



**Capital & Coast
District Health Board**

ŪPOKO KI TE URU HAUORA

**REVIEW OF CERVICAL SCREENING IN THE
CAPITAL AND COAST DISTRICT HEALTH BOARD**

Prepared by

**Service Planning and Funding
Capital and Coast District Health Board**

November 2003

REVIEW OF CERVICAL SCREENING IN THE CAPITAL AND COAST DISTRICT HEALTH BOARD

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EXECUTIVE SUMMARY

- Capital and Coast District Health Board (C&CDHB) can be proud that of all District Health Boards (DHBs) it has the highest enrolments on the National Cervical Screening Programme (NCSP) Register and the highest participation and coverage rate.
- However, women least likely to be enrolled or to have had a cervical smear recorded within the previous 3-6 years are women over 45 and Maori and Pacific women.
- Compared to other Boards Pacific women in C&CDHB have a low rate of participation (a cervical smear recorded within 36 months).
- The capacity of Maori and Pacific providers to provide cervical screening services could be further developed.
- In the last year as a result of a quality improvement initiative waiting times for colposcopy at Wellington Hospital have been dramatically overturned and now meet the national guidelines.

REVIEW OF CERVICAL SCREENING IN THE CAPITAL AND COAST DISTRICT HEALTH BOARD

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INTRODUCTION

This report reviews data on cervical screening for the Capital and Coast District Health Board (C&CDHB) from July-September 2001¹. This is the most recent, available information which compares data between District Health Boards (DHBs). More recent information is available from the Colposcopy Service.

ENROLMENTS

It is pleasing to note that when compared to other Boards C&CDHB has the highest enrolments on the National Cervical Screening Programme (NCSP) register for women aged 20-69 (Graph One). When data is adjusted for hysterectomy 101.1%² of women in this age group are enrolled. This compares to Hutt Valley at 95.6%, Auckland 93.7%, Canterbury 88.5% and South Auckland 91.7%.

Maori and Pacific women are least likely to be enrolled at 73.5% and 80.5% respectively (Graph Two). Over 45 years of age enrolment declines in all groups.

PARTICIPATION

The participation rate is the proportion of women who have had a smear recorded on the NCSP Register within 6 years of the reporting period. Of all boards C&CDHB has the highest participation rate (adjusted for hysterectomy) at 95.2%. By comparison, Auckland has an adjusted rate of 86.7%, Canterbury 84.2% and South Auckland 84.5%. The national target for participation is 80% unadjusted and 90% adjusted for hysterectomy. Maori and Pacific women, and women over 40 are least likely to have had a smear recorded in the previous 6 years (Graphs Three and Four).

COVERAGE

The coverage rate is the proportion of women who have had a cervical smear recorded on the NCSP Register in the 36 months prior to the end of the reporting period. One reason why coverage fails to meet the target is that results of smears recorded immediately after the three year period (for example at 37 months) are not counted.

