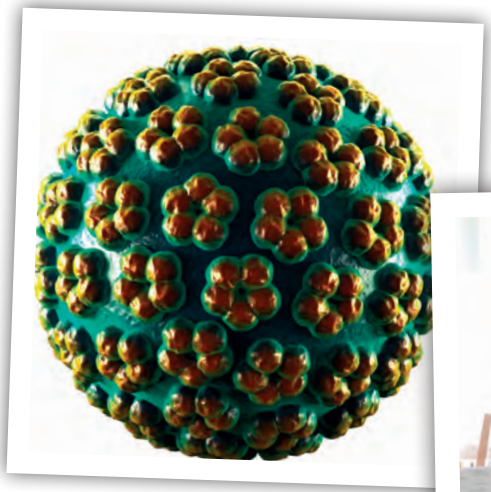
NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Guidance for Good Practice in Cervical Screening

5th Edition



Cervical Screening Training

Acknowledgements

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SECTION ONE

Introduction

This document has been produced by the Cervical Screening Training Department, funded by Health Education England North East and hosted by Newcastle upon Tyne Hospitals to provide standard guidance in cervical screening. It covers all elements of the NHS Cervical Screening Programme (NHSCSP), and is intended to support existing local documentation and the requirements of the GMS contract. It replaces the previous publication 'Guidance for Good Practice in Cervical Screening' 4th Edition.

Aims of Guidelines

- To ensure that practice is in line with current standards and national policy.
- To outline the training requirements for sample takers in the NHSCSP.
- To clarify the roles of practices/clinics in cervical screening.
- To outline the requirements for audit.
- To offer clear advice to support consistent delivery of the NHSCSP.
- To address some of the issues and frequently asked questions that arise in a consultation.

Impact of Cervical Screening

Significant progress has been achieved since the Cervical Screening Programme was established in 1988. The cervical cancer mortality rate in England has fallen from 1,035 in 2000 to 660 in 2015 in women of all ages. [1]This fall is directly related to the NHS Cervical Screening Programme.

[1]The Health and Social Care Information Centre. Statistical Bulletin 2015/16

For more information about cervical screening:
www.gov.uk

The Cervical Screening Programme

The aim of the NHS Cervical Screening Programme is to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by offering regular screening to all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated.

Incidence

What is the incidence of cervical cancer?

In 2014, there were 2,590 new registrations of invasive cervical cancer in England in women of all ages.

Incidence and mortality rates in England have fallen considerably over the past 20 years. During this period, incidence rates almost halved (from 16.2 to 8.7 per 100,000 female population) and mortality rates reduced by almost two-thirds (from 6.4 to 2.1 per 100,000). Incidence fell sharply following the establishment of the Cervical Screening Programme in 1988, but this reduction has slowed in recent years. There is also strong evidence that both incidence and mortality are worse in patients living in the more deprived areas. (Profile of Cervical Cancer in England: Incidence, Mortality and Survival 2012).

Cervical screening is estimated to save approximately 5,000 lives per year in the UK and prevents up to 3,900 cases of cervical cancer per year.
(www.gov.uk)

Mortality

How many women die from cervical cancer?

Death rates from cervical cancer have fallen below 800 per year in England. In 2015, 660 deaths from cervical cancer were registered in England.

Less than 7 per cent of cervical cancer deaths occur in women under 35.

Cervical cancer is the 16th most common cause of cancer deaths in women in the UK, accounting for around 2 per cent of all female cancers and it is the most common cancer in females under 35. Compared with 20 years ago, cervical cancer mortality is lower in all age groups.

In England, for women diagnosed between 2005 and 2007 the one year relative survival rate has increased from 82.2% to 86.2%.

Over the last 20 years, one-year relative survival has improved in all age groups, particularly for women aged 20-39, increasing from 93.0% in 1987-1989 to 96.6% in 2007-2009.

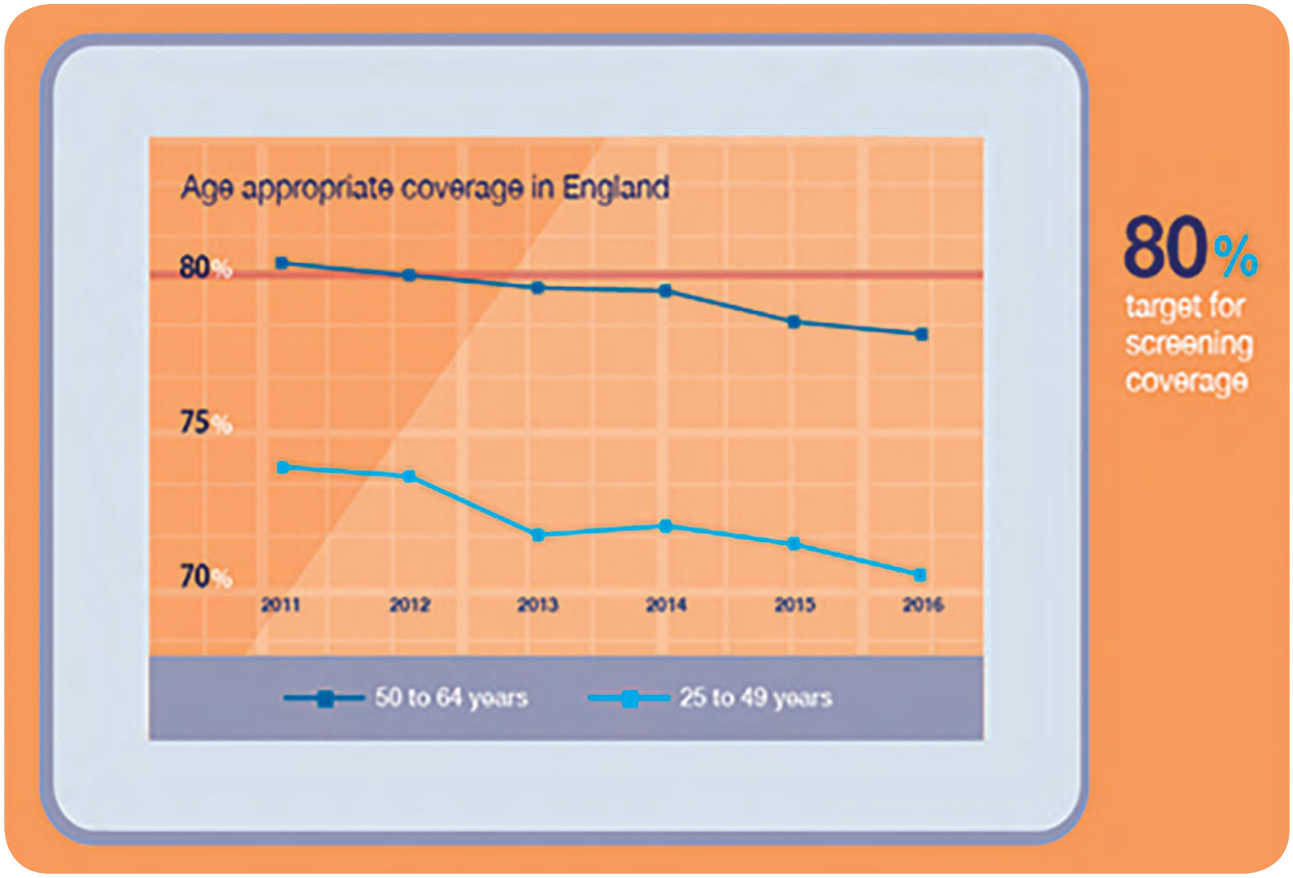
Coverage

Coverage is defined as the percentage of women in a population eligible for screening at a given point in time who were screened adequately within a specific period. The eligible population is women aged between 25 - 64 years with a cervix.

80% coverage is required for the NHSCSP to be effective. However, the information that is required to fulfil the criteria for the Quality Outcomes Framework (QOF) differs, see Section 5.

11 points are given for the percentage of patients aged from 25 – 64 years whose notes record that a cervical sample has been performed in the preceding 60 months. The standard is between 40 – 80%. Women who have been exception reported should be removed from this denominator. If a woman is exception reported, she is still eligible for screening and every effort should be made to encourage these women to be screened.

Of eligible women in England, (aged 25-64) at 31st March 2016, 72.7% were recorded as being tested within 5 years of their last adequate test. This compares to 73.5% in 2015. Coverage has been falling over the last ten years and this is the sixth consecutive year it has remained below 80%. The fall in coverage in 2016 is also apparent in the different age groups, for those aged 25 to 49 (who are invited every 3 years), coverage at 31st March 2016 was 70.2% compared with 71.2% in 2015. Among women in the older age range, 50 – 64 years (who are invited every 5 years), coverage at 31st March 2016 fell from 78.4% in 2015 to 78% in 2016.



Initiatives to Improve Coverage

The National Institute for Health Research (NIHR) Health Technology Assessment Programme commissioned a study to investigate ways of improving screening uptake of women when they are invited for the first time. The project was called 'Strategies to increase cervical screening uptake at first invitation' (STRATEGIC)

It involved over 200 practices in Greater Manchester and 40 in Aberdeenshire and published its findings in 2016. Its objectives were to measure the feasibility, clinical effectiveness and cost-effectiveness of a range of interventions to increase the uptake of cervical screening among young women. The full report can be found here https://dx.doi.org/10.3310/hta20680

A collaborative initiative with local authority and public health in Middlesbrough called 'No Fear' is currently underway and is being rolled out in Newcastle. Specific literature was produced and sent out to beauty clinics and hairdressers as part of this initiative.

- Prior notification lists (PNLs) must be checked carefully to ensure all 'ghost' patients are removed and addresses are correct.
- It is recognised that women often give low priority to their own health needs and may need regular encouragement to attend for screening and advice.
- Use leaflets and information in appropriate languages. Many women are misinformed about various aspects of the tests, particularly women from ethnic minority backgrounds and women with learning disabilities. See next page for resources.
- Consider if clinic times are appropriate. Offer regular evening and weekend clinics and take into account community events, which may be barriers to attendance (e.g. Friday prayers for Muslims, collection of children from school, etc).
- Provide information on alternative clinics where women can attend for screening if more appropriate times are available.
- Information should also advertise the benefits of attending for regular screening. Ensure patients are aware that the test can be done by a female doctor or nurse.

Details of publications and leaflets are available on the NHS Cancer Screening Programmes website:
www.gov.uk or call
Harlow Printing on 0191 496 9735

From April 2018 a new organisation will take over the printing of the leaflets. Please see www.cervicalscreenintraining.co.uk for more information nearer the time.

Above posters available from:
www.sphil.nhs.uk
Tel: 01642 526 933

These posters are limited to 2 copies per order.

- Ensure that the service is culturally sensitive and that a female staff member is available and trained to offer information and guidance where language barriers exist.
- Ensure that the sample taking environment is appropriately equipped and offers complete privacy.
- Highlight medical records and insert computer prompts for all women who fail to attend.
- For non-attendees, ensure the issue is raised at the next appropriate visit and that the patient is fully informed of the benefits of regular screening.
- Ensure reception staff have access to appropriate up to date information so they are fully informed of any changes to the screening programme.
- Primary Care Support England (PCSE) invites eligible women for cervical screening on behalf of GP practices. This is done on two occasions. A third invitation is then undertaken by the practice.

The Smear Test film

The Smear Test film is a health education film resource for women eligible for cervical screening who have mild and moderate learning disabilities. It can be accessed here www.jostrust.org.uk/video-page/smear-test-film select 'The Smear test Film' on the left.

An example of a letter which can be sent to women to represent the third invitation is available on our website www.cervicalscreeningtraining.co.uk (See Appendix 1)

As mentioned previously the Screening Programme has commissioned projects to identify barriers to screening, particularly in younger women especially those aged between 25 to 34. As barriers are identified this information will be shared to implement change strategies.

Your Guide to Cervical Screening (The Smear Test)

The following film was developed by Jo's Trust in different languages to help raise awareness about cervical screening and Human Papilloma Virus (HPV). It can be accessed here https://www.jostrust.org.uk/video-page. It is available in Arabic, Bengali Standard, Bengali (Sylheti), Chinese, Hindi, Urdu, Polish and Tamil.

SECTION TWO

Human Papilloma Virus

Improving Outcomes: A Strategy for Cancer (DoH January 2011) aimed to deliver healthcare outcomes as good as anywhere in the world. It acknowledged that cancer screening remains an important way to detect cancer early, and in some cases, such as cervical screening, prevent cancers. A part of this strategy set out how Human Papilloma Virus (HPV) testing is incorporated into the NHSCSP with the aim of leading to a more patient centred service and major cost savings.

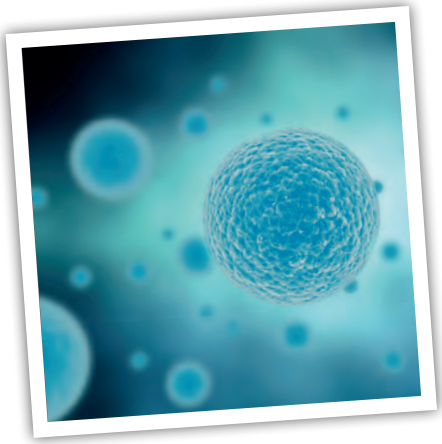
Human Papilloma Virus (HPV)

There are over 100 strains of HPV, 40 of which infect the anogenital tract.

Certain strains are known to be high risk. HPV 16 and 18 are estimated to account for 70% of high grade cervical intraepithelial neoplasia (CIN) and cervical cancer. Strains 31, 33, 35, 52, 56 and rarely 39 and 45 are thought to account for the rest.

Persistent infection by high risk HPV is the most important causal factor for the development of cervical neoplasia.

