Hertfordshire
Cervical Screening
Programme Guidelines

February 2016

The guidance is accurate at publication but subject to change and is agreed and updated annually by the Hertfordshire Cervical Screening Programme Management Board.
# HERTFORDSHIRE CERVICAL SCREENING PROGRAMME GUIDELINES

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1. INTRODUCTION

The purpose of these guidelines is to provide all staff involved in Cervical Screening with a detailed guide to how the programme works. The document gives information on call/recall, laboratory procedures, clinical guidelines, nurse training and the GMS contract.

The Hertfordshire programme guidelines have been produced using relevant sections from publications which are produced by the NHS Cervical Screening Programme (NHSCSP). The NHSCSP publishes guidelines, policy documents and good practice information and are available in full at http://www.cancerscreening.nhs.uk/cervical/publications/numbered-index.html

2. THE CERVICAL SCREENING POLICY

The provision of the cervical screening programme is the responsibility of NHS England and Public Health England Midlands and East (Central Midlands). The Director of Public Health is responsible for ensuring the programme is available to the population, The Screening & Immunisation Lead is responsible for ensuring that policy is adhered to and that the performance targets are monitored and met. The Public Health England Screening Manager is responsible for updating this policy and co-ordinating the services. A multi-disciplinary cervical screening Programme Management Board meets three times a year. This group reviews performance against KPIs, provides guidance, advice and helps to determine policy.

The screening interval policy is as follows:
- **Call:** Inviting women for their first test six months before their 25th birthday.
- **Recall:**
  - Routine Recall aged 24½-49 every three years.
  - Routine Recall aged 50-64 every five years.

The first test taken after a woman’s 50th birthday will move them to 5 year recall.

The Call/Recall programme is operated by the Primary Care Support Services (PCSS).

3. THE CALL/RECALL SYSTEM

This section is taken from NHSCSP publication no.18: http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp18.html

The Call/Recall system uses the Open Exeter population database that contains details of all patients ‘registered’ with a Hertfordshire NHS GP.

The PCSS team receive approximately 70,000 cervical screening results each year that are entered onto the Hertfordshire Open Exeter database. When results are authorised by the cytology laboratories they are sent to the Hertfordshire database electronically using the Open Exeter system. This ensures that test results recorded on the Hertfordshire database are recorded exactly as the Laboratories reported them. By inputting the test date and result code, the woman’s record is updated with a recall date. This is the date when her next test is due. The recall date is a key date that is used throughout the call/recall cycle. Pre populated and printed HMR101 cervical screening request forms downloaded from Open Exeter should accompany samples, this facilitates both results to be sent electronically and matched to the correct woman. Instructions on using Open Exeter to produce HMR101 forms can be found in Appendix 3
3.1 Prior Notification Lists

Prior Notification Lists (PNLs) are produced weekly and sent electronically via Open Exeter to all general practices, they contain details of women who are due for cervical screening. The details should be checked against the patient’s records to confirm that the invitation is appropriate and will be sent to the woman’s most recent address. For example, she may have had a test that is not included on the database or there could be a reason why she should not receive an invitation. The GP is given three options for each woman included on the PNL:

- **Invite**
- **Postpone** – the GP must specify a valid reason for postponement and the new recall date. Under normal circumstances the period for postponement will be no more than 12 months, and under no circumstances must it be greater than the routine recall interval specified so the maximum time for postponement from recall is 5 years. It is recommended that women who refuse screening and disabled women are not postponed but instead continue to receive their invitations (recall and reminders). Should the woman choose not to attend screening she will move on through the system as a Non-Responder.
- **Cease** – this will permanently remove the woman’s name from the screening programme. The GP must specify a valid reason for ceasing and the PNL must be signed by an authorised signatory within the GP’s practice to confirm the instruction.

For women that should be postponed or ceased, this information should be recorded on the ePNL and electronically returned to PCSS. Practices using ePNLs and Open Exeter can request for women to be ceased as an audit trail exists to record the action from the GP.

There is a requirement to record a reason when either postponing or ceasing a woman from the call/recall system. The ePNL menu and Action Sheets and PNLs provide the options that are available. If no action is taken from the ePNLs, women who are due for screening will all be issued an invitation.

The practice is accountable and responsible for any changes they make to the ePNL and for checking and returning them to PCSS. The checking of ePNL’s should be included in the practice protocol for screening.

3.2 Invitations

Standard worded invitation letters are used throughout the programme. Invitations are sent six weeks prior to test due date. These are in the form of a personalised invitation letter that Hertfordshire PCSS send to women on behalf of their GP.

Hertfordshire PCSS send invitation letters for all practices in Hertfordshire. All first invitation letters include the Cervical Screening information leaflet. When a woman attends for a test, the patient’s NHS number, DOB and postcode must be recorded on the request form and vial. The HMR101 request form must be completed and the preferred option for this is the use of pre-populated forms downloaded from the Open Exeter system. Instructions on how to download pre populated HMR101 forms can be found in appendix 3

NHS number is a primary identifier so is used throughout the cervical screening programme by the Call/Recall service, Labs and Colposcopy Clinics.