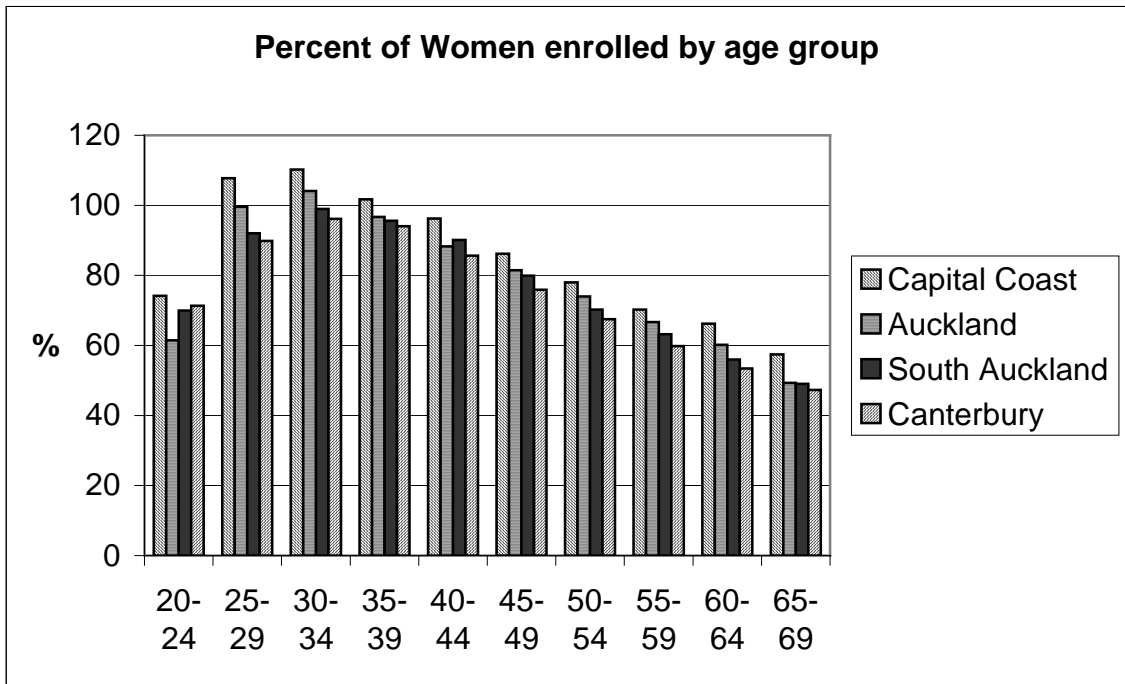
Of all DHBs C&CDHB has the highest coverage rate at 80.3% (adjusted for hysterectomy). The target is 85%. There is a trend for increasingly lower coverage after 45 years of age (Graph Five).

Compared to other comparable DHBs C&CDHB has a slightly higher rate of Maori who have had a smear within 36 months (48.8%), but a lower rate of Pacific coverage at 36.8% (Graph Six). The target is 80% unadjusted and 85% adjusted for hysterectomy. Thus, there is considerable work to be undertaken to promote screening every three years in Maori and Pacific women.

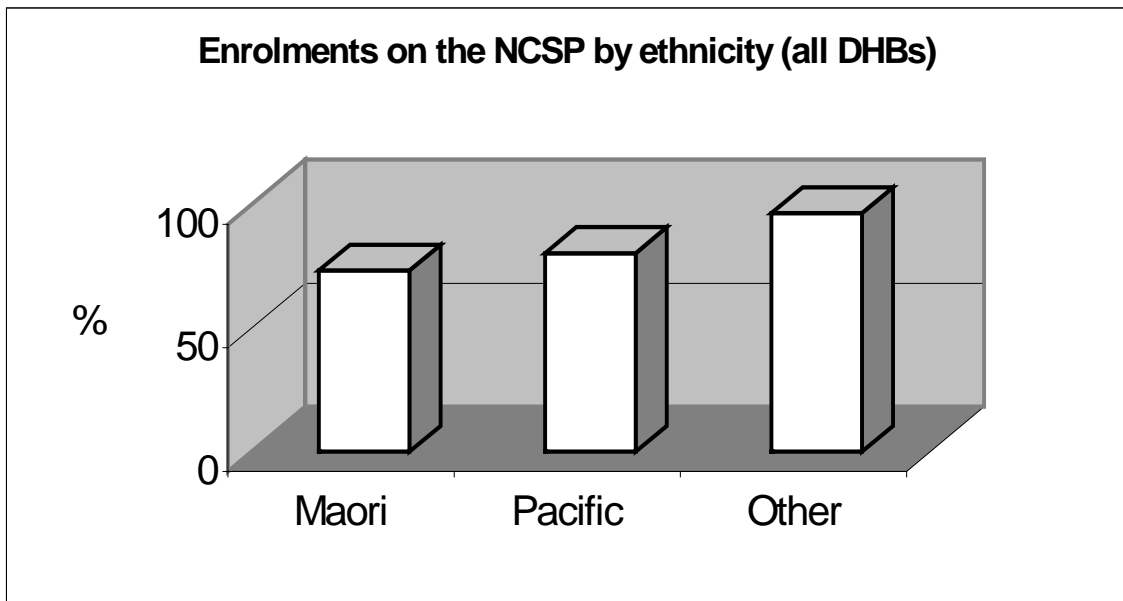
¹ University of Otago. 2002. *Quarterly monitoring report 4, National Cervical Screening Programme*, July-September 2001 (unpublished).