Low-risk strains produce low-grade CIN lesions which tend to regress and usually do not progress. For example, HPV 6 and 11 are associated with genital warts and are unlikely to be associated with cervical cancer.



HPV Risk Factors

The majority of sexually active women will come into contact with high-risk HPV types at some time in their life. In most women, their body's own immune system will get rid of the infection without them ever knowing it was there. Only a minority of women who have persistent infection by high-risk HPV sub-types will develop cervical abnormalities (CIN), which could develop into cervical cancer if left untreated.

Epidemiological studies investigating risk factors for HPV infection have shown clearly and consistently that the key determinants among women are the number of sexual partners, the age at which sexual intercourse was initiated and the likelihood that at least one of her sexual partners was an HPV carrier.[2]

Women with many sexual partners, or whose partners have had many partners, are more at risk of developing cervical cancer. This is because their behaviour is more likely to expose them to HPV. However, a woman with only one partner could contract HPV if that partner has previously been in contact with the virus.

Using a condom offers only very limited protection from transmission of HPV. Women who are immunosuppressed (for example, those who are taking immunosuppressive drugs following an

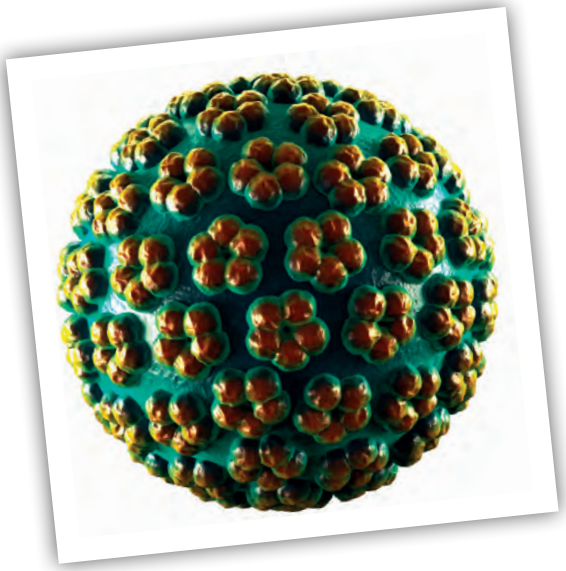
organ transplant or women who are HIV positive) may be at increased risk of developing cervical cancer.

Women who smoke increase their risk of developing cervical cancer. This may be because smoking is associated with high-risk health behaviours, or because it suppresses the immune system allowing the persistence of high risk HPV infection. Stopping smoking appears to help clinical abnormalities return to normal.

Long term use of oral contraceptives increases the risk of developing cervical cancer but the benefits of taking oral contraceptives far outweigh the risks for the majority of women.

Women with a late first pregnancy have a lower risk of developing cervical cancer than those with an early pregnancy. The risk rises with the number of pregnancies.

[2]NHSCSP The Aetiology of Cervical Cancer. Publication No. 22



HPV Testing

HPV testing is designed to speed up the referral to colposcopy, avoid referral for those who do not need it, and allow treated women to proceed to a three year recall.

Women known to be high-risk HPV negative are very unlikely to have significant disease. They can thus be reassured and returned immediately to routine recall without the anxiety of repeat screening tests and possible referral to colposcopy.

Women receive information on HPV testing which is within the leaflet 'Helping You Decide' with their invitation letter for cervical screening.

It should be documented on the request that the woman is aware that the sample may be tested for the presence of HPV. The HPV test is not optional. It is an integral part of the screening programme on offer to women. It is then up to the woman to decide whether to participate or not on that basis. In other words, if the woman declines for the sample to be tested for HPV then she should not have a cervical sample taken.

How does HPV testing affect women?

Triage

Women whose cytology result is borderline or low grade will have a high-risk HPV test performed on their cytology sample. If it is positive they are referred to colposcopy. If it is negative they are returned to routine three of five year recall, depending on their age.

Women whose cytology test shows high grade dyskaryosis (moderate, severe dyskaryosis or worse) will not have an HPV test. They are referred to colposcopy. Women whose cytology test result is negative will not have an HPV test.

Test of cure

All women who have been treated* for CIN and CGIN and have a cytology test six months after their treatment. If cytology is normal or low grade dyskaryosis, a high-risk HPV test will be performed. Women who are high-risk HPV negative will return to three year recall. Women who are high-risk HPV positive or have high grade dyskaryosis will be referred back to colposcopy.

*Treatment is categorized as excision, for example, loop excision of the transformation zone (LETZ), laser or cryotherapy. A punch biopsy is not classified as treatment.

For more information go to www.gov.uk

HPV Primary Screening

In February 2016 the UK National Screening Committee (NSC) recommended HPV screening for adoption by the cervical screening programme as the primary screening test. The D.O.H has announced that this will be implemented by 2019.

HPV primary screening means that the HR-HPV test is the first test performed on the cervical screening sample. Cytology then becomes the triage test, performed only when the HR-HPV test confirms HR-HPV to be present.

HR-HPV testing is performed on the sample taken for a cervical screening test. Where cytology triage is indicated, a slide is prepared and examined under the microscope for abnormal cells. This is carried out on the same sample, so there is no need for the woman to return for a second test. Both test results are issued as part of a single report. If a cytology result is included in the report, this is reflected in the management recommendation provided.

Women receiving a negative HR-HPV test result are returned to routine recall in three to five years dependant on age.

Women who test positive for HR-HPV will have a cytology test performed. Women with abnormal cytology (borderline changes or worse) are referred to colposcopy.

If the cytology test is normal, women are advised to return for a repeat test in 12 months.

If the woman remains HPV positive/ cytology normal at this 12 month repeat test, a further repeat test in another 12 months time is advised. At the next repeat test (24 months after the initial test) the woman will be referred to colposcopy if she remains HR-HPV positive (with no cytology performed), or return her to routine recall if she is HR-HPV negative.

The biggest risk factor is NON - ATTENDANCE


theory
practice
update

SECTION THREE

Sample Taker Training

The resource pack for sample taker training represents best practice for all sample takers and is available at www.gov.uk: see 'NHS Cervical Screening Programme Guidance for the training of cervical sample takers'. It is designed to be used for all sample takers in all settings where cervical samples are taken as part of the NHS Cervical Screening Programme (NHSCSP). The resource pack enables trainers to offer a common core of learning to all sample takers to ensure consistency and provide learning to a minimum recognised standard across the NHSCSP.

Health Care Assistants do not meet the criteria to be trained for taking cervical samples. (www.skillsforhealth.org.uk)

Organisation of training

The Regional Cervical Screening Training scheme, which has been in operation since 2000, is responsible for providing update training to all nurses who are sample takers. (A database is held of all Nurses who take cervical samples in the North East Region).

Update training

Update study days are provided in a variety of venues. A list of scheduled Updates can be viewed on the Cervical Screening Training website www.cervicalscreeningtraining.co.uk

Sample takers should undertake a minimum of one half day's update training every three years. Update training should address the following issues:

- Current developments in the Cervical Screening Programme nationally and locally.
- Recent literature relevant to sample taking, sampling devices and women's needs.
- Changes to local screening policies and procedures.
- Personal learning needs.

E Learning

An e-learning course is available for sample takers. It forms part of the three year update requirements and helps to maintain and improve knowledge of the cervical screening programme. The e learning can be accessed from http://portal.e-lfh.org.uk

Q1. Is the e-learning mandatory?
No, however it is recommended that this training package is undertaken to supplement the 3 year update training for nurses. Others wishing to undertake the e-learning are welcome to do so. If individuals feel they do not need to improve/reinforce their knowledge first they can do the assessment component only, which will decrease the time required for the module.

The Cervical Sample Taker Database (CSTD) devised by the Quality Assurance Reference Centre (QARC) enables screening co-ordinators to see an individual's cervical training record and highlight cases where the e-learning has not been completed.

If a sample taker does not complete the e-learning, it would be their professional risk and the Practice's responsibility as their employer. The practice and individual sample taker would need to be able to assure

themselves that, should they be the subject of investigation, through an incident/invasive cancer audit, staff were adequately trained.

Q2. How long will it take to complete the e-learning?
The course takes around 2 hours 45 minutes plus another 15 minutes for the assessment. However, if you already have the relevant knowledge you can go straight to the assessment.

Q3. Can the e-learning be used instead of undertaking initial training with a competency assessment?
No. The e-learning has been designed as a refresher for the theoretical aspect of cervical screening and is not a substitute for an initial training course with a competency assessment.

Certificate Course in Cervical Screening

A Certificate level course is delivered by Cervical Screening Training.

Training for sample takers is in two parts; a theoretical course followed by a period of practical training which should take place in the practice or clinic where the trainee is based. Each student will be allocated a Cervical Screening Mentor (CSM) for the duration of the clinical practice and asked to identify a Professional Support within their workplace to provide support during the unsupervised clinical practice. Each trainee keeps a record of their training in a portfolio which is submitted as evidence of learning.

Further information is available on our website.

www.cervicalscreeningtraining.co.uk

Practical training

For the first practical session/s, the trainee will be accompanied by the CSM and will:

- Identify personal training needs in discussion with the CSM.
- Observe at least two samples being taken by the CSM.
- Take a minimum of five samples under supervision of the CSM.

The CSM and trainee should then decide whether the student may proceed without further direct supervision. Subsequently the trainee will take and document 20 unsupervised samples with access to a nominated Professional Support. The student will visit the Cytology laboratory, and the Colposcopy clinic, documenting and reflecting on the visits in their portfolio. The trainee should also write three reflective pieces of work related to their practice.

The GMS contract identifies the importance of training in Cervical Cytology Sampling. Refer to CS001 indicator.

Clinical assessment

Both CSM and trainee are expected to maintain regular contact, including contact midway and discuss progress towards meeting identified training needs and any problems. They then meet for an evaluation and clinical assessment. The trainee must have completed 20 samples before the assessment can be undertaken. All training should be completed within a nine month period.

To ensure continued competence in accordance with their professional codes of conduct, sample takers should conduct continuous self-evaluation. They should audit and reflect on their results compared with the rates reported by the local laboratory. They should maintain this in the form of a log book or spread sheet.

Theoretical course

Content includes:

- The NHS Cervical Screening Programme.
- The background to cervical screening.
- Organisation of the NHS Cervical Screening Programme.
- Equality of access to cervical screening.
- Understanding the test results.
- Anatomy and physiology of the pelvic organs.
- Practical aspects of taking cervical samples.

The Cervical Screening Mentors Role

The CSM facilitate and support good practice in relation to the practical aspects of cervical sample taking.

They are the mentor for new nurse sample takers and assist with the development and delivery of the update training programme for established sample takers.

The CSMs have good teaching and communication skills. They undertake regular update training and maintain awareness of developments in the Cervical Screening Programme.

They must be practising sample takers who are able to demonstrate continuing competence in taking samples for cervical screening with particular reference to:

- Transformation zone sampling.
- Technique.
- Equipment and sample preparation.
- Audit of results including adequacy rates & TZ sampling.
- Demonstrate good communication skills.
- Maintain awareness of developments in the Cervical Screening Programme.

Criteria for CSM:

- Registered General Nurse with recent experience, working as a Practice Nurse/Community Nurse.
- Undergone a recognised course for sample takers and have experience in cervical screening in General Practice or contraception and sexual health setting.
- Demonstrate evidence of teaching ability, an understanding of the dynamics of working in Primary Care with a recognised mentor qualification.

The CSMs are accountable to the North East Regional Cervical Screening Training Co-ordinator.

The University of Northumbria deliver a Cervical Screening module.
See www.northumbria.ac.uk

Taking a History

Obtain and record relevant details of:

- Cytology history – any abnormal cytology results, if so when, where, result, treatment, follow up.
  A woman's cytology history is available from Open Exeter. For more information on Open Exeter refer to page 29.
- Contraception.
- Abnormal Bleeding: - post coital bleeding - inter menstrual bleeding - post menopausal bleeding.
- If **YES** to any of above consider referral to gynaecologist/GUM - consider swabs if appropriate.
- Unusual vaginal discharge. Take swabs, consider postponing cervical sample until diagnosis & treatment completed.
- Ensure woman has received the NHS cervical screening: 'Helping you decide' leaflet.

Take the cervical sample before taking swabs.

The following factors do not precipitate additional screening outside of normal call and recall:

Taking or starting to take oral contraception.

Insertion of an IUCD/IUS. Taking or starting to take HRT.

Presence of genital warts. Presence of vaginal discharge.

Presence of infection.

Women who have had many sexual partners.

Women who are heavy cigarette smokers.

Family history of cervical cancer.

There is never a "clinically indicated" reason for taking a sample

You should **not** take a sample in the following circumstances:

- During menstruation, but if this is the only opportunity then it can be taken.
- Less than 12 weeks post-natal.
- Less than 12 weeks following a termination of pregnancy or miscarriage.
- Less than 12 weeks following an inadequate sample.

Women with symptoms or abnormal bleeding should be referred for further investigation. The screening test could offer false reassurance.

The screening test is not a diagnostic tool.

Always look at the cervix.

Cytology Request

There are two ways to request a cervical cytology sample.

Handwritten sample request form (HMR101)

Full name, address and postcode

Any previous names

Date of birth

NHS Number

Name and address of GP and/or Clinic

Sample taker code

Date of LMP

Date of last smear

Hormones/IUS/IUD

Any relevant history including previous abnormal cytology, histology, abnormal bleeding, abnormal appearance of the cervix.

Complete form with black ballpoint pen.

ICE (Integrated Clinical Environment)

ICE requesting provides a web based service that enables cytology requests to be made from clinics and GP surgeries. The system employs 'rules' to ensure only appropriate requests are made and full information is available to the laboratory.