All letters issued from Hertfordshire PCSS are in English, the letter library of invitation and result letters is found in appendix 9. Some women will be unable to understand the letter because they are non-English speaking or cannot read English. NHS Language Line offers a free and confidential telephone translation service. A call to NHS Language Line with someone reading the letter out initially in English will enable a translation to be offered in the relevant language.
The Language Line number is 0845 310 9900. It is thought that there may be a number of patients registering where English is not their first language.

**Learning Disabilities** - If after receiving an invitation the carers and/or practice decide that trying to take a sample on this occasion is inappropriate please notify the screening team at PCSS who will defer the invitation for a further 3 or 5 years.


### 3.3 Reminders

A reminder is sent if women have not attended for a test within three months of being invited. This means PCSS issue two letters in total – an invitation for screening then a reminder if no result is entered on Open Exeter.

### 3.4 Final Non-Responders

Non-Responder (NR) notifications are produced by PCSS and emailed to the GP if a woman does not respond to the 1st invitation and a subsequent reminder. The Call/Recall Programme subsequently re-includes women that have become a Non-Responders after a period of time. When a practice is informed that a woman is a Non-Responder they should send a second reminder to the woman (third invitation for screening) before exception reporting them in line with QOF CS002.

The table below describes the time intervals for invitation letters and notification of non-responder status for screening

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<td>ePNL sent to GP weekly to verify appropriateness and accuracy of proposed invitation, and then return to PCSS</td>
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<tr>
<td>First invitation to patient 6 weeks prior to test due date</td>
<td>Letter to patients address</td>
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<td>Second invitation to patient 12 weeks after issue of first invitation</td>
<td>Letter to patients address</td>
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<td>Non-Responder Notification to GP 14 weeks after issue of second invitation letter</td>
<td>Good practice is GP to send 3rd invitation letter in order to exception report (ref QOF CS002)</td>
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3.5 Attending for screening

- When women attend for their tests, it is important to explain the process and to give information on the benefits and limitations of screening. Some practices give an advice leaflet to women when they attend giving information on what happens after they have attended. This may answer some questions patients may be unwilling to ask when they have the test.
- It is important that patients are told about HPV testing and that their screening sample may be tested for HPV.
- It is important that patients are told how and when they will be notified of the result.
- Women should be advised that the screening test can never be 100% accurate.
- See Appendix 1 for taking an LBC sample.

3.6 Result Notifications

- GPs and clinic doctors are asked to record sample results (written/electronic), and preferably to retain their copies of the sample reports. This is particularly important when there has been an abnormal sample in the past. Should there be any enquiry regarding a sample report, there is much more helpful information (e.g. laboratory slide number) on the actual form than is likely to be logged in any record book or computer record. Sample takers are recommended to log results received against their records of samples taken.
- It is good practice to keep a record of samples sent, results returned, women ceased and in suspension. This should be checked regularly and should form the basis of the practice fail-safe system.
- Hertfordshire PCSS issue result letters Monday to Friday to all women for all results. The only exception to this is for tests done in Colposcopy clinics or non-NHS tests, when the taker of the test will issue the result. Any tests entered onto the system taken more than 6 months prior will not generate a result letter.
- Standard word result letters are used throughout the programme. Women should receive their result in writing within 14 days of attending.

4 POSITIVE AND ABNORMAL RESULTS

The information provided in this section is taken from the NHSCSP national guidance on failsafe in the programme, which the Hertfordshire cervical screening multi-disciplinary team also endorse. [http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp21.html](http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp21.html)

4.1 Positive/Abnormal result notification

A patient may have an abnormal test and is placed on early recall. In these cases Hertfordshire PCSS will advise her of her result and will also issue her with an invitation when her repeat test is due, using the procedure described earlier.

A patient having an abnormal result which requires colposcopy assessment is ‘suspended’ from the recall system for 12 months whilst she undergoes investigation or treatment at a colposcopy clinic. Hertfordshire PCSS issue result notifications to these women advising them of their result and letting them know they will be contacted by the local hospital’s colposcopy service to arrange a suitable appointment for them. The reporting laboratory sends abnormal results direct to the colposcopy department so they have information available to book appointments as required. When the woman has been discharged from colposcopy her cervical screening recall date will be amended on Open Exeter by PCSS as advised directly by colposcopy. The return to
recall date will be shown on the Cytology Report on the cytology report page not on her Cytology History page on Open Exeter. Tests taken by hospital consultants will not have a result letter produced by the PCSS. It is the responsibility of the colposcopy unit to issue test results to their patients.

5. FAILSAFE PROCEDURES


5.1 NHS England and Primary Care Failsafe

The local NHS England team monitor that failsafe procedures are in place in the
- Laboratory
- Call/Recall system
- Colposcopy clinic

And that all failsafe procedures are linked and co-ordinated. These systems are audited annually.

PHE has to satisfy itself that GPs, or the responsible clinician and colposcopy staff have in place systems to ensure that all reasonable steps are taken to contact women who are the subject of laboratory failsafe enquiries.

All tests taken by a hospital consultant will not have a result letter produced by the PCSS system and it is the responsibility of the consultant to inform women of the result.

Failure of a GP or the responsible clinician to respond to laboratory failsafe enquiries is a clinical governance and patient safety issue and will be dealt with as such (NHSCSP publication number 21, page 16).