² Percentage >100% most likely due to duplicate enrolments on the Register

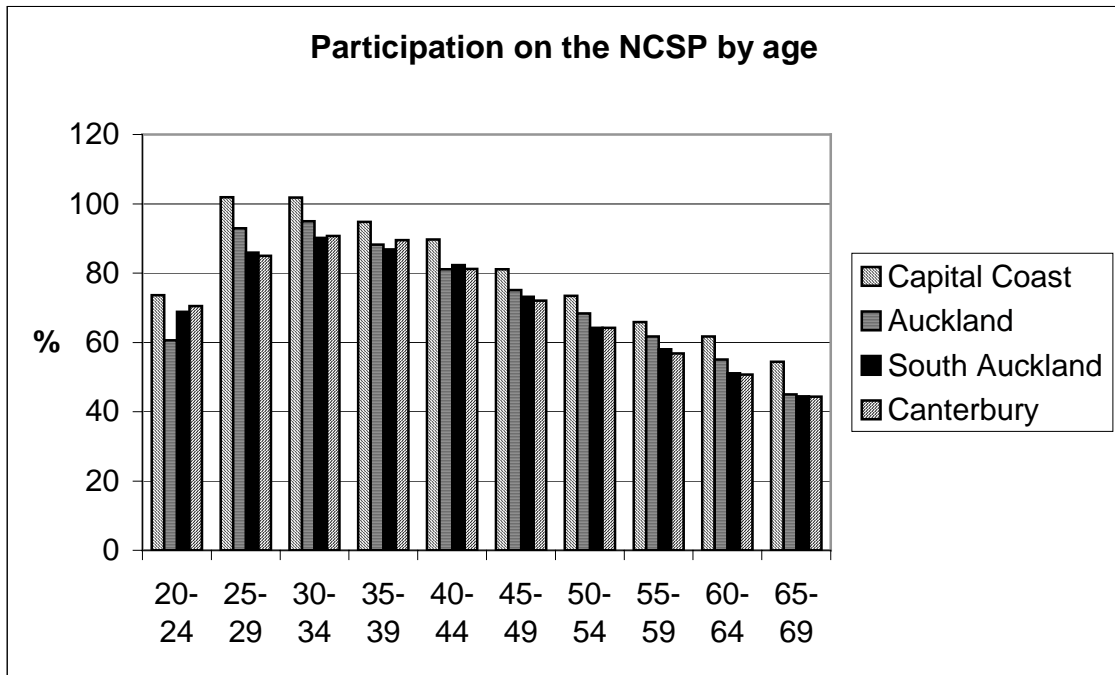
**Graph One: Women aged 20-69 years enrolled on the NCSP
July-September 2001**



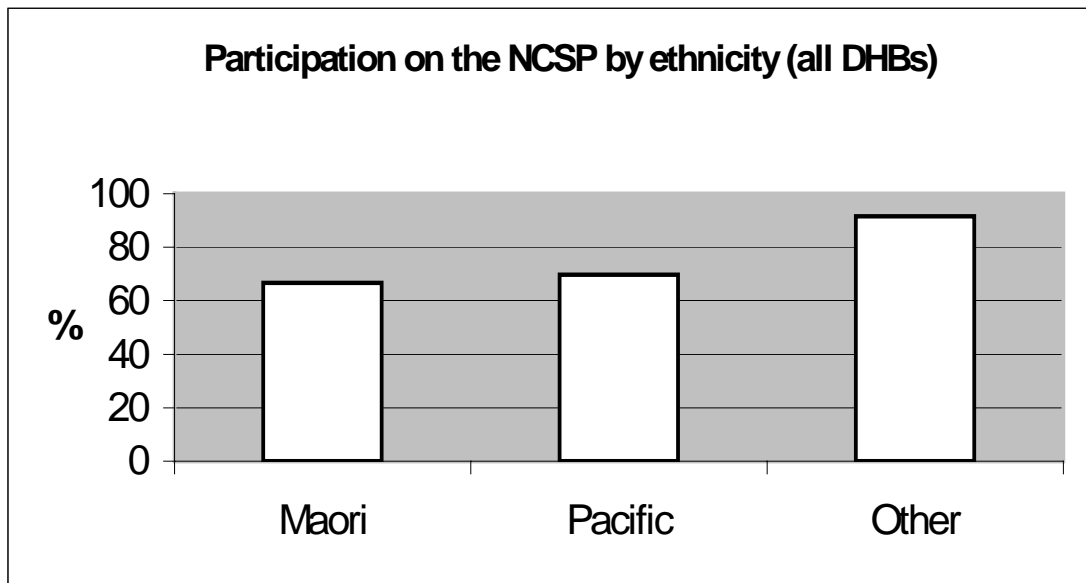
**Graph Two: Women aged 20-69 years enrolled on the NCSP by ethnicity
July-September 2001**