Always keep a small number of request forms available in case ICE is not accessible.

Please remember to check the expiry date of the vial. The HPV test may be invalid if the vial has expired; the shelf life is 3 years.

SurePath™

ThinPrep™

Labelling the vial

- Name
- Date of birth
- NHS number
- Date taken
- Attach the label vertically to the vial

Taking the Sample

The clinical environment:

- Private and relaxed
- Well lit
- Screened area for privacy
- Trolley or work surface next to the couch
- Area for hand washing and drying
- Clinical waste/bin nearby
- Lockable door if patient gives consent
- 20 minute appointment

Equipment:

- An examination couch
- A good light source
- Range of different sized speculae
- Disposable gloves
- Lubricant, single use sachets
- Disposable modesty sheet
- SurePath™ and Thinprep™ LBC Kits, which include:
  25 Cervex Brushes® and vials and labels
- Tissues & panty liners
- ICE forms

Explaining the process:

You should explain to the woman the purpose of cervical screening and what will happen at each step of the procedure. Ensure that women have received the 'Helping you Decide' leaflet and understands the procedure. Every woman should know:

- The purpose of cervical screening and its limitations.
- The likelihood of a normal test result (about 93% of adequate tests).
- The meaning of a normal test result (low risk not no risk).
- The likelihood of an inadequate test.
- The meaning of being recalled following an abnormal test result.
- When and how test results will be made available.
- The importance of the woman always reporting any abnormal bleeding or discharge to her doctor.
- Obtain consent regarding HPV testing.

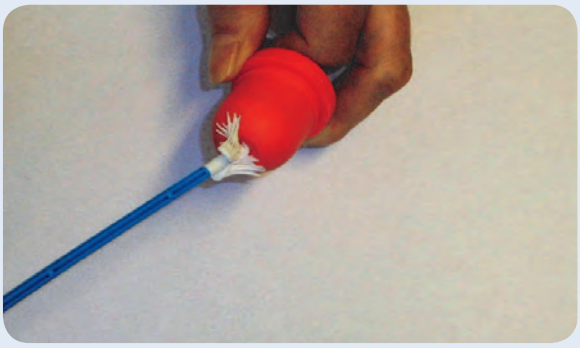
Explain clearly to the woman what you are going to do during the procedure and what to expect. Women who are having a test for the first time may need a more detailed explanation, including an explanation of the speculum and the sampling device. Women need to know that they will have to remove their underwear and that the speculum will be inserted into their vagina. All women should be offered a chaperone irrespective of the gender of the sample taker.

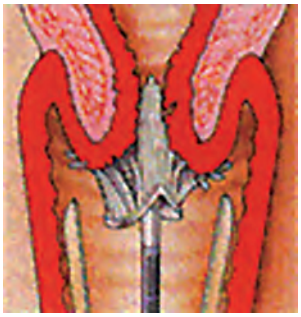
Taking the Sample

There are two methods of liquid based cytology (LBC)SurePath and ThinPrep. Please ensure that you are using the correct equipment and method when taking samples. For both technologies ensure the vial has not passed its expiry date.

Using the Cervex Brush, insert the central bristles of the brush into the endocervical canal so that the shorter, outer bristles splay out over the ectocervix. Applying pencil pressure, rotate the broom through **FIVE** complete 360° rotations. In order to ensure good contact with the ectocervix, the plastic bristles of the Cervex Brush are bevelled for **CLOCKWISE** rotation only.

A good sample will only be achieved with correct use of the Cervex Brush.





Slide courtesy of Surepath/Medical Solutions

Immediately fix the sample

SurePath

- Remove the head of the brush from the stem and place into the vial of fixative.
- Remove gloves
- Screw the lid on and shake gently.

It is essential that the sample is placed in the vial at once in order to achieve immediate fixation. Do this before you remove the speculum.

ThinPrep

- Rinse the brush into the fixative vial using a vigorous swirling motion.
- Push the brush into the bottom of the vial at least 10 times, forcing the bristles apart. Firm pressure is necessary or the cells will cling to the brush.
- Inspect the brush for any residual material and remove any remaining by passing the brush over the edge of the fixative vial.
- Ensure that the material reaches the liquid or it will not be preserved.
- Dispose of the brush.
- Tighten the cap so that the torque line passes the torque line on the vial.
- Shake the vial if you wiped any material on the edge.

Using an endocervical (EndoCervex Brush®) as well as a Cervex Brush®

- On **rare** occasions when there is difficulty in inserting the Cervex Brush into the os i.e. if the os is narrow or stenosed.
- The woman is being followed up for a previously treated endocervical glandular abnormality.

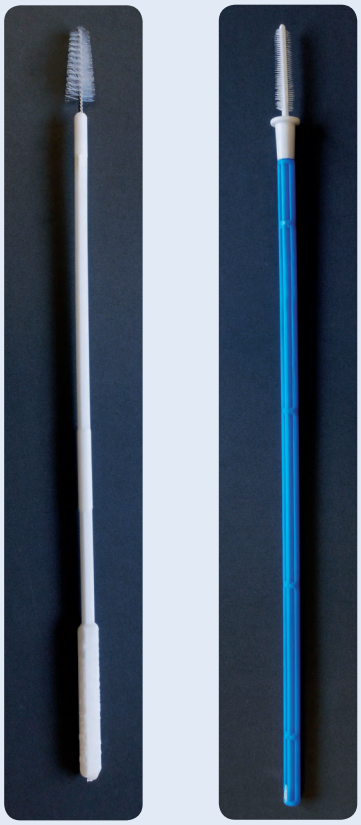
You should take the EndoCervex Brush® sample after the Cervex Brush sample.

Insert the brush gently into the os with the lower bristles remaining visible and rotate slowly between half and a whole turn.

Both samples should be placed in the same vial. Details of use of an additional sampler must be recorded on request form.

The EndoCervex Brush® should never be used alone but always in combination with a Cervex Brush®.

Cervical Samplers



Endo cervex brushes

Taking the Sample

Ending the consultation

- Allow the woman to dress in private.
- Complete the request with any further clinical details.
- Ensure that the woman understands how and when she will receive her result.
- Give the woman written information on results and possibility of Direct Referral.
- **If the woman requires an interpreter, ensure that this is documented on the cytology request. In the event an interpreter is required, then it can be arranged prior to the woman attending colposcopy.**
- Ensure that the woman understands that if she has any abnormal bleeding or discharge in the future she must see her GP.
- Complete log book with details of sample taken.
- To avoid delay, ensure sample is sent promptly to the cytology laboratory via the appropriate transport system.

Documentation

The consultation should be formally documented in the patient's records.

The following points should be noted:

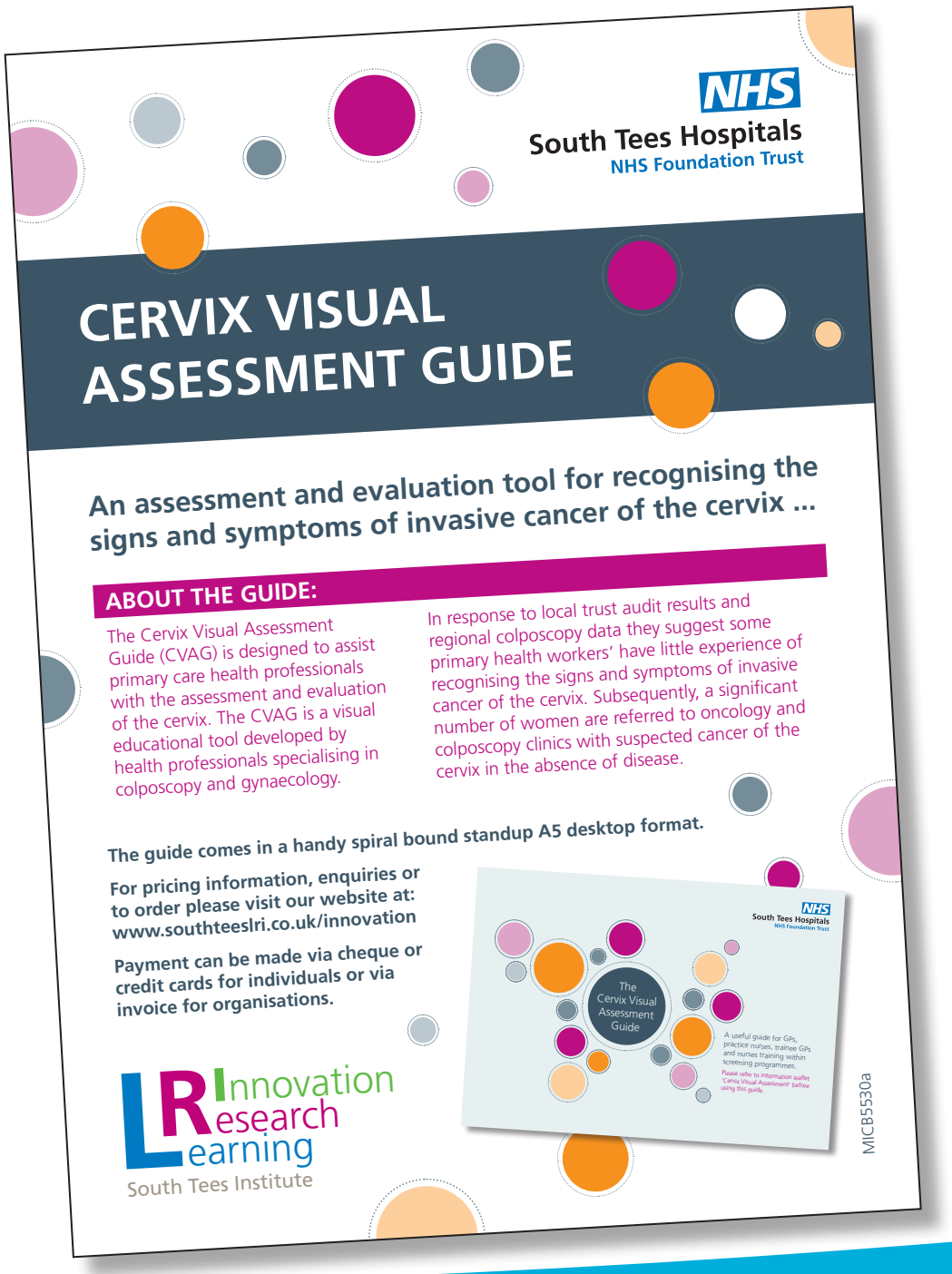
- The cervix was fully visualized and the squamo-columnar junction was sampled with five complete 360° clockwise rotations.
- If a vault sample is taken this should be clearly specified.
- Date sample taken and by whom.
- Clinical details – unusual appearances.
- Chaperone offered/declined
- Details of swabs if taken
- Details of additional sampler if used
- Consent for HPV testing

The Cervix Visual Assessment Guide

The Cervix Visual Assessment Guide (CVAG) has been designed to assist primary care health professionals with the assessment and evaluation of the cervix. The CVAG is a visual educational tool developed by health professionals specialising in colposcopy and gynaecology. In response to local trust audit results and regional colposcopy data they suggest some primary health workers' have little experience of recognising the signs and symptoms of invasive cancer of the cervix. Subsequently, a significant number of women are referred to oncology and colposcopy clinics with suspected cancer of the cervix in the absence of disease.

Orders are accepted from individuals or organisations.

For more information, visit the website at www.southteeslri.co.uk/innovation



SECTION FOUR

Sample Result and Management Guidelines

Summary of the recommended management of screened women according to the result of their cervical sample

Routine Reports and Action

Sample Result	Recall Interval/Action
Negative	Routine Recall 36 or 60 months, depending on age
Unsatisfactory/Inadequate	Repeat at 3 months. Reason for inadequate will be given by laboratory. Direct Referral to colposcopy is indicated if 3 inadequate samples.
Borderline Squamous/ Endocervical Low Grade (mild)	See HPV Triage & Test of Cure
High Grade dyskaryosis (Moderate/Severe Dyskaryosis) **Severe Dyskaryosis? Glandular Neoplasia**	Direct Referral to colposcopy

As per NHSCSP Publication No. 20 Colposcopy & Programme Management 2017.

Inadequate Samples

Less than 1-2% of samples are reported as inadequate. Reasons for sample inadequacy include:

- Poor cellular sample (scanty)
- Sample consisting largely of blood, neutrophils or polymorphs with few squamous cells.
- Sample showing marked cytolysis where few intact squamous cells remain.
- Samples lacking endocervical cells in follow up of treated endocervical dyskaryosis (CGIN).
- No brush head in vial (SurePath LBC).
- Too much lubricant (ThinPrep LBC).
- Fluid spilt/leaked from vial.

Helpful tips to reduce inadequate rates

Apply sufficient pencil pressure to splay lateral bristles of brush on surface of endocervix.

Perform five complete 360° rotations.

Rotate clockwise.

For LBC technology, immediate fixation is required.

Do not take a sample if there is abnormal vaginal discharge; unless the woman is a poor attender, in which case always take cervical sample first before swabs.

In women who are menopausal consider topical oestrogen.

Cervical Screening is a test for precancer NOT infections. These are incidental findings. Any abnormal discharge should be investigated according to protocols.

A breakdown of the information on cervical samples will be provided by the Cervical Sample Taker Database, see Section 5. However it is the sample takers responsibility to audit their own practice. This should include:

Total of samples taken by practice and by individual sample takers.

- Overall inadequate rate for practice (number and percentage).
- Inadequate rate for individual sample taker (number of cases and percentage).
- Breakdown of reasons for sample inadequacy.
- Transformation Zone pick up.

