 100
\]

**Numerator**
Number of women referred to colposcopy in the previous 12 months with a cytology result of borderline or low grade dyskaryosis whose colposcopic outcome is CIN2, CIN3, adenocarcinoma in situ/CGIN or cervical cancer.

**Denominator**
The number of women referred to colposcopy in the previous 12 months with cytology result of borderline or low grade dyskaryosis whose colposcopic outcome is colposcopy NAD or a histological diagnosis of normal, HPV, CIN1 or worse*.

*CIN1 or worse is defined as: CIN1, CIN2, CIN3 adenocarcinoma-in-situ/CGIN or cervical cancer.

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Appendix B – Definitions
Achievable standards – RV for CIN2 or worse

Referral Value (RV) is defined as the number of women referred to colposcopy (excluding inadequate referrals) per detection of one CIN2 or worse lesion.

(Numerator / Denominator)

Numerator

Number of women referred with all results except inadequate with outcome of referral: cervical cancer, adenocarcinoma in situ / CGIN, CIN3, CIN2, CIN1, HPV only, no CIN/HPV, seen but no abnormality detected/no biopsy taken.

Denominator

Number of tests as per numerator, but only including outcome of referral: cervical cancer, adenocarcinoma in situ / CGIN, CIN3 or CIN2.

From April 2013, RV excludes women referred to gynaecology following a test result of ?glandular neoplasia (non-cervical).

Women with negative cytology but who test positive for HPV and are referred to colposcopy are not currently included in the calculation of referral value.

Appendix B – Definitions

Inadequate samples as a percentage of all samples
Number of inadequate samples as a percentage of all samples.

Percentile
A percentile is the value of a variable below which a certain percent of observations fall. For example, the 10th percentile is the value (or score) below which 10 percent of the observations may be found.

Other
For definitions of further medical terminology please visit the NHS Cancer Screening Programmes website at:

https://www.gov.uk/topic/population-screening-programmes/cervical
Appendix C – Types of invitation

Call
Women invited for screening who have not previously been screened.

Routine recall
Women invited for screening in the year as a result of a routine recall for screening.

These women will have either had a previous negative cytology result or a previous negative HPV test and been recalled after the usual interval (normally 3 or 5 years).

Under the HPV triage pathway, women with a borderline or low grade cytology with an HPV-negative result will also be returned to routine recall.

Repeat recall
Women invited in the year as a result of an early repeat recall for screening.

Repeat recalls can be for the following reasons:

• Surveillance
  Women invited for early screening because of a previous abnormal screening result or following treatment for cervical abnormalities or a previous positive HPV test.

• Abnormality
  Women invited for screening because their last sample showed some abnormality and a repeat was advised.

• Inadequate
  Women invited for screening because their last sample was inadequate.
Appendix D – Cytology test result categories

Negative
This indicates that no cell abnormalities were found.

Borderline change (in squamous or endocervical cells)
These are small changes found in the cells of the cervix which often return to normal by themselves.
The term ‘borderline change in squamous cells’ describes morphological alterations to squamous cells that fall short of low-grade dyskaryosis.
Borderline change in endocervical cells describes atypical endocervical cells where dyskaryosis cannot be excluded.

Low-grade dyskaryosis
Dyskaryosis is the name given to small changes that are found in the cells of the cervix (the neck of the womb). Low-grade dyskaryosis is associated with CIN1 (see Appendix E).
These changes are not cancer, and in most cases do not lead to cancer in the future.

High-grade dyskaryosis (moderate) or high-grade dyskaryosis (severe)
These areas of changed cells are associated with CIN grades 2 and 3 respectively (see Appendix E).

High-grade dyskaryosis/?invasive squamous carcinoma
This indicates probable CIN3 with additional features suggesting the possibility of invasive cancer.
NB: ?invasive squamous carcinoma is shown as ?invasive carcinoma in the tables and commentary for ease of reporting.

?Glandular neoplasia of endocervical type
This shows cytological features suggestive of cervical glandular intra-epithelial neoplasia (CGIN) or endocervical adenocarcinoma.