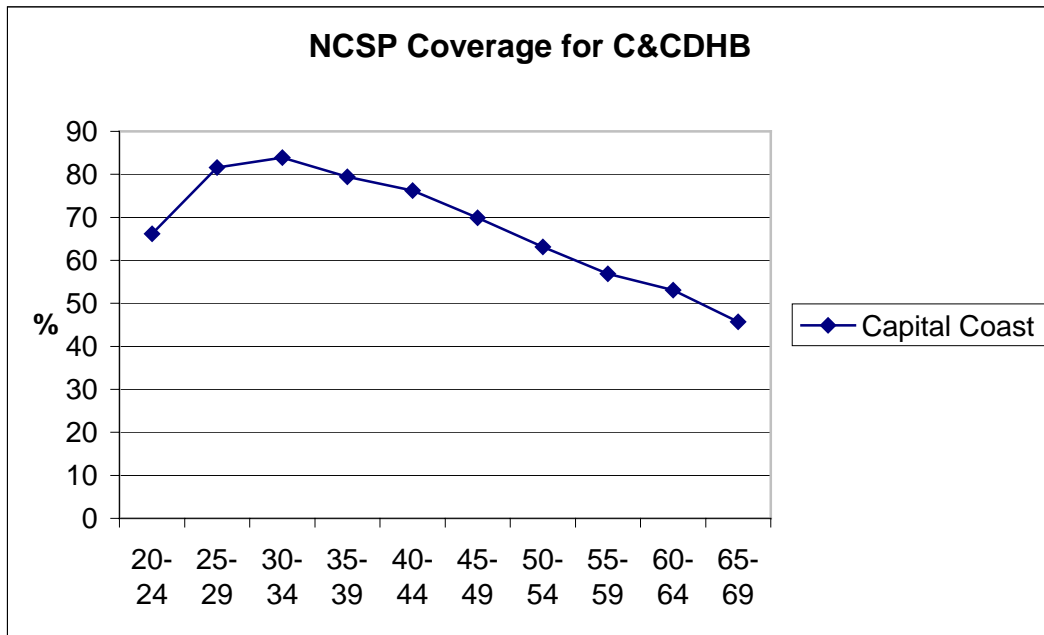
Graph Three: Participation: Women aged 20-69 who have had a smear recorded on the NCSP in the previous 6 years (not adjusted by hysterectomy) - July-September 2001