Negative results, with organisms identified

Guidance from the National Office of Cancer Screening Programmes and the National Screening Committee, states that laboratories will not report the presence of organisms to the PCSE but will include them on the cytology report to the sample taker.

Incidental findings:-

- Actinomyces - like organisms are identified. This organism is usually associated with the presence of an IUD/IUS. If the patient was symptomatic at the time the sample was taken, please refer to your local gynaecological or GUM/Sexual Health Service for advice on management. If asymptomatic, advise return for clinical examination if symptoms develop.
- Endometrial Cells - see NHSCSP publication 20, 3rd edition.
- Candida - the reporting of candida on the cytology report does not require the woman to have treatment if she is asymptomatic.
- Trichomonas - like Organisms; this does not indicate a definitive diagnosis. In order to manage the woman appropriately further investigations may be required. The laboratory report will state "Please refer to your GUM/Sexual Health Service for confirmation of diagnosis and advise on treatment."

Women with symptoms

Women presenting with symptoms of cervical cancer, i.e. postcoital bleeding in women over 40 years, intermenstrual bleeding and persistent vaginal discharge, should be referred for gynaecological examination and onward referral for colposcopy if cancer is suspected.

Contact bleeding at the time of cervical sampling may often occur and is not an indication for referral for colposcopy in the absence of other symptoms or an abnormal cytology result.

Clinical practice guidance for the assessment of young women aged 20-24 with abnormal bleeding

The number of women aged 20-24 years who develop cervical cancer is generally fewer than 50 cases per year and this will fall over the next 10 years as a consequence of the national HPV vaccination programme.

By contrast abnormal vaginal bleeding is relatively common in this age group. It has been estimated from a general practice dataset in Scotland that postcoital bleeding is reported by around 1 in 600 women aged 20-24 per year. Intermenstrual bleeding is more common than this and it may be that 0.5-1% of women in this age present with abnormal vaginal bleeding each year. There are around 1.5m women aged 20-24 in England and it could, therefore, be estimated that 7,500 – 15,000 women per year will report abnormal vaginal bleeding. In practice the number could be larger than this.

In Clinical Practice Guidance for the Assessment of Young Women aged 20-24 with Abnormal Vaginal Bleeding, (see Appendix 3) the Department of Health advises that the cardinal symptom of cervical cancer in this age group is postcoital bleeding, but persistent intermenstrual bleeding (which is more common) also requires attention.

The critical intervention in the diagnosis of cervical cancer is a speculum examination to enable a clear view of the cervix. Following a relevant history, it is therefore necessary for women who present with postcoital bleeding or persistent intermenstrual bleeding to be offered a speculum examination either in primary care or at a GUM clinic.

This could be performed by a practice nurse experienced in cervical screening. If the cervix looks abnormal and suspicious, which will be the case in a very small proportion of cases, the correct action is urgent referral to colposcopy.

The guidance can be obtained from www.gov.uk

Colposcopy Direct Referral

The laboratory will refer women directly to Colposcopy if indicated. The woman must be given clear instructions on how the appointment may be easily changed if it is not convenient.

GPs that provide cervical screening services in accordance with the nGMS contract are responsible for ensuring that the test result for each woman is followed up appropriately and that referral for colposcopy is undertaken when indicated.

Follow up after Hysterectomy

Vault cytology is no longer part of the NHS Cervical Screening Programme. The NHAIS (Exeter) System will not recall women for vault cytology or record Quality Assurance results.

The Colposcopy Quality Assurance Committee recommends that the responsibility for patient follow up lies initially with the gynaecologist and later with the GP after discharge to primary care. It is important to remember that women who undergo a subtotal hysterectomy will still have their cervix in situ and so must remain within the National Screening Programme. These women will still require to be followed up as per guidelines in NHSCSP Publication No 20: Colposcopy and Programme Management (2016)

Guidelines for cytological follow up after hysterectomy

This summary is based on NHSCSP Publication No 20: Colposcopy and Programme Management (2016) and is supplemented by expert opinion regarding the sample taker and technique of vault sampling. (See Appendix 4)

The recommendations are as follows:

1. Women on routine recall for at least 10 years prior to hysterectomy and no CIN in hysterectomy specimen: No vault cytology required.
2. Women with <10yrs routine recall and no CIN in hysterectomy specimen: A sample should be taken from the vaginal vault 6 months after hysterectomy and if negative no further cytology is necessary.
3. Women with completely excised CIN in hysterectomy specimen: A sample should be taken from the vaginal vault at 6 and 18 months after surgery with no further cytology if both are negative.
4. Women with incomplete or uncertain excision of CIN in hysterectomy specimen: Follow up should be conducted as if the cervix were still in situ i.e. for low grade disease at 6, 12 and 24 months after surgery (low risk follow up) and for high grade disease at 6 and 12 months followed by annual follow-up for at least the subsequent nine years (high risk follow up).
5. Women who have undergone radical hysterectomy for cervical cancer: In general, cytological follow-up is not recommended in the assessment of these women but decisions regarding this small group of patients should be determined by the gynaecological oncologist who carries out the procedure.
6. Women who have undergone radiotherapy for the treatment of a cervical cancer: Cervical or vaginal vault cytology should not be performed on women who have undergone radiotherapy as part of their treatment.

Guidance on performing a vault sample

When performing a vault sample the preparation, patient positioning and equipment required are exactly the same as for a cervical sample. The cytology request form should be completed with all relevant history including the reason for the hysterectomy. A full explanation should be given to the woman prior to commencing the procedure. The woman should be asked to adopt a comfortable position. The required speculum size should be selected and inserted in the same manner as when taking a cervical sample.

When the speculum is fully inserted and gently opened, the area of the vault can sometimes be identified as a scar line with residue tissue at either end. A Cervex Brush should be used to sweep over the entire area in a clockwise direction, making sure that this includes both of the corners of the vault. The Cervex Brush should then be placed immediately into the LBC vial following the manufacturers instructions. The speculum should then be removed and the clinical details completed on the cytology request form.

SECTION FIVE

Practice / Clinic Responsibilities

14 Day Turnaround

The NHSCSP relies on each of the disciplines involved to work cohesively to ensure that the aims of the programme are met. Waiting for screening results can be an anxious time for women. Should further investigations or treatment be needed, the earlier this is confirmed the better and therefore turnaround times, namely the time between taking the sample and reporting the test results, should ideally be as quick as possible. Both the Cancer Reform Strategy (DH 2007) and the Improving Outcomes: A Strategy for Cancer (DH 2011) identified reducing turnaround time as a key challenge for cervical screening.

A few years ago only 43% of results were available within two weeks. Now, results are available in over 98% of cases within two weeks. (NHS Cervical Screening Programme - Statistical Bulletin 2015-16). In England, the North East had the quickest turnaround time of women receiving their result within two weeks and almost all within three during this period.

The Operating Framework for the NHS in England 2011/12 states that commissioners should ensure that cervical screening results continue to be received within 14 days. In 2016, 98.8% of women in the North East region were receiving their results within 14 days.

The Advisory Committee on Cervical Screening (ACCS) has recommended that the threshold for achieving this is 98%. Public Health England will continue to reflect the advice of the ACCS in commissioning the service.

By taking a complete screening pathway approach, achieving a 14 day turnaround time has also been shown to be cost saving, with an average £100,000 saved per unit per year. Some cancer networks are using this in their local Quality Innovation Productivity Prevention (QIPP) programmes.

Sample takers can ensure that this target is maintained by ensuring that the request form and vial are filled in correctly at the time the sample is taken and all samples are sent promptly to the cytology laboratory.

Failsafe

All GPs (or other clinicians responsible for requesting tests) are responsible for:

- Maintaining a register of tests taken.
- Ensuring that there is a system for notifying women of their test results in writing (this may be through the routine call and recall system administered by the PCSE).
- Ensuring that arrangements are made for women who fall outside the call and recall system (e.g. temporary residents, women not registered with a GP and women requesting 'no correspondence') to be given their test results, checking that a test result has been received from the laboratory for every sample taken.
- Acting on non-responder notifications for women who have not responded to an invitation for a routine test.
- Acting on non-responder notifications for women who have not responded to invitations for an early repeat test.

- Giving a woman her test result in person when urgent referral is required.
- Referring a woman for colposcopy if required.
- Acting on the non-responder notification from the colposcopy clinic for women who have not attended for colposcopy.

- Responding to failsafe enquiries from laboratories.
- Ensuring system in place for call & recall for vault cytology as per guidelines

Further information is available at: www.gov.uk see NHSCSP Publication No 21: Guidelines on Failsafe Actions for the Follow-Up of Cervical Cytology Reports.

Open Exeter

Open Exeter is a web-enabled viewer from the NHS Connecting for Health that gives agencies the opportunity to share information on the NHAIS (Exeter) database with their local GP practice and other NHS organisations.

The system holds details of women's screening history i.e. details of all tests including the date, result and the recommendation made by the laboratory for recall interval. As there are links between all NHAIS systems, and copies of the screening history are electronically transferred between systems when a woman moves, this information is particularly useful for GP practices to view the screening history of newly registered patients.

The Prior Notification List (PNL) is one of the key documents in the call/recall programme. It is essential that the lists are completed each week to ensure that women are invited for screening at the appropriate time. To reduce the paperwork for GP practices the PNL can be made available via Open Exeter. Practices can then access the list, process and submit the response electronically. Once registered to complete the PNL on-line the practice will no longer receive the paper listing. Instead it will receive an e-mail advising that the PNL is available for completion.

Non Responder notifications are sent to practices if there is no record of a woman attending for a test after having been sent an invitation and reminder letter. These notifications which were previously sent on cards can be made available via Open Exeter. The vast majority of these notifications are for information only and will require no action from the practice, other than to click a button to acknowledge receipt. However, as with Prior Notifications, there is the facility for the GP practice to request that recall should be postponed or ceased.

The Open Exeter System can also be used to record details of HPV vaccinations to ensure the information is recorded against cervical screening records for the future. Once vaccination details have been recorded the information is stored on the NHAIS system and should the girl subsequently move to live in another area then details of vaccinations will be forwarded to the NHAIS system that serves that area.

All access to Open Exeter is very strictly controlled with only certain organisations having sufficient access to correctly identify patients registered at GP practices. For practices access is controlled so that only information relating to patients registered with that practice can be accessed. It is also recognised that even within a practice there are different access requirements and therefore all access is granted on an individual basis with the practice controlling which staff have access to the different information types.

You can apply for access to the Open Exeter site by selecting; https://digital.nhs.uk/NHAIS/open-exeter and selecting the relevant form. Fill in your chosen form and contact Primary Care Support England (PCSE) who will be able to advise who to fax or post it to. The contact number is 0333 014 2884, please select option 6 for 'Open Exeter'.

If your practice is already registered and you wish to register additional users your practice Primary Contact will need to approve the registration. The Primary Contact for the practice is usually the Practice Manager or one of the GPs. Your Primary Contact will advise you whether you will need to complete a Data User Certification form or whether registration can be done on-line.

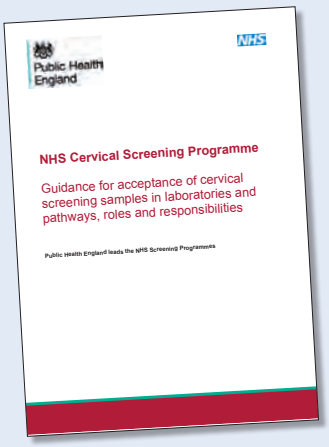
The Cervical Sample Taker Database (CSTD)

A web based system provides a register of all sample takers and holds training and performance data which will allow quality to be monitored. Sample takers need to be registered on the system by either their practice based Sample Taking Co-ordinator (formerly known as Clinical Lead), see below for responsibilities, or Practice Manager in order to be allocated a unique sample taker code.

The web based system will also be able to provide practice profiles; for example, overall practice performance, performance broken down by sample taker and practice coverage rates. This system is being hosted and managed by Gateshead Health NHS Foundation Trust. For more information e-mail gan-tr.northCSTD@nhs.net or telephone 0191 445 6549.

Role of Sample Taking Co-ordinator

- Act as a link for the practice/department with the other professionals in the programme and advocate for all aspects of cervical screening.
- Ensure that the screening activity taking place at that location meets national and local guidance.
- Ensure that all sample takers operating at that location are adequately trained, and participate in regular updates.
- Produce and update local protocols. See example of Practice Protocol (Appendix 5).
- Disseminate information from the Screening and Immunisation Teams and other relevant bodies to all sample takers at that location.
- Inform their employer and the Screening Imms Team of any concerns from (or about) sample takers operating at that location.
- Support sample takers to:
- Comply with national guidance & quality standards.
- Undertake self-audit.
- Monitor attendance of sample takers at update training.
- Monitor sample taker performance data and act accordingly.
- Monitor the performance of the practice with regards to the NHSCSP such as coverage and non-attendance.
- Ensuring processes are in place to respond to failsafe enquiries and that sample takers follow these.
- Register the sample takers at their location on the Cervical Sample Taker Database.
- Ensure the list of sample takers practicing at their location is kept up to date on the Cervical Sample Taker Database.
- Regularly access the Cervical Sample Taker Database as a performance monitoring tool.
- Ensure that the sample taking status of the sample takers at their location is up to date on the Cervical Sample Taker Database.
- Ensure that their personal details are up to date on the Cervical Sample Taker Database.