Watford Laboratory sample takers should print their name and their NMC number (if a practice nurse) or GMC number (if a GP) so that they can be correctly identified as responsible for the sample. When a new potential sample taker joins the practice, they should inform the laboratory so that they can be added to the sample taker register if appropriately trained.

Sample takers requesting tests are responsible for:
- Ensuring the test is appropriate
- Ensuring they are appropriately trained
- Ensuring there is a system to notify women of their test result in writing
- Ensuring that arrangements are in place for women who request ‘no correspondence’ (also to include temporary residents and women not registered with a GP) to obtain their results
- Checking that for each test sent to the laboratory a result has been received
- Following up on women who they have been advised are non-responders or who have not attended for an early repeat test
- Giving a woman her test result in person when an urgent referral is required. In Hertfordshire the laboratory will contact the surgery direct when a test is reported as
  - ? invasive or ?glandular neoplasia, so the woman can be immediately contacted by the GP practice and advised of her result in person.
- Referring a woman for colposcopy if required following screening is dealt with via ‘direct referral’
- Following up on any women who the colposcopy clinic have advised them failed to attend
- Responding immediately to failsafe enquiries by the laboratories
5.2 Laboratory Failsafe

The laboratory operates a failsafe system for women who require referral to colposcopy indicated by the Action code S on the cytology report. A direct referral system is in place whereby the laboratory forwards a copy of the test result to the Colposcopy clinic, later checking that it has been received.

The laboratory will check within six weeks that the woman has been seen in the clinic and records the result or contacts the GP if necessary. If the laboratory has no information from colposcopy after six months a letter will be sent to the GP and Colposcopy clinic to ascertain any reason for non-attendance, these actions will be recorded, the call/recall team informed and failsafe will be closed.

5.3 Call/Recall Failsafe

The NHS Cervical Screening Programme requires women to be re-invited for a test if they are still suspended from the recall system after 12 months. Invitations will be issued to women 12 months after her abnormal test unless she has either had a further test already or her GP has indicated that an invitation should not be issued at this time.

The Call/Recall software provides a further mechanism for ensuring that if women with an abnormal test move out of the county they shall be quickly included in the new area’s screening programme to continue their care.

There are occasions when a woman will have a test reported as normal, but gynaecological referral is recommended. This may be when there is an incidental finding such as abnormal cells from the lining of the uterus, non-cervical abnormality that require hospital assessment or treatment, or other clinical reasons for referral.

5.4 Colposcopy Failsafe

Colposcopy clinics, as part of their failsafe, are responsible for the following:
- Making and sending appointments to women referred for colposcopy.
- Sending reminder letters or second appointments to women who do not attend.
- Notifying GPs and responsible clinicians of women who do not respond to invitation letters or appointments.
- Informing women of the results of investigation or treatment and discharging them back to their GP or the responsible clinician.
- Informing Call/Recall firstly of discharge from colposcopy to ensure ‘suspend’ from her recall is removed on her Open Exeter record. Secondly to confirm date of next screening recall so this can be added to Open Exeter. Cytology sample takers should check the Cytology Report page on Open Exeter.
- Responding to, and acting on, failsafe enquiries from laboratories.

5.5 Annual Screening and follow-up

Hertfordshire PCSS receives notifications from West Hertfordshire Hospitals (Watford), Addenbrookes, Wycombe, Stoke Mandeville, Princess Alexandra Hospital, Harlow and Barnet and Chase Farm Hospitals when patients should be placed on follow-up after colposcopy. These are acted upon to ensure the appropriate recall.
6. **CEASING GUIDANCE**

6.1 **Ceasing Policy**

The information provided in this section is taken from the NHSCSP national guidance on ceasing, good practice publication no. 1, which the Hertfordshire cervical screening multi-disciplinary team also endorse.

http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp01.html

Women should only be ceased from cervical screening call and recall as follows:

- following the first test after their 60th birthday if they are on routine recall
- persistent Non-Responders should be ceased from recall on their 65th birthday
- women making an informed choice that they do not want to have future screening
- women who have undergone radiotherapy for cervical cancer
- the ‘absence of cervix’ marker is used for
  - women with a total hysterectomy
  - male to female transsexuals
  - congenital absence of cervix.

The following women should not automatically be ceased from cervical screening call and recall:

- women who have never had sex with a man
- terminally ill women
- women who have been circumcised
- women with physical disabilities (including severe arthritis and obesity)
- women with learning disabilities
- when ‘clinical’ or ‘medical’ reasons alone are cited.
- Female to male transsexuals if still have a cervix

Women who are mentally competent yet have a disability that prevents them from having regular screening can make an informed decision to be ceased from the programme, but only at their expressed wish. Some of these patients are unable to sign the written withdrawal form, in these circumstances it is acceptable to cease if the patient has given a verbal instruction that has been witnessed by 2 members of staff. In this situation please ensure a standard disclaimer form is completed with signatures of two witnesses and sent to the screening team at PCSS, who will in turn write to the patient at the verified address to confirm that her name has been removed from the programme.

Practices requesting to cease a patient’s recall must submit the relevant documentation with an authorised signature.