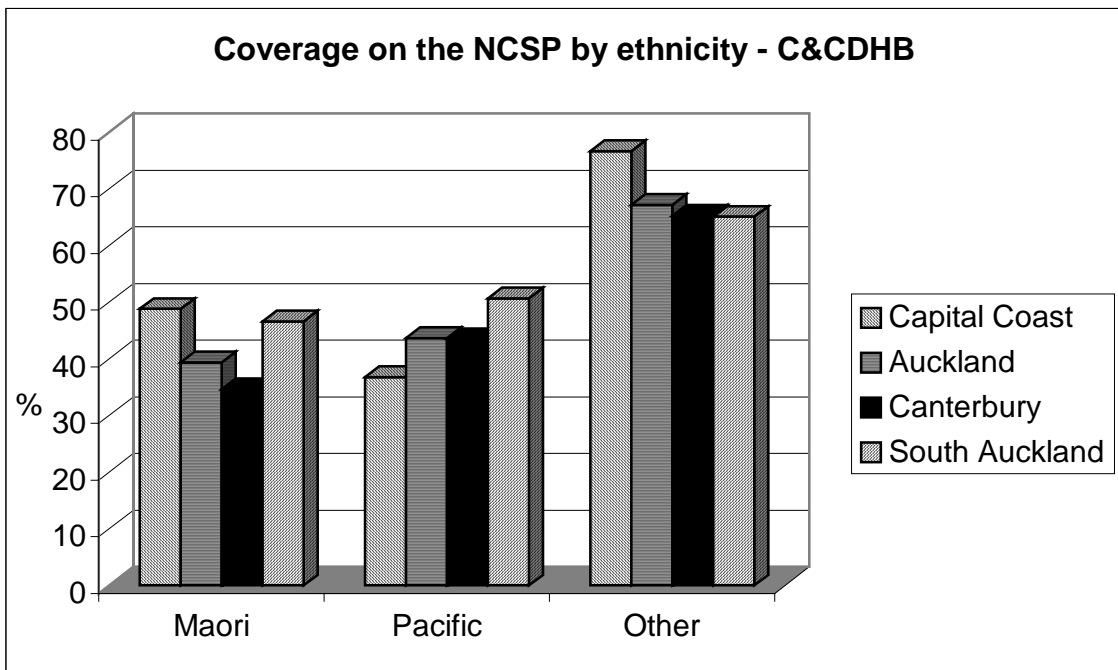
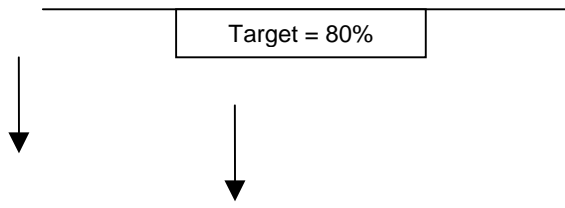
Graph Four: Participation: Women aged 20-69 who have had a smear recorded on the NCSP in the previous 6 years by ethnicity (adjusted for hysterectomy) – July - September 2001



Graph Five: Coverage – Women aged 20-69 in C&CDHB enrolled on the NCSP screened the previous 36 months (not adjusted for hysterectomy) - July-September 2001



Graph Six: Coverage: Women aged 20-69 in C&CDHB enrolled on the NCSP screened in the previous 36 months by ethnicity – (not adjusted for hysterectomy) - July-September 2001



SHORT INTERVAL RESCREENING

Short interval re-screening is the proportion of enrolled women with a normal smear history who have had a smear prior to 33 months (i.e. earlier than the recommended three year interval). Excessive short interval re-screening represents an overuse of limited resources.

In C&CDHB the short-interval re-screening rate for satisfactory (A1) smears is 17%. This compares to 22.7% in Auckland, 17.4% in Canterbury and 18.5% in South Auckland. The target for short-interval re-screening is less than 10%. Boards with the lowest short interval re-screening rate for A1 smears were Waikato at 9.7% and Nelson/Marlborough at 10.6%. Thus, further effort needs to be directed at encouraging local smear takers to maintain a three yearly screening interval.

COLPOSCOPY SERVICES

The national guidelines of the NCSP are that women with a high grade cervical abnormality should wait no longer than 4 weeks from referral for a colposcopy, and women with a low grade cervical abnormality wait no longer than 26 weeks.

Between April and June 2002 at Wellington Hospital at least 12 women each month with a high grade cervical abnormality were waiting for a first appointment to be seen for colposcopy. In the same period at least 80 women each month with a low grade cervical abnormality were waiting over the national guidelines of 6 months for a first appointment. In July 2002 the maximum waiting time for Colposcopy at Wellington Hospital for women with a low grade cervical abnormality was 13 months. The flow-on effect of this extended waiting time was a high rate of default.