This document was issued in September 2017. The guidelines are now implemented in all of the cytology laboratories in the North East. It is available from www.gov.uk

Screening Intervals

Age Group (years)	Frequency of Screening
24½	First invitation
25-49	3 yearly
50-64	5 yearly
65+	Only screen those who have not been screened since age 50 or those who have had recent abnormal tests

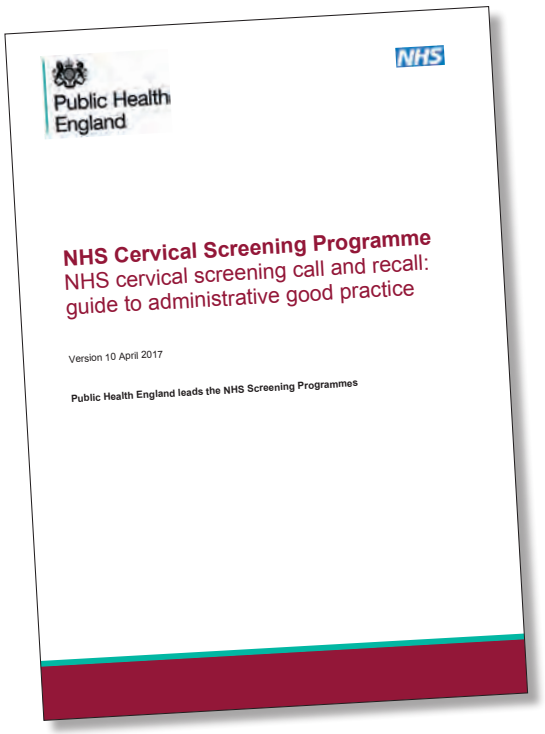
The administrative tasks associated with the call and recall of women within the NHS Cervical Screening Programme are undertaken by the Primary Care Support England.

These tasks include:

- Ensuring all eligible women aged 25-64 are included in the screening programme.
- Inviting all eligible women to attend for screening.
- Notifying women of their test result.
- Ensuring appropriate follow up/recall.

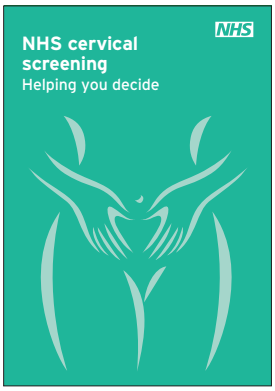
Call and Recall

The NHS Cervical Screening call and recall: Guide to Administrative Good Practice (Version 10 2017) is an updated version and lays out the basic principles and requirements for the call and recall service. The document can be accessed from www.gov.uk.



Ensuring eligible women are included in the screening programme:

- Ensure all women are included in the programme by their 25th birthday.
- Ensure all women aged 25–64 and registering in the area for the first time are included in the programme.



Cervical Screening leaflets can be downloaded in PDF format, in several languages from the NHSCSP website: www.gov.uk.
At the point where the PNL's are being checked and returned to the PCSE, it is a good opportunity to send a leaflet to a woman whose language is not English, to ensure that she has the opportunity to read this information.

Available in several languages, large print, Braille and audio format.

Inviting Eligible Women:

- Send the NHSCSP leaflet 'Helping you Decide' with all invitation and reminder letters.
- If invitation letters are returned 'undelivered' set recall status to ensure new letter produced on receipt of new address.

Recording and notifying test results:

- Return any results which fail system validation checks to the laboratory for clarification.
- Notify the woman's GP if the result letter is returned 'undelivered' and set the call/recall system to ensure a new letter is produced on receipt of a new address.
- Send the result letter to the address given by the woman at the time of her test, unless records show she has moved since that date.

Ensuring appropriate follow up / recall:

- Send non–responder notifications to GP practices for any women who fail to respond to the two invitation letters.
- Send notification to GP practice for any newly registered women who are on early recall.
- Set the computer system to ensure screening histories for women who move to live in another area, are transferred on a daily basis.

Gender reassignment

- Where someone has gender reassignment, they have the right to be registered with the NHS under their new gender. The document, NHS cervical screening call and recall guide to administrative good practice, sets out guidelines for practice.

Summary of Primary Care Support England and Practice Responsibilities for Programme Management

PCSE	PRACTICE
Call and Recall	
Ensure all woman are included in the Programme. Check with the GP Practice to ensure invitation is appropriate (Prior Notification Lists or e-PNL) Send a disclaimer letter to women who wish to withdraw from screening and are fully aware of what this involves.	Complete and return Prior Notification Lists (PNL). GP or PN to sign/authorise PNL if a woman is removed for any other reason than moved away. Ask Primary Care Support England to postpone invitation if appropriate: • Sample not appropriate at time. • Fully informed woman who declines current invitation. Practices should email any Ceased, Deferral, and Amendment to Cytology forms to pcse.enquiries@nhs.net before the cut off shown on the Open Exeter PNL to avoid inappropriate invitations.
Invitation	
Send the woman an invitation 4-6 weeks before sample is due. This is 1st invitation letter. Send reminder letter 18 weeks later if the woman fails to respond to the invitation. This is 2nd invitation letter. 12 weeks later send non-responder card to the practice if no result is received after 2 invitations. At this point the women is returned back into the system for appropriate months depending on the result of her last test. (At this point the practice can exception report the lady as she has been invited 3 times in the preceding 12 months).	Flag records for discussion when woman next attends the practice. The practice can exception report the woman as she has been invited three times in preceding 12 month period. Practice should send 3rd invitation letter to women who have not attended. Sending a 3rd invitation letter is a requirement of the GMS contract. (See Appendix 1)
Sample Taking	
NHS England are responsible for commissioning suitable and adequate cervical screening services.	Obtain informed consent in accordance with the Helping you Decide leaflet. Agree with the woman how she will be informed of the result. Take cervical sample according to national guidance (see section 3). Complete request form with accurate name, demographic and clinical details, sampler used, previous abnormalities, treatment & HPV discussed with the woman. Record sample taker code on request form. Document the consultation. Give woman information on results and possibility of Direct Referral. Verify the sample labelling and send the sample on the same day to the laboratory.

Summary of PCSE and Practice Responsibilities for Programme Management

PCSE	PRACTICE
Results	
Send the woman result letter (unless asked not to). Notify the sample taker/GP practice if for any reason the result cannot be sent.	• Always give the woman her test result in person if invasive. Ensure appropriate referral is made. • If urgent referral is required, the woman should be notified on a personal basis in a manner that is appropriate for her individual circumstances. • Document result in medical records.
Managing Non-Attendees/Failsafe	
Send non-responder card to practice if no result received after two invitations. (3rd invitation must be sent by practice).	Fully inform the woman of implications of non-attendance, preferably face-to-face. Urgency depends on the situation: • Call/routine recall – flag record for discussion when the woman next attends practice. • Early repeat sample – flag record and ask the woman to attend practice. • Non-attendance at colposcopy – flag record and ask the woman to attend practice. • GP is responsible for ensuring colposcopy has taken place even if direct referral operating. • GP responds to laboratory failsafe enquiry.
Ceasing Policy	
Only cease women who fulfil criteria or who have asked in writing to be removed from the screening programme. Ensure that they have received sufficient accurate information to make an informed choice. Ensure the woman has been advised in writing of how she can be included in the programme at a future date should she change her mind. **For further information see:** NHS Cervical Screening Programme NHS Cervical Screening: Call and Recall Guide to Administrative Good Practice. Withdrawing from the NHS Cervical Screening Programme: interim guidance, NHSCSP October 2009. Both are available at www.gov.uk	Ask PCSE to cease recall due to: • Age. • No cervix. • Radiotherapy for cervical cancer. • Other. In accordance with current NHSCSP guidelines. If a woman requests to withdraw from the Cervical Screening Programme, ensure she has sufficient, accurate information to make an informed choice, is capable of making and communicating that choice, and that she has expressed the desire to be ceased in writing. Women are required to provide written confirmation to the PCSE of their intention to be removed from the programme and must sign the appropriately worded Disclaimer Form/letter.

Organisational Indicator for GP Practices

The following cervical screening indicators have been taken from the GMS Contract.
www.nhsemployers.org

Public health domain - additional services

For contractors providing additional services the following indicators apply.

Please note exception reporting does not apply to those additional services indicators that do not have achievement thresholds.

Cervical screening (CS)

Indicator	Points	Achievement thresholds
CS001. The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates	7	
CS002. The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years	11	45-80%
CS004. The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years	2	

CS indicator 001

The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates

CS 001.1 Rationale

If a robust system for the management of cervical screening is not in place then this is an area of great risk for general practice. The policy may have been drawn up outside the practice and is recommended to be in line with national guidance.

See guidance on exception reporting in section CS 002.1 contractor guidance.

The contractors protocol could be in the form of a written policy covering the issues outlined in the indicator wording.

CS 001.2 Reporting and verification

See indicator wording for requirement criteria.

The relevant practice staff are to be aware of the policy and the NHS CB may require that the contractor can demonstrate how the systems operate.

CS indicator 002

The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years

CS 002.1 Rationale

This indicator is designed to encourage and incentivise contractors to continue to achieve high levels of uptake in cervical screening.

The contractor may be required to provide evidence of the number of eligible women, aged 25 or over and under the age of 65, who have had a cervical screening test performed in the last five years/60 months.

This indicator differs from all the other additional service indicators in that a sliding scale will apply between 45 and 80 per cent, in a similar way to the clinical indicators.

Exception reporting (as detailed in the clinical domain) will apply and specifically includes women who have had a hysterectomy involving the complete removal of the cervix.

The exception reporting rules regarding criteria A require that three separate invitations are offered to the patient before that patient can be recorded as 'did not attend'. Therefore:

- In those areas where the first two invitations are sent via the central screening service, then contractors are responsible for offering the third invitation before exception reporting patients as DNA; or
- Where the central screening service sends out only one letter, then contractors are responsible for offering the second and third invitations before exception reporting patients as DNA.

The exception reporting criteria is not applicable to contractors that have opted to run their own call/recall system. These contractors will still be required to offer all three invitations directly in order to meet the DNA criteria. Copies of the letters sent by the contractor may be required for assessment purposes.

Women can choose to withdraw from the national screening programme. As the indicator requires that screening is delivered every five years, in order for a woman to be exception reported for this period, criteria G which requires that a discussion has taken place between the patient and the practitioner before 'informed dissent' can be recorded.

Women who withdraw from cervical screening call/recall will receive no further offers of screening from the central screening service.

CS 002.2 Reporting and verification

See indicator wording for requirement criteria.

The NHS CB may require that the contractor can provide a computer print-out showing the number of eligible women on the contractor list, the number exception reported and the number who have had a cervical screening test performed in the preceding five years. Contractors can exception report patients in the same way as the clinical indicators and the NHS CB may enquire how patients who are exception reported are identified and recorded.

CS indicator 004

The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years

CS 004.1 Contractor guidance

In this audit the criteria, the results, corrective action, the results of the re-audit and a discussion of them needs to be presented. The standard or level of performance against which the criterion is judged would usually involve looking for sample-takers who are obvious outliners in relation to the reading laboratory's average for inadequate samples.

CS 004.2 Written evidence

See indicator wording for requirement criteria.

The NHS CB may require that an audit of inadequate samples is recorded.

The NHS CB may also request a discussion takes place with sample-takers covering the audit and any educational needs which arose and how these were met.

For Screening and Immunisation queries please email: england.cane.screeningimms@nhs.net or call 011382 53017.

This service is for Healthcare Professionals only.

SECTION SIX

Quality Assurance

The role of the Quality Assurance Reference Centre (QARC) is to monitor and maintain minimum standards of service, performance and quality across all elements of the Cervical Screening Programme and to promote and lead the continual pursuit of excellence in these areas.

The NHSCSP published National Quality Assurance Guidelines for the Cervical Screening Programme in 1996, and has a regional system of quality assurance which includes:

- A Quality Assurance Director for Cervical Screening.
- The identification of lead professionals to oversee co-ordination of audit in each area of professional activity in the Cervical Screening Programme.
- The review of the performance of the Screening Programme against National Quality Standards.
- Facilitate external quality assessment schemes.
- An administrative structure including a Quality Assurance Reference Centre to co-ordinate professional activity, statistical returns, and liaison with national activities.
- The development of training programmes within the region and support of training efforts in each laboratory and regional cytology training schools.
- Liaising with regional cancer registries to identify and audit cases of invasive cancer to evaluate the effectiveness of the Screening Programme.

Quality Assurance Reference Centre
Blenheim House, Duncombe Street,
Leeds, LS1 4PL
0300 3038598
Public Health England leads the NHS Screening Programmes.

What to do if there is suspicion of a critical incident affecting the programme

In the last 15 years or so there have been a number of widely publicised incidents in the Cervical Screening Programme. Most of these have involved problems with the reporting of samples by cervical cytology laboratories. However, there have been examples of problems with other areas of the programme, for example the quality of sample taking, reporting of results to sample takers, the transfer of results from laboratories and problems with the quality of colposcopy.

There are robust mechanisms in place should you suspect that an incident has, or may occur that could affect the programme. In the first instance, any suspicions should be directed to the Trust Clinical Governance Team and QARC who will investigate the matter.

Physical / Learning Disabilities

It should not be assumed that disabled women are sexually inactive and therefore do not require screening. Women should not be automatically excluded from the screening programme on the grounds of any physical or learning disability.

Disabled women have the same rights of access as all other women to the NHS Cervical Screening Programme. Wherever possible women with a disability should:

- Have access to information to enable them to make their own decisions about whether or not to accept an invitation to attend for cervical screening.
- Know what to expect when they attend for screening so that it is a positive experience.
- Understand the possible consequences of screening and of not having screening and the need to be aware of changes in their own bodies.