6.2 **Women with disabilities and those who lack the mental capacity to consent**

It is recommended that women who are disabled are not postponed but continue to receive their invitations. Should the woman choose not to attend screening she will still move on through the system as a Non-Responder. The decision whether or not to participate in cervical cancer screening involves consideration of the benefits and disadvantages of the screening process.

People with learning difficulties may benefit from information materials in more accessible formats. The NHS Cancer Screening Programme have produced picture leaflets entitled "An Easy Guide to Cervical Screening" which may be helpful in explaining the screening process and enabling people to make their own screening decisions. These can be downloaded from the website at www.cancerscreening.nhs.uk

A woman who lacks the mental capacity to consent to screening can only be permanently removed from a screening programme when a ‘best interests’ decision to do so has been taken
on their behalf. In most cases, the least restrictive option is for that woman to remain in call/recall and receive screening invitations at routine intervals. The invitations can be considered and accepted or declined on each occasion. See Appendix 7 for Best Practice Guidance for Management of Women with a Lack of Capacity within the NHS Cervical Screening Programme.

6.3 Disclaimers – women who do not want to attend screening

Wherever possible, patients should remain on the Call/Recall system as ‘Non-Responders’. It’s recommended that women who refuse screening and disabled women are not ‘postponed’ but instead continue to receive their letters (recall and reminders). Should the woman choose not to attend screening she will still move on through the system as a Non-Responder. If she chooses to withdraw from the screening programme she can then sign a disclaimer. If a patient insists that she does not wish to attend cervical screening she can be invited to read and sign a disclaimer form to permanently remove her name from the recall register thus ceasing her from the programme. Please copy and only use the form in appendix 5 for this purpose. Only women making an informed choice not to participate in the screening programme should sign a disclaimer. The disclaimer states the woman is making an informed decision, she understands the benefits of cervical screening, she is taking responsibility for her decision to be removed from the programme and she understands that she will not be contacted or invited for screening again by NHSCSP (appendix 5). The original signed disclaimer should be retained in the medical record, a copy sent into the PCSS screening section and a copy given to the woman. Women should be encouraged to read the national cervical screening leaflet and should be counselled as part of their decision making process.

The wording of the disclaimer form is taken from the published guidance ‘Consent to cervical screening’. The wording has been approved and considered appropriate by the legal advisors to the NHS screening programme. If you have a letter within the practice that has previously been used for this purpose, you must now use the standard version in this policy.

Disclaimers that do not meet the required standard of information will be returned to the practice / sender and the woman will not be ceased.

It should be noted that despite the woman’s name being withdrawn from Call/Recall, she remains part of the eligible population.

The national guidance, issued in 2008, Cancer screening publication no. 4 indicates that Call/Recall programmes are unable to cease a patient due to woman’s choice without their written consent.

(Please remember to send a copy of the signed disclaimer form to Hertfordshire PCSS, otherwise the woman will not be taken out of the recall programme.)

6.4 Notifications relating to women ceased from Call/Recall

Advice /confirmations are sent electronically to GPs when a woman is ceased from the programme that is registered with their surgery to notify them of the reason for ceasing

A letter is sent by PCSS to all patients being ceased from the programme to notify them that they have been ceased from the programme and inform them of the reason why.
7. **GENERAL CERVICAL SCREENING QUERIES**

7.1 No trace test reports

When Hertfordshire PCSS has received a test report and the patient's details cannot be traced on the computer database, searches are made on the national strategic tracing service to trace their registration. If unsuccessful, form R106 is sent to the sender of the test. This should be completed and returned as quickly as possible to enable Hertfordshire PCSS to trace the patient and enter the smear result on the computer. While a reply is awaited the patient is assigned to a "dummy" code to enable a result letter to be issued.

7.2 Removal and new patients

Hertfordshire PCSS uses the NHS network to transfer cervical screening data between Call/Recall registers. When a woman registers with a doctor in Hertfordshire an application is made, via the network, for her screening history. The speed of this procedure means that the screening history is normally updated on the computer quickly and often before the medical record is received. This process operates in reverse for women leaving Hertfordshire and registering with a doctor outside the area.

7.3 Private and Foreign tests

National guidance issued states that when a woman has a test done as part of a private health-screening plan e.g. BUPA, Nuffield, that the test should not be considered as part of the call/recall programme. For example if she has an NHS test done in July 2008 and a private test done in July 2010, she should still be invited for an NHS test in July 2011 or 2013, depending on her age. The pathology laboratories that report the private tests are aware of this guidance and report tests so that we can input the result, but the original NHS recall date remains unchanged. Women should be offered NHS tests in accordance with the national recall policy which is every 3 years, age 24½-49 and every 5 years, age 50-64.

Similarly the guidance states that tests done overseas can only be input onto the Call/Recall system if the GP is confident of its origin. Many other countries do not have as rigorous quality standards in pathology laboratories, and the quality of reporting cannot be guaranteed.

If a woman indicates she has had a test either overseas or privately, an NHS test should still be offered. If she does not wish to attend for this, her recall date can be postponed as ‘patient wishes to defer’.

7.4 Cervical Screening for new patients registering from overseas

Women with no screening history are called for cervical screening two months after registration, which is in accordance with national guidelines. The two month delay is to enable screening history to be received in respect of women moving; the same time is set for women coming into the area from overseas as moves within the UK.