?Glandular neoplasia (non-cervical)
This category is used where no cervical cell abnormalities were found but the sample contained features suggesting a diagnosis of endometrial, ovarian or metastatic lesions from beyond the genital tract.
Appendix D – Cytology test result categories

The terms “potential cervical cancer”, “abnormal”, “negative” and “inadequate” are used within the report to represent groupings of the result categories on page 17. They are defined as follows in terms of the categories used on the cytology report form HMR 101/5:

Potential cervical cancer
HMR 101/5 cat. 5 (high-grade dyskaryosis/?invasive squamous carcinoma) or cat. 6 (?glandular neoplasia of endocervical type); women who have such test results should be referred urgently for further investigation.

Abnormal
HMR 101/5 cat. 8 (borderline change in squamous cells), cat. 9 (borderline change in endocervical cells), cat. 3 (low-grade dyskaryosis), cat. 7 (high-grade dyskaryosis (moderate)), cat. 4 (high-grade dyskaryosis (severe)), cat. 5 & 6 (see potential cancer above).

Negative
HMR 101/5 cat. 2 (negative); women with a negative test result will usually be returned to the screening programme to be called again at the normal interval (3 or 5 years).

Shorter recall intervals may be appropriate for women under surveillance or follow-up after treatment.

Inadequate
HMR 101/5 cat. 1 (inadequate); inadequate means it was not possible to obtain a valid result from the sample.

Women with inadequate samples will be recalled for a repeat test. Women with three consecutive inadequate results should be referred to colposcopy for further investigation.
Appendix E – Outcomes of gynaecological referral

The NHS Cervical Screening Programme uses the following categories to record the results for women who are referred for gynaecological investigation at colposcopy clinics.

Cervical cancer
The outcome of investigation shows cervical cancer.

CIN (cervical intra-epithelial neoplasia)
CIN is an indicator of the depth of abnormal cells within the surface layer of the cervix, and is divided into 3 grades.

The higher the number/grade the more severe the condition:

• CIN1 – one third of the thickness of the surface layer of the cervix is affected.
• CIN2 – two thirds of the thickness of the surface layer of the cervix is affected.
• CIN3 – full thickness of the surface layer of the cervix is affected (also known as carcinoma in situ)

Adenocarcinoma in Situ
A localised growth of abnormal glandular tissue that may become malignant.10

HPV only
Biopsies which were diagnosed as showing features consistent with HPV infection only. See Glossary section in the Cervical Screening Programme 2018-19 main report for more information on HPV.

No CIN/No HPV
Biopsies where no evidence of cervical disease or HPV infection can be identified and is to be used for specimens of normal tissue only.

Seen in colposcopy - result n/k
Women who have had a biopsy taken but the result is not yet known or available.

Inadequate biopsy
Biopsies which are known to be inadequate or unrepresentative due to deficiencies in the sampling process.

Colposcopy – no abnormality detected
Women with an adequate colposcopy result showing a normal result for cervical neoplasia or HPV infection without a biopsy being required.

Appendix F – Data validation and data quality

Information on the NHS Cervical Screening Programme is collected on the following returns:

• **KC53** – Information collected from the call and recall system, and reported by LA.

• **KC61** – Information on screening samples examined by pathology laboratories, collected from laboratories carrying out cervical cytology.

• **KC65** – Information on referrals to colposcopy, subsequent treatment and outcomes, collected from clinics/trusts providing colposcopy services.

In addition to the above returns, data on time from screening to receipt of results and age-appropriate coverage is obtained from reports produced by the Open Exeter system\(^\text{11}\).

For 2018-19, submissions have been made for all LAs and all pathology laboratories.

Presentation of LA data

On 1 April 2019, Bournemouth LA, Poole LA and Christchurch (part of Dorset LA) merged to form a new Bournemouth, Christchurch and Poole LA. This also resulted in boundary changes for Dorset LA.