For women with learning disabilities, as with other women, the issue of valid consent is crucial. The following points should be considered when assessing a woman's capacity to consent to cervical screening:

1. Does the woman have a basic understanding of what cervical screening is, its purpose, and why she has been invited?
2. Does she understand that the test does not always find that something is abnormal?
3. Does she understand that an abnormal test result will mean having more tests?
4. Is she able to retain the information for long enough to make an effective decision?
5. Is she able to make a free choice (i.e. free from pressure from supporters or health professionals)?

Learning disabilities alone are not a reason for not taking a cervical sample. Materials are available at: www.gov.uk to assist women with learning disabilities to make an informed choice about whether to participate in the programme or not.

It should always be assumed that a woman has the capacity to make an informed choice unless it is agreed by a combination of people acting on her behalf that this is not the case. If those acting on her behalf believe that cervical screening is not in her best interests, she may be ceased from the programme on mental capacity grounds. This is known as a 'best interest's decision'.

A small number of women with more severe learning disabilities may lack the mental capacity to make an informed choice to participate in the programme. In these circumstances a 'best interest's decision' should be made and recorded under the guidance of the Mental Capacity Act 2005.

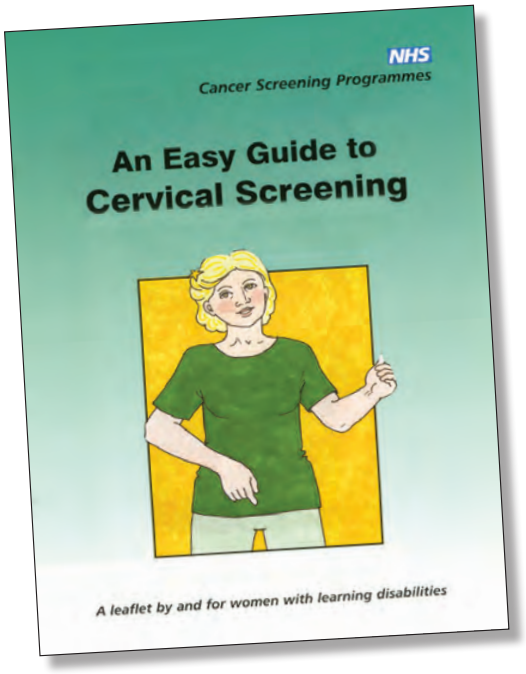
A resource pack has been developed to help sample takers and GP practise staff support women with learning disabilities in accessing cervical screening.

The pack includes: information to support assessing capacity and best interest decisions, an easy read letter that can be adapted for the third invitation, template letters for parents / carers of women considering screening and for those who are not able or do not wish to complete screening and some top tips to support admin and reception staff. To access the resources go to www.cervicalscreeningtraining.co.uk, go to 'Resources' then 'Supporting Women with Learning Disabilities'.

There are some instances in which a woman with physical disabilities may find it difficult to achieve a position whereby the cervix can be fully seen and a cervical sample taken. Some difficulties may be overcome by:

- Offering a screening venue with equipment such as a hoist.
- Offering a longer screening appointment (there are some medical conditions whereby a woman will be able to comply with screening requirements given sufficient time).

If a cervical screening test is not technically possible at a screening appointment, the woman should still remain in the call and recall programme, as increased mobility at a future date may subsequently facilitate screening.



These other resources have been developed to enable women with learning disabilities to make informed choices about attending for cervical screening and colposcopy.

Colposcopy Leaflets

What happens at the Colposcopy Clinic?

Treatment at the Colposcopy Clinic

To access the colposcopy leaflets click here.

www.cervicalscreeningtraining.co.uk, go to 'Resources', then go to 'Support for Women with Learning Disabilities'.

'The Smear Test Film' is a health education film resource for women eligible for cervical screening who have mild or moderate learning disabilities. It has been made by Public Health England in association with Jo's Cervical Cancer Trust by women who have learning disabilities to give women and their carers information about smear tests and their role in preventing cervical cancer.

To access the video click here. www.jostrust.org.uk/video-page/smear-test-film

Screening in Other Circumstances

Women with a terminal illness
Women in this situation should continue to be treated in the same way as women who do not have a terminal illness for as long as possible. This includes being invited for cervical screening as long as they are well enough. It is then the woman's decision to attend or not. Women should be treated depending on their individual situation.

Radiotherapy
It may not be possible to take a reliable sample for a woman who has undergone radiotherapy for cancer in the pelvic area. This includes cancer of the bladder and rectum as well as cervical cancer. All cases should be considered individually and a decision made by the woman in consultation with her GP practice. In some cases women may choose to defer screening or to be ceased from recall. Women undergoing radiotherapy to other parts of the body remain eligible for screening.

Female Genital Mutilation
Female genital mutilation (FGM) is a serious crime under the Serious Crime Act 2015. It is a specific type of sexual trauma. As for other types of trauma and abuse, extreme sensitivity is required from sample takers in supporting women who wish to be screened. Women who have undergone genital mutilation may have been exposed to high risk HPV and therefore remain at risk from cervical cancer. As such they should remain within the screening programme; however, taking a cervical sample should be handled sensitively and may not be possible in some cases. Every woman should be considered individually. In certain circumstances it might be appropriate to refer the woman to colposcopy. Women who have been badly injured may find it difficult or impossible for a sample to be taken. FGM is not a legitimate justification for ceasing without the full informed consent of the woman.

Pregnant/post natal women
Avoid routine screening during pregnancy. It is not advisable to sample the cervix until 12 weeks post natal. Women who are being followed up from a previous abnormality may require follow up at the Colposcopy Clinic. Seek advice from a colposcopist.

Hysterectomy
Women who have undergone total hysterectomy no longer require cervical screening. Women with a sub-total hysterectomy still have a cervix, and should therefore remain in the programme since they continue to be at risk. Detailed guidance on the management of women undergoing hysterectomy is provided in NHSCSP publication 20: 'Colposcopy and Programme Management Guidelines'. It is very important that there is absolute certainty over the type of hysterectomy before a woman is ceased from recall.

Gender Reassignment
Where someone has gender reassignment, they have the right to be registered with the NHS under their new gender. Whether screening should be offered must be assessed on a case by case basis using the guidance on Page 32.

Female to Male gender reassignment
Following the change of gender, the individual will be recorded as male on the GP registration system and will no longer receive invitations from the call and recall service. It is not necessarily the case that the individual will have undergone gender reassignment surgery. If the individual has not undergone a hysterectomy which included the removal of the cervix they are still eligible for screening and should be encouraged to attend. Where the individual chooses to continue to be screened, the GP practice is responsible for managing invitations and sample taking at the appropriate intervals and for notifying results. The practice should notify the cervical screening laboratory that results should be sent back to the practice and not to the call and recall service. When the change of gender takes place, the call and recall service must send a copy of the individual's screening history to the GP practice in a sealed envelope marked 'Strictly Private and Confidential'.

Male to female gender reassignment

Following the change of gender the individual will be recorded as female on the GP registration system and on all linked NHS national systems including cervical screening. The woman will receive automatic invitations from the call and recall system until the absence of cervix is formally notified to the programme.

Intersex

Intersex covers a range of conditions where a person's reproductive and or sexual anatomy does not fit the typical definitions of male or female. This means intersex people's gender as identified in national NHS IT systems may not reliably indicate whether they should be offered cervical screening. In this circumstance, it becomes the responsibility of the person's GP practice to provide cervical screening for those intersex people that need it, and for ceasing those that do not. For intersex people who identify as male but who require cervical screening, a similar approach should be adopted to female to male transgender patients. The GP should take responsibility for the screening process, and notify the laboratory that results should be returned to the practice directly and not to the call and recall service.

Women who are immunosuppressed

Women who are immunosuppressed may, depending on the causes of the immunosuppression, be at increased risk of developing cervical cancer. The following categories of women need more frequent screening and/or earlier referral for colposcopy:

- Women undergoing renal transplantation should have had cervical cytology within one year. If no history of CIN is present cytology screening should continue as per the national guidelines for non-immunosuppressed.
- Women newly diagnosed with HIV over 25 should have cervical cytology performed by, or in conjunction with, the medical team managing the HIV infection. Annual cytology should be performed with an initial colposcopy if resources permit.

Accessibility

The programme provides call and recall letters and information to support informed choice in English. This must be available in an accessible format. It is assumed that people who cannot read English will have access to some form of local support. Information to support patient choice is provided in other languages via downloads from the GOV.UK website (www.gov.uk), and other accessible information formats are available on request.

Further information is available at:
www.gov.uk NHSCSP Publication No 20, Colposcopy and Programme Management

The following categories do not require more frequent screening:

- Women receiving long term cytotoxic drugs for rheumatological disorders.
- Women receiving cytotoxic chemotherapy for non-genital cancers.
- Women receiving long term steroids.
- Women receiving oestrogen antagonist such as tamoxifen.

All such women should have cytological screening in accordance with National Guidelines.

For more information go to www.gov.uk where the following document is available
NHS Cervical Screening Programme
NHS cervical screening call and recall: guide to administrative good practice
Version 10 April 2017

Frequently Asked Questions

Q: Why are women under 25 and women over 65 not invited for screening?

Cervical cancer is rare in women under 20. However, infection with Human Papilloma Virus (HPV) which causes cervical cancer is very common in teenagers and women in their early 20s. Most of these infections will resolve spontaneously and do not need treatment. Screening of this age group may therefore do more harm than good.

The evidence suggests that screening can start at age 25. Lesions that are destined to progress will still be screen-detectable and those that would regress will no longer be a source of anxiety, and therefore younger women will not have to undergo unnecessary investigations and treatments.

Any woman under 25 who is concerned about her risk of developing cervical cancer or her sexual health generally, should contact her GP or Clinic.

Cervical screening is not a diagnostic tool. Women presenting with symptoms under 25 years of age, please see Clinical Practice Guidance for the Assessment of Young Women aged 20-24 (See Appendix 3).

Women aged 65 and over who have had three consecutive negative samples are taken out of the call/recall system. The natural history and progression of cervical cancer means it is highly unlikely that such women will go on to develop the disease. Women aged 65 and over who have never had a smear are entitled to a test.

Q: What should I do if requested to take a sample from a woman who is under 25 years old and sexually active?

Cytological abnormalities in the cervix, changes to formation, structure & function of the cells are common in women under 25. However these natural & harmless changes can often be identified as cervical abnormalities during screening, which could lead to unnecessary further investigations & treatment. In addition, women in this age group frequently contract the Human Papilloma Virus (HPV) which causes cervical abnormalities. If found at screening these are treated but if left alone they usually resolve spontaneously by the age of 25. Therefore taking a sample from a woman in this age group could do more harm than good.

Q: Should women who are not sexually active still have cervical screening?

Women who have never been sexually active with a man are at a very low (although not zero) risk for developing cervical cancer. In these circumstances, it is usually left up to the woman to decide after providing her with the facts. If the woman is currently not sexually active but has previously been with male partners, then cervical screening is recommended.

Q: *What should I advise a lesbian woman who attends for cervical screening and has never had sexual intercourse with a man?*

A lesbian woman is entitled to the same cervical screening interval as a heterosexual woman. Sometimes, lesbian women have been advised by health workers that they don't need screening because they don't have sex with men. Or, they may be told by other lesbians that they don't need to be screened. However, women should be offered screening and consider attending, regardless of their sexual orientation. Research suggests that although HPV is more easily transmitted through heterosexual intercourse, it can also be transmitted through lesbian sexual contact. As with other sexually transmitted infections, HPV is passed on through body fluids. This means that oral sex, transferring vaginal fluids on hands and fingers, or sharing sex toys, can all be ways of being exposed to HPV.

A leaflet from the NHSCSP for lesbian women can be downloaded from www.gov.uk

For more information go to: http://lgbt.foundation/screening

Q: *What is the likelihood of an abnormal cervical test result?*

In 2015/16, of the tests which were adequate 93.8% were reported as negative. Of the abnormal test results, 2.5% were reported as borderline. Only 0.5% were reported as moderate and 0.7% showed severe dyskaryosis.

Q: *When is the optimum time to obtain a cervical sample?*

Mid cycle is the optimum time to get a good sample. When a woman is menstruating is not the best time to take a sample, but if this is the only opportunity then it can be taken.

Q: *Can the Cervex Brush® be used when an extensive ectropion is present?*

Yes, anchor the brush in the os, rotate the brush 360° five times in a clockwise direction, then gently retract the brush from the os. Whilst maintaining contact with the cervix, use a circular sweeping action to cover the ectropion and rotate the brush again 360° twice in a clockwise direction.

Q: *What action should be taken if the cervix appears "abnormal"?*

Obtain a second opinion from an experienced colleague. Take the sample if it is due and refer immediately to gynaecology. ***Do not wait for result of the sample prior to referring.***

Q: *What happens if you drop the brush before putting it in the vial (Surepath), or before immersing the brush and swirling it around (Thinprep) or if the vial is spilt after either method of LBC?*

Do not discard the brush head (Surepath) or the vial (Thinprep). Place the brush head in the vial (Surepath) in the usual way and record the incident on the request form. If the result is abnormal the case will be reported as such, if it is negative, an inadequate result will be reported with a repeat recommended in 3 months. Each vial has 10mls of the ethanol fixative in it.

Q: What is the significance of endocervical & metaplastic cells?

The presence of either of these cells suggests that the transformation zone (where abnormal cell changes usually occur) has been sampled. This may give some indication of the adequacy of the sample.

In the follow up of women treated for cervical glandular intraepithelial neoplasia (CGIN) the presence of endocervical cells in the sample are mandatory for appropriate sampling.

See NHSCSP Publication 20 Colposcopy and Programme Management March 2016 (page 30)

In cases of possible invasion/suspicion of cancer, it is important that patients are seen within the two week guidelines. GPs have the ultimate responsibility to ensure that these patients are seen in colposcopy clinics.