It is thought that there may be a number of patients registering where English is not their first language. The standard invitation leaflet is available for download in 19 languages from the NHS Cancer Screening programme website [www.cancerscreening.nhs.uk](http://www.cancerscreening.nhs.uk) therefore if the language and nationality of a patient is known the leaflets can be printed as necessary. The cancer screening website also provides the facility to download the ‘Abnormal results’ leaflet in 7 languages, which again may be helpful.
7.5 Screening for younger women

It is a national recommendation that women under 24½ are not screened. Women under 24½ are not included in the NHS Cervical Screening Programme unless they have had a previous abnormal result.

Women receive their first invitation to attend for cervical screening at the age of 24½. There may be occasions when the invitation is not appropriate. Hertfordshire PCSS sends out invitation letters to all women unless the general practitioner indicates at prior notification stage. Under 25s with symptoms or visualised cervical abnormalities should be referred for gynaecological assessment. www.cancerscreening.nhs.uk/cervical/publications/doh-guidelines-young-women.pdf

7.6 Confidentiality on tests done in Family Planning and GU Medicine Clinics

Some women prefer to attend the family planning or GUM clinic for cervical screening. The woman's GP generally receives copies of any tests taken in these clinics. On very rare occasions the woman may object to her GP being informed of her test details although clinics will counsel against this. Patients will be advised that if they do not consent to a copy being sent to their GP that confidentiality cannot be guaranteed. If they fail to attend for follow up tests or treatment the fail-safe procedure eventually involves their GP.

If a patient has attended for a test at a clinic and has expressed that she does not wish her result to be sent to her home address, the clinic must contact Hertfordshire PCSS directly to provide alternative address details. It is not sufficient to record the alternative address on the screening test request form, as by default, all letters are sent to home addresses as recorded on Open Exeter.

7.7 Confidentiality and Disclosure

The NHS Cancer Screening Programmes place a very high importance on the confidentiality of information maintained and processed on behalf of the NHS and patients. All staff involved with the cervical screening programme will have signed the confidentiality policy that was issued towards the end of 2003. The policy is based on the recommendations made in the following legislation and publications: Caldicott Guidelines, Data Protection Act 1998, Health and Social Care Act 2001 – Section 60, GMC Guidance and British Standard BS7799 (1995/1999). All practices, laboratories, CCGs and Colposcopy Clinics have access to the Confidentiality and Disclosure policy and should ensure that its contents are brought to the attention of staff involved with the programme.

7.8 Completion of cytology request form, and LBC vial

The HMR101 request form should be printed and completed when a woman attends for a test. Vial - Please print the patient details clearly on the vial and always include patient’s NHS number and date of birth. Pre-populated HMR101 request forms with all the woman’s details can be downloaded from the Open Exeter system, use of pre-populated forms minimises the risk of human transcription errors (see Appendix 3 for instructions to download HMR101) Pathology laboratories now record the NHS number on their computer system. This helps to trace patients when necessary and enables the laboratory to confirm details so previous slides can be made available when needed.

Sample takers should record on the request form whether they have been able to sample the cervix in accordance with LBC sampling guidelines. LBC vials should be completed with
surname and first name, date of birth and NHS number. Laboratories require a minimum of 3 of these 4 identifiers. Ideally, date taken should also be stated.

**Laboratories will discard samples that are unlabelled or where identifiers are missing or do not match. Samples not labelled or wrongly labelled should be treated as an incident within the practice. (See appendix 4).**

**Best Practice Protocol for Labelling Samples:**
- Use Open Exeter to pre-populate and preprint HMR101 cervical screening request forms. This should be done by the smear taker while the patient is present.
- Ask the patient to confirm her patient details on the printed form (ie, name, date of birth and address) and ask her to confirm they are correct
- Do not pre label vials
- Take test
- Label vial
- Ask the patient to confirm name and date of birth you have put on the vial.
- Each vial and request form must be placed in to an individual specimen bag prior to the patient leaving the room.

A copy of the HMR101 form can be found in Appendix 4

Laboratories also recommend, as good practice, that tests should be ‘booked out’ of the surgery and checked when results are subsequently received. This will provide a guarantee to the practice that results are received for every test that is taken. Laboratories strongly favour the use of pre populated HMR101 request forms from the Exeter system.

The following samples will be rejected by the reporting laboratory as mislabelled or “Out of Programme” samples:
- Samples where there is a major discrepancy or multiple minor discrepancies in demographic details between the vial and request form
- Samples from women under the age of 24.5 years who have not had a previous cervical sample
- Samples from women aged 25-49 whose last sample was a routine negative and less than 33 months have elapsed
- Samples from women aged 50-64 whose last sample was a routine negative and less than 54 months have elapsed*
- Samples from women aged 65 and over with previous consecutive routine negative tests in the last ten years
- Symptomatic referrals of any age - the cervical cytology test does not perform well as a diagnostic test for existing cancer, or for infections or other gynaecological conditions and is therefore an incorrect test to support referrals

*NB: women are not changed to a 5 yearly screening interval until the first test after her 50\(^{th}\) birthday, therefore samples for women aged 50, 51 and 52 who had their last test 3 years ago will not be rejected.