Due to the way that organisational data updates are applied at a system level, the LA boundary change of 1 April 2019 has been applied to the PHOF and KC53 data for this year, which was collected on 31 March 2019.

The VSA15 data is reported based on the LA boundaries as of 31 March 2019. Therefore the presentation of KC53 and PHOF data at LA level will differ from that of VSA15 data.

KC53 and PHOF data cover 151 LAs and VSA15 data cover 152 LAs.

In all LA data tables Isles of Scilly have been combined with Cornwall, and City of London with Hackney, to ensure the data are non-disclosive.

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\(^{11}\) 'Exeter' system (NHAIS), Cancer Screening Statistics VSA15 and PHOF Reports.
Appendix F – Data validation and data quality

Cervical screening programme incident

An incident was identified within the Cervical Screening Programme prior to last year’s 2017-18 publication.

Between January and October 2018, approximately 43,220 invitation or reminder letters were not sent, equivalent to less than 1% of women invited in 2017-18 or 2018-19.

A further 4,508 test result letters were not sent, equivalent to less than 0.2% of test results in 2017-18 or 2018-19.

Further information on the incident is available here: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-11-15/HCWS1086/
Appendix F – Data validation and data quality

The NHS Cervical Screening Programme includes regional Screening Quality Assurance Services (SQASs) which quality assure the data collections. Validation undertaken by SQASs varies between regions but some examples of the types of quality assurance checks that SQASs undertake are:

• checks on data completeness

• identification of any unusual figures which are then followed up individually

• comparisons with previous years’ data to ensure that any unusual trends are identified and explained

• consistency checks between different parts of the returns

• checks that totals equal the sums of parts

• checks on the calculations of statistics

Data validation and quality assurance checks are also carried out by NHS Digital as part of the publication process. Validation checks undertaken by NHS Digital include:

• comparisons with previous years’ data to ensure that any unusual trends are identified and explained

• consistency checks between different parts of the returns

• checks that totals equal the sums of parts

• checks on the calculation of statistics

• checking for outliers (figures that are particularly low or high compared to other areas)

Part of NHS Digital’s quality assurance procedure includes returning data tables to the SQASs for verification prior to publication.
Appendix F – Data validation and data quality

The sections below describe the issues/areas identified for further investigation through NHS Digital’s validation processes and the outcomes of follow-ups with the SQASs.

KC53
Some queries were raised with SQASs where the totals of one part did not match another, or a woman below the age of 60 had been categorised as ‘ceased for age reasons’. All of these were resolved following contact with the SQAS, either with resubmissions or an explanation of the discrepancy where a resubmission was not possible.

Where applicable these explanations are provided within the publication and data tables as footnotes.

Some queries were raised where there were notable differences to previous year’s submissions (year on year sense checks). All of these were signed off following contact with the SQAS with no resubmissions necessary.

KC61
Consistency checks between different parts of the return identified a small number of mismatches. These were raised with the SQASs and corrected through resubmissions.

Some queries were raised where there were notable differences to previous year’s submissions (year on year sense checks). All of these were signed off following contact with the SQAS with no resubmissions necessary.

No other data quality issues were identified by the SQASs for any laboratory submissions in 2018-19.
Appendix F – Data validation and data quality

KC65
Consistency checks between different parts of the return identified issues in the submissions made by some colposcopy clinics.

All of these were resolved following contact with the SQAS either with resubmissions or an explanation of the discrepancy if a resubmission was not possible. Where applicable these explanations are provided within the publication and data tables as footnotes.

There were a number of queries raised in relation to differences from the previous reporting year’s figures. Some of these were cleared with resubmissions of data and the remaining signed off by the SQAS.

Time from screening to receipt of result (VSA15)
No data quality issues were highlighted through the quality assurance and validation procedures. However, an increase in the turnaround time of cervical screening sample results since 2016-17 was noted. Where applicable the report and data tables have been footnoted to reflect this.

For more information on the issue, please see Appendix J of this document.