Q: Does a girl aged 12 years who had the Cervarix vaccine require the Gardasil vaccine?

No she does not. From September 2013, although a different vaccine was used in the HPV vaccination programme, Gardasil, she will not require further vaccinations. Gardasil protects against the two types of HPV virus that cause more than 70 per cent of cervical cancer in England and two types of HPV virus that cause 90 per cent of genital warts. The HPV vaccination programme was implemented in September 2008 following advice from the independent experts on Immunisation. The Joint Committee on Vaccination and Immunisation recommended that the HPV vaccine should be offered routinely to females aged 12 to 13 years, and also offered a catch-up programme for girls up to 18 years of age.

Q: Is there a new HPV vaccine?

There is a new vaccine which covers the four strains (6, 11, 16 and 18) and five additional ones (31, 33, 45, 52, and 58). The latest study indicates this may provide protection against 90% of cases. Researchers found the new vaccine reduced the incidence of cancer from these extra five strains to 0.1 cases per 1,000 person-years, compared with 1.6 cases per 1,000 person-years.

It is important to note that the study was conducted in women aged 16 to 26, which is much older than the 12 to 13 age group currently offered vaccination, and may affect the results. In addition, the participants were only followed up for 4.5 years. Longer studies including other age groups are now required.

The double-blind randomised trial has shown that the new HPV vaccine provides increased protection from additional strains of HPV that cause cervical, vulval and vaginal cancers.

Strengths of the study included:

- Blinding of the pathologists to the vaccine type, and blinding of the participants (they didn't know which vaccine they had been given), which reduces any bias – a double-blind randomised controlled trial is considered the gold standard of how best to assess a treatment or intervention.
- The large number of women included in the study, with diverse ethnic backgrounds, makes it likely that the results would be applicable to most women in this age group.

However, there are some limitations:

- It was widely reported in the media that the two vaccines offer the same protection for the original four HPV

strains, but there was no direct comparison between the vaccines for their ability to protect against the four types of HPV virus. The comparison was restricted to incidence of invasive cancers and high-grade abnormalities, which may take longer to occur than the 4.5 years of the study's duration. The researchers acknowledge that longer studies are required.

- The study group were much older than the age of girls who are currently vaccinated, presumably so that they could provide their own consent to participate. This may have a bearing on the results.

Further studies will be required to address these issues before it is known whether there will be a change in the type of vaccine offered in the UK.

While vaccination is an important component in reducing the risk of these types of cancer, it is important to reduce the risk in other ways, too.

This includes not smoking, as this increases the risk of cervical cancer – chemicals from cigarettes have been found in cervical mucus, and it is thought this damages the cervix. Safe sex, such as using condoms, is also important.

Q: What is a trachelectomy?

For some women with a very early cancer of the cervix, it may be possible to have a trachelectomy. In this type of surgery the cervix and the upper part of the vagina are removed, but the rest of the uterus is left in place. The lymph glands in the pelvis are also removed. The operation may be done as an open operation or through a combination of keyhole and vaginal surgery.

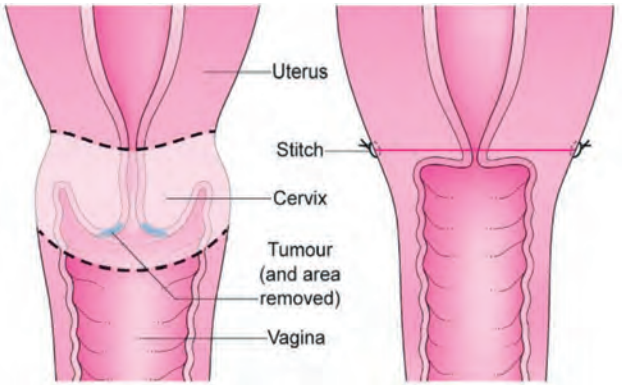
As the uterus is not removed, a trachelectomy allows for the possibility that the woman could have children. During the operation or during pregnancy, a stitch is made at the bottom of the uterus to keep it closed. There is a significantly higher chance of miscarriage or premature delivery after this procedure and the baby will be delivered early by Caesarean section [1].

Trachelectomy is only suitable for women with early stage cancer of the cervix.

This type of surgery is not common and is only done in Specialist Gynaecological Cancer Centres.

References

1. Shepherd H et al., 2006. Radical vaginal trachelectomy as a fertility-sparing procedure in women with early-stage cervical cancer-cumulative pregnancy rate in a series of 123 women. BJOG 113 (6), 719-24.



Resources

NHSCSP www.gov.uk

Jo's Trust www.jostrust.org.uk

QARC Tel: 0300 3038598

The Lesbian and Gay Foundation www.lgf.org.uk/screening

Cervical Screening Training www.cervicalscreeningtraining.co.uk

NHSCSP Publication No 25. Cervix chart for sample takers in Primary Care. April 2006. Available from Harlow Printing on 0191 496 9735

Informed Consent in Health and Social Care Research: RCN Guidance for Nurses. RCN 2011. Publication Code 002 267

Leaflets and publications are available from NHS Cancer Screening Programme website www.gov.uk
Posters available from www.sphil.nhs.uk or Tel: 016442 526 933

For further information please contact:

Cervical Screening Training
New Croft House
Market Street East
Newcastle upon Tyne
NE1 6ND

Email: michelle.harrison5@nhs.net

Tel: 0191 2292950

Information and support from

Jo's cervical cancer trust

Jo's Cervical Cancer Trust is the only UK charity dedicated to women affected by cervical cancer and cervical abnormalities.We provide information and support for women affected by cervical cancer and cervical abnormalities, raise awareness of prevention and campaign for excellence in care and treatment.

Support we can provide health care professionals

- Free materials including posters, factsheets and leaflets for you to use with your patients to raise awareness of cervical cancer and prevention. This includes information on primary HPV testing
- Films for you to share and use including a film about cervical screening in eight different languages
- Resources designed for women with a learning disability including an EasyRead guide on cervical screening
- Support for sample takers including best practice guidance for before, during and after a cervical screening test
- A wide range of research into the barriers preventing different groups of women from attending cervical screening to help inform activity to increase uptake in your area
- Insight and best practice into national and local activities that have increased cervical screening uptake
- Support to increase uptake in your area

What we can provide your patients

- Online and printed information about every aspect of HPV vaccination, cervical screening and cervical cancer
- A free national Helpline on 0808 802 8000
- An Online Forum available 24 hours a day
- An Ask the Expert service
- Support groups and events for women affected by cervical cancer

Our vision is a future where cervical cancer is disease of the past.
With your help we can get there.

For more information visit jostrust.org.uk or email info@jostrust.org.uk

APPENDICES

APPENDIX 1

Dr Drake and Partners
Riverview Surgery
1 The Pond
Duckland

Dear

I am writing to remind you that your cervical screening test is overdue. The reason for reminding you is that screening allows us to detect and treat small changes before they develop into cancer. By attending for screening you are significantly reducing your risk of developing cervical cancer.

If there is a reason that you have been put off attending I would be grateful if you could give me a call to discuss it and to allow me to update your medical records.

All the nurses that undertake screening have been trained to a high standard. The equipment we now use is all disposable and the sample which is sent to the Laboratory uses the latest technology. The number of samples which the laboratory are unable to report on has reduced dramatically which means less women will receive an inadequate result requiring a re-test.

The time between having your sample and receiving the result has also greatly improved. All women should now receive their result in writing within 2 weeks.

If you have any concerns around screening please do not hesitate contacting me either by phone or by making an appointment with me. I am available on ……

It is your choice if you do not wish to participate in screening but it is known to save lives.

APPENDIX 2

Dr Drake and Partners
Riverview Surgery
1 The Pond
Duckland

Thank you for attending for your cervical screening test which was done by

..... on .....

- The result will be sent to your home address, and also to the person who has taken your sample within 2 weeks.
- If the result is negative, which means normal, you will need to have another test in 3 years if this test was taken before your 50th birthday or in 5 yrs if you are over 50.
- If the screening result shows mild abnormalities (called borderline or mild dyskaryosis) an HPV test will be carried out on the sample. If HPV is found in the sample then you will be invited to go for colposcopy. Colposcopy involves looking closely at the cervix to see whether any treatment is needed. The laboratory will refer you to the colposcopy clinic. Only very rarely does this happen, and you will be contacted by post. It will include an information leaflet explaining about the clinic and your future care. Please do not ignore this appointment; it is important that you attend.
- If the screening result shows moderate or severe dyskaryosis you will be referred to Colposcopy.
- Sometimes, in approximately 1 - 2% of women, the sample is reported as being unsatisfactory and you will need to come back for this test to be repeated. This is no indication of an abnormal result.
- If this is your first test after treatment at colposcopy and the result is normal, borderline or mild the sample will be tested for HPV. If HPV is not found you will not need to be screened for another three years. If HPV is found, or if the screening result shows moderate or severe dyskaryosis, you will be invited for colposcopy again.
- Occasionally a reminder letter is sent by the Screening Office after you have had your sample taken but before the result is known. Disregard this and wait for your letter informing you of your result.
- If you have any unusual symptoms, such as bleeding after sex or between your periods, please make an appointment to see the Doctor or Nurse.
- If you have any questions or concerns between tests please contact .....

APPENDIX 3

NHS

Clinical Practice Guidance for the Assessment of Young Women aged 20-24 with Abnormal Vaginal Bleeding

Background

A recent review by the Advisory Committee for Cervical Screening recommended no change to the age of commencing cervical screening and that the screening range would remain at 25-64 years.

This decision was based on the potential for more harm, through morbidity consequent to screening, than benefit achieved by preventing cervical cancer. It was recognised, however, that in the rare cases of cervical cancer which do occur in women younger than 25 years (around 50 per year, with 0-5 deaths). There is a delay in diagnosis in a significant proportion because of delayed pelvic examination following self-referral with abnormal bleeding. The explanation for these delays, which have been documented at 4-6 months in some cases, is that relatively common symptoms of abnormal vaginal bleeding may be attributed initially to dysfunctional bleeding, or related to oral contraceptive use. The ACCS recommended the development of clinical practice guidance, which would reduce the risk of a delayed diagnosis of cervical cancer, by identifying those women most at risk of cervical cancer.

The Size of the Problem

The number of women aged 20-24 years who develop cervical cancer is generally fewer than 50 cases per year and this will fall over the next 10 years as a consequence of the national HPV vaccination programme. By contrast abnormal vaginal bleeding is relatively common in this age group. It has been estimated from a general practice dataset in Scotland (unpublished) that postcoital bleeding is reported by around 1 in 600 women aged 20-24 per year. Intermenstrual bleeding is more common than this and it may be that 0.5-1% of women in this age present with abnormal vaginal bleeding each year. There are around 1.5m women aged 20-24 in England and it could, therefore, be estimated that 7,500 – 15,000 women per year will report abnormal vaginal bleeding. In practice the number could be larger than this.

Developing a Guidance for Clinical Practice

The cardinal symptom of cervical cancer in this age group is postcoital bleeding, but persistent intermenstrual bleeding, which is more common, also requires attention. The critical intervention in the diagnosis of cervical cancer is an immediate speculum examination as recommended by SIGN2 and NICE3 Guidance, to enable a clear view of the cervix. Following a relevant history, it is, therefore, necessary for women who present with postcoital bleeding or persistent intermenstrual bleeding to be offered a speculum examination either in primary care or at a GUM clinic. This could be performed by a practice nurse experienced in cervical screening.

If the cervix looks abnormal and suspicious, which will be the case in a very small proportion, the correct action is urgent referral to colposcopy under the 'two week wait' rule. If there is a benign lesion, such as cervical polyp, a routine gynaecological referral will suffice. If the cervix looks normal, the recommended action will be a pregnancy test and testing for cervical infection (e.g. Chlamydia, N Gonorrhoea, Herpes), which could be performed in general practice, family planning clinics or GUM clinics. Any positive tests for sexually transmitted infections would need to be appropriately treated.

This pathway is illustrated below.

The impact of this guidance will be monitored by the Advisory Committee for Cervical Screening.

NHS Cancer Screening Programmes produce *Cervix chart for sample takers in primary care*, with pictures of the cervix showing various abnormalities. Copies of the chart can be ordered from www.orderline.dh.gov.uk, quoting NHSCSP publication No 25.