**7.9 Inadequate Samples**

The percentage of tests reported as inadequate throughout the county varies from 0.5% for some practices and up to 5% for others. Laboratories keep a record of practice inadequate rates and will approach practices if they have a continual high rate of inadequate tests compared to other users of the same laboratory, to offer help and support. The two main laboratories Hertfordshire samples are sent to endeavour to classify inadequate tests using the same definitions and guidelines. For example: insufficient cells, cells obscured by pus/red blood cells or lubricant contamination.
Every attempt should be made to ensure the transformation zone is fully sampled so that endocervical cells are included on the slide. If a test is taken and it has not been possible to see the transformation zone this should be indicated on both the test request form and the woman’s notes.

If a test is received in the laboratory and there are no endocervical cells on the slide and there are no abnormal cells present, the test will be reported as negative as long as the sample taker visualised the cervix and a full sweep was performed. There is no need to repeat these tests. The exception to this rule is for women with previous CGIN; in these women an endocervical component is an absolute requirement for sample adequacy. This history should be indicated on the request form.

Pathology laboratories will always provide a reason on the report as to why the test was inadequate. If no reason is given please contact the laboratory concerned.

Laboratories report tests as ‘Inadequate’ and request a repeat in 3 months. The sample should not be repeated earlier than this as the cervical epithelial cells require time to regenerate.

8. **LIQUID BASED CYTOLOGY**

LBC was introduced across Hertfordshire in October 2007. (See appendix 1: Cervical Taking Guidelines)

9. **NATIONAL TARGETS**

The National Cervical Screening Programme sets a coverage target of at least 80%. The Commissioning Board has its screening coverage rate assessed based on the number of women tested in the last 5 years as a percentage of the number of women eligible.

Here are a few suggestions to improve uptake:

- When checking prior notification lists (PNLs) for cervical screening ensure that ‘ghost’ patients are removed and addresses are correct.
- Consider whether clinic times are appropriate. Offer regular evening and weekend clinics and take into account community events which may be barriers to attendance.
- Use the Open Exeter system to establish the screening status of newly registered patients.
- Consider (where appropriate) text or telephone reminders.
- Provide information on alternative clinics outside the practice where women can have samples taken if more convenient times are available.
- NHS CSP information leaflets for cervical screening should be readily available. Reception staff should encourage attendance for screening, if appropriate. Computer prompts may help with this.
- Ensuring that patients are fully informed of the benefits of screening, what it involves and how to access the service
- Reception staff should have access to appropriate update training and information sessions so they are fully informed of any changes to the screening programme.
- National leaflets and posters are available for all national screening programmes.
- Make sure that your 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 suitably equipped and offers complete privacy.
The National Standard is that all women who have a cervical screening sample taken should receive their written test result within 14 days.

10. GMS CONTRACT

10.1 Quality Outcomes Framework

The GMS Contract, which was implemented in April 2004, sees cervical screening as an additional service. Cervical Screening is to be part of the Quality Outcome Framework with quality points being awarded for undertaking certain pieces of work. On 1st April 2006 changes were made to QOF for Cervical Screening. Below is a summary of quality points and definitions that can be awarded for cervical screening.

CS 1 - 11 points
The percentage of patients aged from 25 to 64 (in Scotland from 21 to 60) whose notes record that a cervical screening test has been performed in the last five years Standard 40 – 80%

CS 5 - 2 points
The practice has a system for informing all women of the results of cervical screening tests

CS 6 - 2 points
The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical samples in relation to individual sample-takers at least every 2 years.

CS 7 - 7 points
The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate screening sample rates. The template protocol was revised in September 2008.

Most practices should achieve all of the 22 points available by fully participating in the Call/Recall programme. NHS England Primary Care Team will undertake assessments to validate the Quality Outcome Framework payments.

10.2 Exception Reporting

The NHS England screening team has seen an increase in the number of signed disclaimers from women opting out of the cervical screening programme. Practices should be reminded that the disclaimers (appendix 5) should only be used if a woman is making an informed choice, usually following counselling, that they do not wish to attend for cervical screening ever in the future. When a lady is ceased as ‘woman’s choice’ the call/recall system does not issue any further invitations. It is not the intention that women who are exception reported are asked to sign a disclaimer withdrawing them completely from the programme.

This has been the subject of national debate and the national cervical screening programme, which the BMA have reviewed and agreed to, has issued the following guidance on exception reporting in relation to cervical screening.
Exception reporting – Non-cancelled (CS 1)

Exception reporting is purely a basis for practices to calculate their coverage claim as part of the Quality and Outcomes Framework process (updated Aug 2004) and it does not affect the Call and Recall process.

The process within the call/recall system is:

1. Women are invited twice via the call recall system.
2. When a woman reaches NR (Non-Responder) stage the GP practices should communicate with her, inviting her for a test. This should be clearly documented by the practice and the appropriate read code assigned.
3. If the woman then fails to respond she can then be exception reported by the practice.
4. The woman can be exception reported for a period of five years when she has been invited on three occasions but failed to attend.
5. The woman’s recall date will default to 3 or 5 years or when clinically indicated and the call/recall system will invite her accordingly.