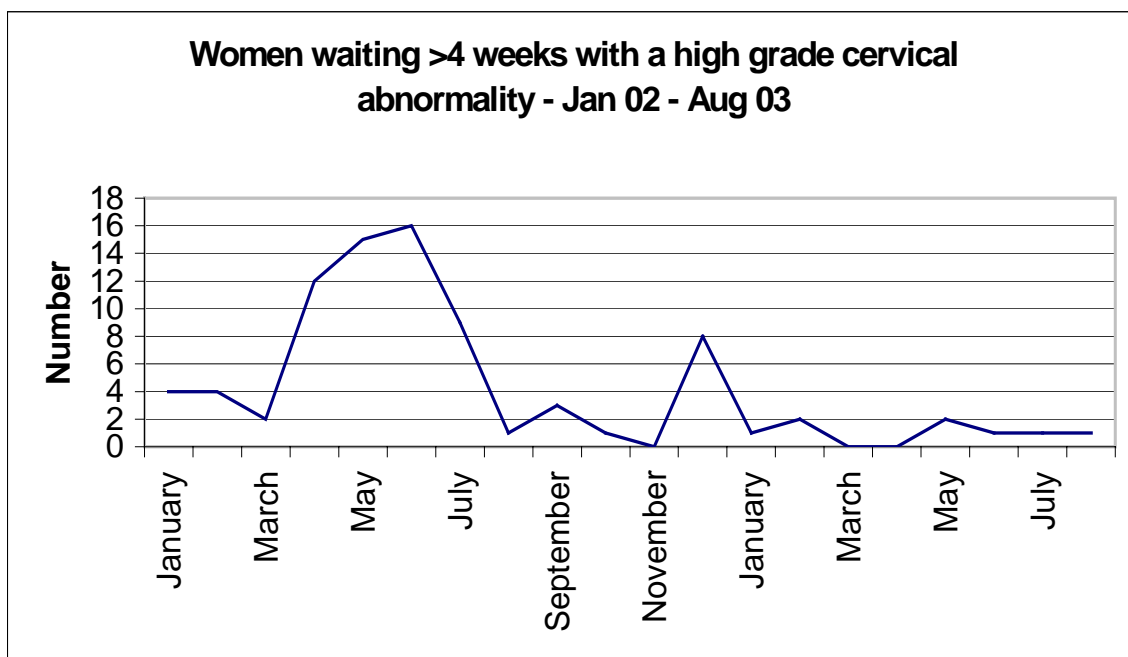
The Service Leader initiated a plan to improve waiting times. This included:-

- All women with a low grade abnormality waiting greater than 6 months were contacted by phone or in writing to verify the need for consultation and contact details. If the service was unable to verify a woman's details by this process the referrer was contacted.
- Two vacant colposcopy positions were filled.
- An additional two new colposcopy sessions were provided each week for a period of 6-8 months.
- Women were phoned and reminded of their clinic appointment 2-3days prior.
- Cancellations were efficiently replaced by women awaiting their first specialist appointment.
- All women who defaulted were contacted by phone or letter to ensure a further appointment was required before rescheduling. If the service was unable to verify a woman's details by this process the referrer was contacted.

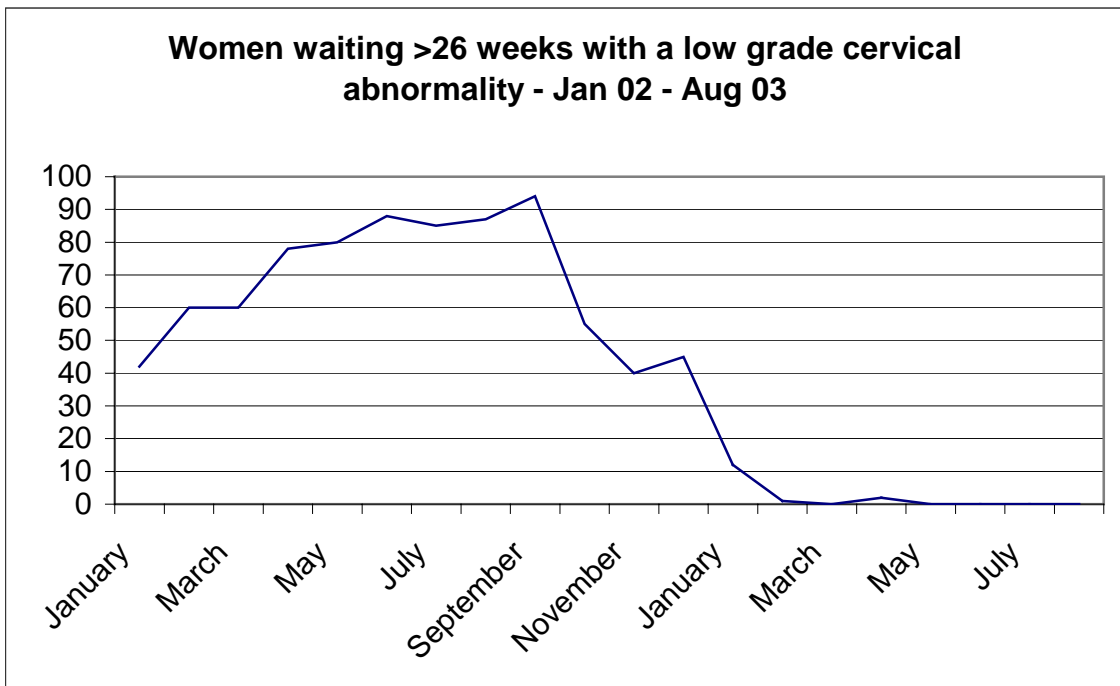
At September 2003 the total number of women waiting for their first specialist appointment had reduced, with no women with a low grade cervical abnormality waiting greater than 4 months for a first specialist appointment (Graphs Seven and Eight). The reduction in waiting time positively impacted on the default rate.