Age-appropriate coverage (PHOF)
Queries were raised in relation to low numbers for Blackburn, Blackpool and Cumbria LA. These were due to an issue with the initial data update on Open Exeter and were resolved by the data being refreshed.

Conclusion
Almost all issues that were highlighted through NHS Digital’s validation processes for follow-up with SQASs were resolved satisfactorily.

Where data issues were outstanding, footnotes have been placed against the relevant tables as described above.

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Appendix G – Uses of statistics by known users

This section details known users of the report and the purposes for which they use the statistics. All these users have found the information in the report useful for the purposes set out.

Department of Health and Social Care (DHSC)
Use the statistics from this publication to inform policy and to monitor the quality of screening services through regional quality assurance teams. The statistics are also used by DHSC to respond to public and Parliamentary business.

Public Health England (PHE)
Screening and immunisation managers in PHE use the statistics for performance management purposes, comparing local statistics with regional and national figures. Statistics are also used in the NHS Screening Programmes in England annual report.

NHS Cancer Screening Programmes (NHSCSP), PHE
Use the bulletin as a reference document to monitor the quality and effectiveness of the NHSCSP and progress against their key targets for screening the eligible population in England.

The screening programme uses the statistics to compare local statistics against national figures in reviewing and developing national screening standards in programme development.

NHS England
Use the statistics from this publication to monitor the quality of screening services commissioned against key performance indicators set out in the Section 7a agreement with DHSC.

Regional Screening Quality Assurance Services (SQAS), NHSCSP
Utilise the report as part of their role in ensuring the screening process is achieving its primary targets across England.
Appendix G – Uses of statistics by known users

Local Authorities (LAs)
LAs and NHS Clinical Commissioning Groups (CCGs) are required to prepare Joint Strategic Needs Assessments of Health and Wellbeing (JSNAs), which inform local commissioning of health and wellbeing services. Indicators from the publication form part of the Local Government Association’s Joint Strategic Needs Assessment: Data Inventory (via the Compendium of Population Health Indicators).

Academics
The Cancer Epidemiology Unit, University of Oxford use the raw data supplied by NHS Digital and supplement it with additional data to provide a more evaluative analysis to improve the performance of the national screening programmes through peer reviewed research papers and the dissemination of such information through appropriate channels.

Compendium of Population Health Indicators
Indicators from the publication are included in the Compendium of Population Health Indicators which is widely used within the NHS as well as outside it. https://digital.nhs.uk/data-and-information/publications/ci-hub/compendium-indicators

Annual Report of the Chief Medical Officer
Coverage data from the publication, together with supplementary information provided by NHS Digital, was used to inform the Annual Report of the Chief Medical Officer's on the State of the Public's Health.

The report draws attention to major health challenges requiring immediate action and details progress made in key areas identified in previous annual reports. Data from the KC53 on coverage by PCT for women aged 25-64 is used in Chapter 5 of this report.


Jo’s Cervical Cancer Trust
Jo’s Cervical Cancer Trust is a UK charity dedicated to supporting those affected by cervical cancer and cervical abnormalities. The charity regularly runs awareness campaigns to improve screening uptake both at a national and local level. Cervical screening data are used by the charity to help identify how it can best focus its work towards improving screening uptake. https://www.jostrust.org.uk/
Appendix G – Uses of statistics by known users

Cancer Research UK
Cancer Research UK use the report for planning and evaluating their work. The statistics are used to inform a wide range of work including the charity’s policy positions and public communications about screening. For example, they are able to inform people potentially taking part in screening about the frequency of abnormal results and all the possible outcomes of screening.

https://www.cancerresearchuk.org/

Media
The data are used to underpin articles in newspapers, journals, etc. on matters of public interest.

Unknown Users
The cervical screening publication is free to access via the NHS Digital website and therefore the majority of users will access the report without being known to NHS Digital. It is important to put mechanisms in place to try to understand how these additional users are using the statistics and also to gain feedback on how we can make the data more useful to them.