Note – Practices who receive NR cards (Non-Responder cards) for women whose previous cervical screening was routine must ensure that they issue a third invitation to enable them to exception report these women.

11. HEALTH PROFESSIONALS’ ROLE IN CERVICAL CANCER SCREENING

The aim of the cervical screening programme is to provide women with a comprehensive, high quality cancer prevention service that is acceptable, efficient and cost effective.

The delivery of a high quality cervical screening service in primary care is absolutely dependent upon having suitably educated, trained and experienced GPs and nursing staff.

It is recognised that practice nurses play a key role in providing this service. To fulfil this responsibility, high standards of knowledge and skills need to be developed and maintained. It is recommended that all sample takers attend a nominated / accredited course prior to taking samples. The overall aim of any cervical cytology-screening course is to develop in participants the appropriate knowledge, skills and attitudes to enable them to contribute effectively to the cervical cancer-screening programme. The ability to carry out the technique of cervical sample taking to a good standard is a fundamental requirement of the course. Participants should also be encouraged to familiarise themselves with all the diagnostic and curative procedures in secondary care, so that they may offer a holistic service to women.

Health Care Professionals should only undertake the technical procedure of taking a cervical screening sample if they are competent to do so. This means they must be able to demonstrate appropriate training has been undertaken and updated as recommended.

It is recommended that all health care professionals should attend a course prior to taking cervical samples. All nurses are bound by the code of professional conduct, which clearly sets out that each nurse is personally accountable for her actions.

Most University Post Graduate Schools of Nursing, offer an entry level course for all new sample
takers, which can be extended to complete an academic module within the nursing diploma or
degree. Some Universities also run a half day update course.
It is recommended that all cervical sample takers who work for the screening programme on behalf
of NHS England:

- Access and recognised novice cervical screening training programme prior to undertaking
  the procedure
- Regularly update to maintain competency by attending a half day update 3 yearly or
  undertaking self-directed learning to an equivalent standard to maintain awareness of
  local developments in the cervical screening programme
- Undertake annual self-audit

12. INFORMATION LEAFLETS
The national programme has an information leaflet which must be included with all invitations
(except reminders) that are issued. Women should be asked prior to having the test whether they
have received the leaflet as this forms part of the ‘Informed Consent’ procedures. Supplies of
leaflets are available from dh@prolog.uk.com.

There are two further leaflets available ‘What your abnormal result means’ and ‘The Colposcopy
examination’. Both leaflets are sent out with all results to women who have had an abnormal
screening test result and require colposcopy. ‘What your abnormal result means’ and a fact sheet
“HPV testing Information for women” is sent out with borderline and mild dyskaryosis results. They
give information on what happens if the woman has an abnormal result and requires further tests
or treatment.

13. HIGH RISK HPV TRIAGE AND TEST OF CURE (TOC)

Triage
Since April 2013, a cervical screening sample with a test result of borderline changes or low grade
(formerly mild) dyskaryosis will automatically be tested for “high-risk” HPV. If HPV is found, the
woman will be referred for colposcopy. If HPV is not found regardless of the low grade or
borderline cytology result, the negative HPV means the woman is at very low risk for the
development of cervical cancer and she will be returned to routine screening every 3 or 5 years
depending on her age.

Only women with a first result of borderline or mild dyskaryosis are automatically sent for HPV
testing. Women with previous abnormal results may be sent for HPV testing depending on the
particular smear history.

Test of Cure (ToC)
In addition to ‘HPV triage’, an HPV ‘Test of Cure’ is done on screening samples from women who
have undergone definitive treatment for CIN1, CIN2 or CIN3 and who are still being followed up,
i.e. who have not returned to normal recall. This means that HPV tests will be carried out on
samples from women who have a normal, borderline or low grade dyskaryotic screening test result
after their treatment for CIN. If HPV is not found, then a woman is at very low risk for the
development of cervical cancer and will not be recalled for screening for a further three years. If it
is found, or the screening test shows high grade dyskaryosis, she will be referred again to
colposcopy. At colposcopy, the cervix will be re-assessed and if the colposcopy is satisfactory and
negative and the woman was referred back with negative or only low grade changes and a positive
HPV test, she can be discharged from colposcopy and a repeat cervical sample taken in 3 years.
See Appendix 6 for the management flowcharts involving referral to colposcopy of all grades of dyskaryosis (including HPV triage for low grade samples) and Test of Cure (TOC) following treatment for CIN.

**CGIN Test of Cure**

Women with adequately treated CGIN are eligible for CGIN Test of Cure (ToC). This means that HPV tests will be carried out on samples from women who have a normal screening test result after their treatment for CGIN. If HPV is not found the woman will be recalled in 12 months where a second HPV test will be carried out if the screening test result is again negative. If HPV is not found, then a woman is at very low risk for the development of cervical cancer and will not be recalled for screening for a further three years. If HPV is found in either of these 2 tests or the screening test shows high grade dyskaryosis, she will be referred again to colposcopy.

See appendix 6 page 4

It should be noted that women treated for CGIN, who have any grade of abnormal cytology at 6 months or 18 months will require annual cytology for the subsequent 10 years before returning to routine screening recall. These patients are no longer eligible for a CGIN Test of cure.