References

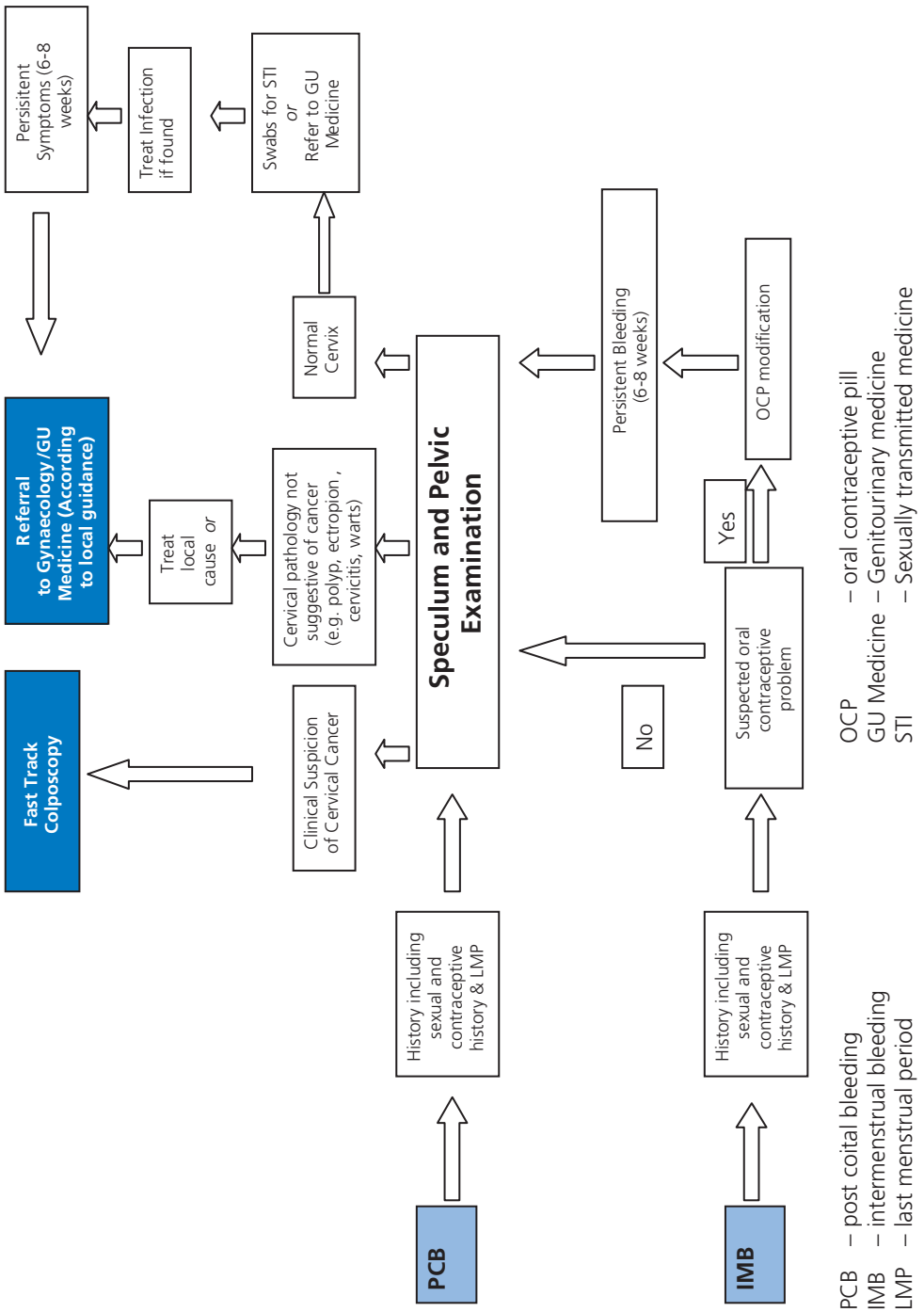
1. Cancer Research UK Cancer Stats, Cervical cancer mortality by age http://info.cancerresearchuk.org/cancerstats/types/cervix/mortality/index.htm Accessed 25th January 2010.

2. Scottish Intercollegiate Guidelines Network (SIGN). Guideline 99, page 4, Management of Cervical Cancer, January 2008, Edinburgh, http://www.sign.ac.uk/pdf/sign99.pdf Accessed 25th January 2010.

3 National Institute for Clinical Excellence (NICE)/The National Collaborating Centre for Primary Care (NCC-PC) Referral guidelines for suspected Cancer in adults and children, page 68. June 2005. http://www.nice.org.uk/nicemedia/pdf/CG027fullguideline.pdf Accessed 25th January 2010.

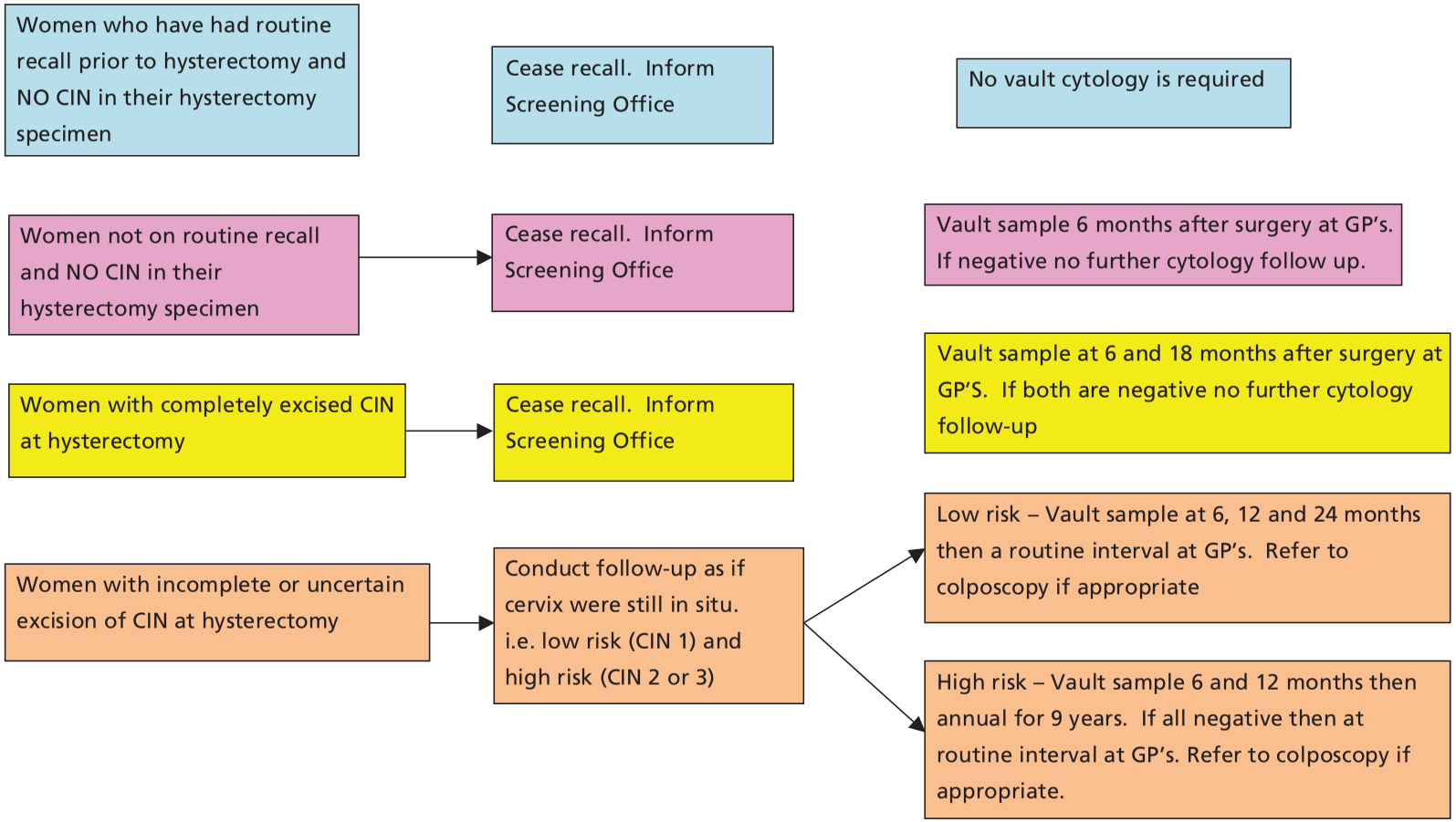
This guidance was developed by a working Subgroup of the Advisory Committee on Cervical Screening:

HC Kitchener	(ACCS Chair)
C Sonnex	(ACCS, GUM)
J Butler	(DH, Gynaecology)
S Firth	(ACCS, GP)
K Moss	(ACCS, GP)
M Shafi	(ACCS, Gynaecology)
P Walker	(Invited member, Gynaecology)


PCB
IMB
History including sexual and contraceptive history & LMP
History including sexual and contraceptive history & LMP
Speculum and Pelvic Examination
Suspected oral contraceptive problem
No
Yes
Persistent Bleeding (6-8 weeks)
OCP modification
Clinical Suspicion of Cervical Cancer
Cervical pathology not suggestive of cancer (e.g. polyp, ectropion, cervicitis, warts)
Normal Cervix
Fast Track Colposcopy
Referral to Gynaecology/GU Medicine (According to local guidance)
Treat local cause or
Swabs for STI or Refer to GU Medicine
Treat Infection if found
Persisitent Symptoms (6-8 weeks)
PCB – post coital bleeding
IMB – intermenstrual bleeding
LMP – last menstrual period
OCP – oral contraceptive pill
GU Medicine – Genitourinary medicine
STI – Sexually transmitted medicine

v

VAULT SAMPLE



Ref: Luesley D & Leeson S. Colposcopy and Programme Management NHSCSP Publication No. 20, second edition 2010

APPENDIX 5

Example of Practice Protocol for Cervical Screening

AIMS	To reduce mortality and morbidity from cervical disease, to work in accordance with the NHS cervical screening programme, and to promote sexual health of the practice population
OBJECTIVE	• to encourage attendance for cervical screening • to promote patient understanding and awareness of the procedure and the implications of screening and follow-up • to adhere to a systematic call and recall system • to promote sexual health opportunistically where appropriate • to perform the sample tests effectively and minimise physical and psychological distress
CLIENT GROUP – INCLUSION	In accordance with National Guidelines • consenting patients between the ages of 25 and 64 with an intact uterus or partial hysterectomy where the cervix has been left in place • only screen those who are 65+ who have not been screened since age 50 or have had recent abnormal tests • women being followed up for a previous abnormal sample as per local guidelines • this includes lesbian and bisexual women *(NHSCSP Colposcopy & Programme management Publication No 20 (2016))*
CLIENT GROUP – EXCLUSION	• women who have had a hysterectomy (see vault guidelines for those women who may require vault samples) • women under 25 years of age • women over 64 years of age who have had 3 consecutive negative samples Follow guidelines if ceasing women. NB: Non consenting patients or those unable to make an informed choice (learning disabilities) should be treated in accordance with local and national guidelines. *(Best Practice Guidance for the Management of Women with a 'Lack of Capacity' within the NHSCSP (2009))*

STAFF REQUIREMENTS	• all nurses with a valid NMC registration working within the NMC Code of professional conduct: Standards for conduct, performance and ethics (2015) who hold a recognised cytology course qualification or has had relevant experience. • attends update training every three years. It is required that in addition the elearning package is also completed. See www.cervicalscreeningtraining.co.uk
EQUIPMENT	• private lockable room. • couch. • moveable strong spot light. • assorted sizes of single use specula or re-usable specula sterilised to DoH standards. (The Health and Social Care Act 2008) • patient information leaflets. • swabs. • gloves - seamless, unpowdered latex or vinyl • disposable modesty sheet roll. • single use sachets of water based lubricant. • LBC sample taker kits and endocervical brushes. • disposable apron
CLINICAL ASPECTS	
ACTION	**RATIONALE**
• act at all times in a manner which maintains the woman's dignity and safety (psychological and physical) • Offer a Chaperone *(RCN 2006) Chaperoning: the role of the nurse and the rights of the patient; GMC (2013) Intimate examinations and chaperones.*	• maintenance of woman's dignity and confidence in the screening programme • to protect the dignity and rights of the patient, and to protect the healthcare professional from any future accusation of malpractice • ensure understanding • gain informed consent
• explain and discuss procedure including rationale, limitations of sample test, abnormal results and follow-up procedure • adhere to the principles of infection control e.g. handwashing, decontamination of equipment (DoH The Health and Social Care Act 2008)	• to protect self and client from contamination
• take a general and sexual health history, including discussing the possibility of an HPV test	• to determine suitability for screening and contributing factors which may influence the procedure and laboratory screening
• take the sample using the appropriate technique ensuring: - full visualisation of cervix - sampling of transformation zone in its entirety 360° sweep x 5 • if procedure unsuccessful refer to appropriate practitioner.	• ensure adequate sample to enable efficiency of screening programme • to obtain adequate sample

ADVICE & REFERRAL Post procedure advice: • reassure, give appropriate leaflet and information to ensure the woman is fully informed about all aspects of procedure, follow up, including direct referral and how patient will be informed of results	• minimise anxiety and maximise confidence in screening programme
RECORD KEEPING In accordance with NMC recommendations written and computerised records will be maintained including relevant history and any abnormalities e.g • post coital bleeding or pain • inter-menstrual bleeding • post menopausal bleeding • unusual vaginal discharge • appearance of cervix	• protects welfare of patient and clients. *(NMC The Code 2015)*
AUDIT • All sample takers should be registered on the CSTD(Cervical Sample Taker Database) • All sample takers should audit a random sample of a minimum of 20 consecutive samples annually including the adequacy rate • Use individual sample taker code on all requests • Receive annual individual feedback from laboratory to include Tz sampling rate for women aged 25-50 years • Monitor population coverage	• ensure individual sample taker is able to monitor personal performance • assess whether any local health promotion campaign would be required
SYSTEMS A system should be in place to ensure • a named individual in each practice is the Sample Taking Coordinator, responsible for overseeing the running of the screening programme • That there is a system in place for notifying women of their test results in writing • That a register of samples taken is maintained • That results are received for samples sent to the laboratory – this can be achieved by using a specific record book or relevant Read codes on the computer • Abnormal results are acted upon appropriately • That action is taken on a non-responder (defaulter) notifications from the PCSE • Consider sending a 3rd invitation letter. • That a women receives her result in person when urgent referral is required • That arrangements are made for women who fall outside the call and recall system to be given their results • That systems are in place for referring women for who Colposcopy is required • That a fail-safe system operates for defaulters for routine cytology, and for follow-up after an abnormal result or treatment *(NHSCSP Publication 21 2004)*	• ensures responsibility and accountability framework in place • minimises clinical risk • enabling monitoring of uptake to meet national targets • best practice

This document is available to download from
www.cervicalscreeningtraining.co.uk

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