Feedback on this publication can be sent to the following e-mail address: enquiries@nhsdigital.nhs.uk

Feedback on the following themes would be particularly useful:

• How useful did you find the content in this publication?
• How did you find out about this publication?
• What type of organisation do you work for?
• What did you use the report for?
• What information was the most useful?
• Were you happy with the data quality?
• To help us improve our publications, what changes would you like to see (for instance content or timing)?
• Would you like to take part in future consultations on our publications?

All feedback is passed to the team responsible for the report to consider.
Appendix H – Feedback from users

NHS Digital publishes around 90 series of Official Statistics and National Statistics each year. Use of health and care statistics helps those involved to manage the system more effectively, commission better services, understand public health trends in more detail, develop new treatments and monitor the safety and effectiveness of care providers.

Our Strategy for 2015-2020 sets out that over the next few years we are committed to analysing and making openly available data, statistical information and insights about the health and social care sector in ways which better meet our users’ needs.

However, these changes come at a time when spending on central services is being squeezed, and we must better prioritise our current services.

In our 2016 consultation on changes to statistics produced by NHS Digital, we proposed a series of changes over the next three years which will help us to better prioritise resources from our stretched budget while developing our statistical products to better meet the needs of our users. The consultation results are available on the NHS Digital website here.

To date changes to the main publication including greater use of visuals, such as infographics, and simplifying the content and layout of documents for users.

The responses also highlighted the desire to retain the annual data tables as these are regarded as crucial for performance monitoring, benchmarking and trend analysis, as well as contributing to JSNA updates.

Some responses highlighted a requirement to publish timely data at a more granular level, i.e. CCG/GP practice level, in addition to LA, as this will support the needs of commissioners. Since June 2017, interactive dashboard with quarterly coverage data at GP, CCG and LA level have been accessible through our website:


We continue to work with colleagues at PHE to ensure publications remain relevant and explore potential future improvements.
Appendix I – Related publications and useful web links

The main bulletin and copies of the KC returns (KC53, KC61 and KC65) can be found on NHS Digital’s website at:
http://digital.nhs.uk/pubs/cervical1819

More information about the Public Health Outcomes Framework (PHOF) dataset can be found at:
http://www.phoutcomes.info/

Since 2004-05 this bulletin has been published by NHS Digital. Previous editions published by the Department of Health and Social Care, can be found at:

Audit of invasive cervical cancer - national reports:

Further information about cervical screening is available from the NHS Cancer Screening Programmes website:
https://www.gov.uk/topic/population-screening-programmes/cervical

Cervical screening quarterly coverage statistics (Management Information) at GP, CCG and LA level are available via the following link:
Appendix J – Impact of HPV primary screening

The National Screening Committee recommended that the NHS Cervical Screening Programme replaces cytology with Human Papilloma Virus (HPV) testing as the primary screen within the NHS Cervical Screening Programme.

By December 2019, HPV primary screening is planned to be fully rolled out across England for the Cervical Screening Programme with cytology acting as a triage for whether further investigation at colposcopy is required.

Replacing cytology with Human Papilloma Virus (HPV) testing as the primary screen within the NHS Cervical Screening Programme, aims to increase efficiency and prevent more cases of cervical cancer.

Evidence from the six HPV pilot sites and international studies suggests that the need for cytology tests may reduce by around 80 to 85%.

Due to the reduction in future cytology requirements combined with ongoing HPV implementation and procurement plans, providers have experienced a difficulty retaining and recruiting staff to continue the existing cytology screening service.

This has severely impacted on the turnaround times of cervical screening samples since 2016-17, leading to increases in time to receipt of results.

To reduce the backlog and stabilise service delivery, a national mitigation plan has been in place whereby the HPV pilot sites have increased the amount of HPV Primary screening to release cytology capacity12.

The increase in the HPV primary screening population can impact on the data as this has the ability to increase the amount of invitations or recalls in the programme as the screening follows a different follow up pathway.

Further information on HPV Primary screening can be found at: https://www.gov.uk/government/publications/cervical-screening-primary-hpv-screening-implementation

References