This project was recently submitted to C&CDHB Quality Quest and won an award for excellence.

Graph Seven: Women with a high grade cervical abnormality waiting >4 weeks for a first colposcopy appointment



Graph Eight: Women with a low grade cervical abnormality waiting >26 weeks for a first colposcopy appointment



FOLLOW-UP OF WOMEN WITH HSIL

Follow-up of women with HSIL is defined as the proportion of enrolled women with a high grade or more serious cytology result for whom a histology report has been recorded by the NCSP within specified time periods from the time the smear was taken. The time periods are within 12 weeks, between 13 and 26 weeks, between 27 and 52 weeks and more than 52 weeks. The target is 90% within 12 weeks and 99% within 52 weeks.

In Wellington 77.6% of women with high grade smears had histology results recorded within 12 weeks. A majority (92.3%) had histology results recorded within 26 weeks and 99.5% within 52 weeks. The 12 week rate compares to 79.4% in Auckland and 84.7% in Canterbury. Manawatu/Wanganui had highest follow-up rate of 85.9% of women with a high grade cervical abnormality having histology results available within 12 weeks. This data indicates that further effort is required to ensure that women in Wellington with high grade abnormalities are able to be seen in a timely way by a specialist for a biopsy. However, it is likely that improvements in the colposcopy service (above) have since impacted on the timeliness of results.

LABORATORY SMEAR REPORTING

In the period from July-September 2001 the Medical Laboratory in Wellington was able to report 78.7% of smears within 7 working days. The balance were provided from 8-14 working days. Three other laboratories in New Zealand have a similar rate but 12 other laboratories in New Zealand were able to report a majority (97%) of smears within 7 working days. It is understood that the laboratory experienced recruitment difficulties at this time. Up-to-date information from the second and third quarters of this year identifies that 98.8% and 99.9% of smears were reported within 7 working days.

DISCUSSION

C&CDHB can be proud that of all DHB's it has the highest rate of enrolment on the Register and the highest participation rate (a smear recorded within 6 years). Despite this achievement women least likely to be enrolled are 20-24 and over 45 years of age, and Maori and Pacific women. Continued effort will be required to reach these women.

Women who default on cervical screening or who have a cervical smear at greater than the recommended three year cycle are at risk of developing cervical cancer. While many women are having cervical smears, coverage and participation (a smear recorded within 3 years and 6 years) declines after 40 years of age. Pacific and Maori women have a low rate of coverage and participation. Continued efforts will therefore be required to ensure that women are screened regularly every three years, particularly women over 45 years of age, and Maori and Pacific women. Health providers should be alerted to this service gap and the needs of these groups.

In terms of service delivery the capacity of Maori and Pacific providers to provide information and screening services could be further developed. Health promotion programmes should also continue to target older women as a priority group.

In July 2002 the Service Leader of the Colposcopy Service identified a service issue related to waiting time for a first appointment for women with low and high grade smear abnormalities. Waiting times have been dramatically overturned and now meet the national guidelines.