In all of these cases the absence of endocervical cells indicates an inadequate sample and a repeat will be requested.

**Untreated CIN1**

Women referred to colposcopy with a low grade cytology result (borderline or low grade dyskaryosis) and where HPV is found and with a cervical biopsy result of CIN1 are classified as untreated CIN1. A further cytology test is carried out 12 months later and if it again shows borderline or low grade dyskaryosis a further HPV test is performed. If HPV is found she will be referred again to colposcopy. At colposcopy, the cervix will be re-assessed and if the colposcopy is satisfactory and negative and the woman was referred back with negative or only low grade changes she can be discharged from colposcopy and a repeat cervical sample taken in 3 years. If the 12 month follow up cytology after the initial referral is negative a further 12 month screening test is carried out and if this next test is again negative she and will not be recalled for screening for a further three years.

See appendix 6 page 2

Women who have been treated for invasive carcinoma of any type are not eligible for HPV TOC and, if the cervix is still present, will require follow-up cytology at 6 months and 12 months following treatment and then annually for the following 9 years. If the cervix has been removed see section 14.4 for follow-up after hysterectomy.

For the Cytology Code matrix please see HPV ABC3 matrix for practices (appendix 9).

14. **CLINICAL GUIDELINES and COLPOSCOPY**

The NHS Cervical Screening Programme publishes evidence-based guidelines regarding Colposcopy and Programme Management, publication no. 20 (latest edition May 2010). This is complemented and, in areas, updated by "Achievable Standards, Benchmarks for Reporting and Criteria for Evaluating Cervical Cytopathology", publication no.1 (3rd edition, January 2013), often referred to as ABC3 (Appendix 8).

http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp01.html
Many of the guidelines relate to the service provision within the colposcopy clinic, whilst the programme management guidelines relate to screening frequency and the Call/Recall programme. Detailed below are the key factors that have an impact on Primary care.

### 14.1 Referral patterns

Referral patterns reflect both the above documents and the major change in protocol to the management of low grade abnormalities (borderline and low grade dyskaryosis) which will henceforth be HPV-tested according to the triage protocol (see above). The referral pattern for high grade abnormalities is unchanged.

### 14.2 Follow up after treatment of CIN, CGIN AND CERVICAL CANCER

Previously, women treated for CGIN were followed up with annual cytology for many years. This guideline has now been changed by HPV CGIN test of cure (see above).

Women who have been treated for invasive cancer and their cervix remains still require a sample at 6 months, 12 months and 9 further annual samples.

### 14.3 Other referral and follow-up matters

If a woman is referred to colposcopy following three inadequate samples she should not have a smear. She should have a colposcopic assessment and if negative can be returned to appropriate recall. If inadequate colposcopy or there is some doubt at least 3 months should pass before a repeat cytology test otherwise it will be reported as inadequate again.

Local oestrogen therapy may be appropriate especially in post menopausal women.

Discussion at MDT may be appropriate for some of these women.

### 14.4 Follow up after hysterectomy

Patients who have had a hysterectomy should have their records reviewed by a clinician to ascertain that there has been complete removal of the cervix, ie TOTAL hysterectomy. A vaginal hysterectomy will necessarily be total and an abdominal hysterectomy is likely to be but may be subtotal (ie removal of uterine body, leaving the cervix behind). Note that removal of the uterus and cervix, leaving ovaries and Fallopian tubes behind, is still a total hysterectomy.

Following total hysterectomy, vault samples are not part of the cervical screening programme. Vault samples will not be entered on the recall register and it is the gynaecologist’s responsibility to ensure appropriate follow up is undertaken. Women undergoing hysterectomy will require these follow-up arrangements:

- For women who were on routine recall and no CIN was present in the hysterectomy specimen then no further vaginal vault cytology is required.
- For women not on routine recall and with no CIN in the hysterectomy specimen the gynaecologist may need to arrange appropriate investigations. These may include colposcopic examination of the vaginal vault or vaginal vault cytology.
- For women who undergo hysterectomy and are found to have completely excised CIN it is still recommended these women should undergo vaginal vault cytology at 6 and 18 months following hysterectomy, consultant gynaecologist should advise.
- In women who undergo hysterectomy and have incompletely excised CIN then follow up should be conducted as advised by the operating consultant which should be sent in writing to the woman and the GP.
Women who undergo radical trachelectomy as part of conservative management of cervical cancer should remain under the care and guidance of the treating gynaecologist. Future follow up will be determined by the treating gynaecologist.

The responsibility for undertaking the above follow up policies will reside with the gynaecologist. Gynaecologists discharging a patient who requires further vault cytology should make sure that the GP and the woman receives specific written guidance as to future follow up. The clinician in charge, i.e. gynaecologist or GP when the woman is discharged back to their care, will be responsible for failsafe mechanisms for this small group of women. This includes their call and recall.

If information about follow-up is not included in the discharge notification the practice should refer back to the hospital clinician for further clarification.

### 14.5 Cervical Screening in Pregnancy

- Unless a pregnant woman with negative history has gone beyond three years without having cervical screening then the test should be postponed.
- If a woman has been called for her first routine screening and she is pregnant then the test should be deferred.
- If a previous test was abnormal, and in the interim the woman becomes pregnant, then the test should not be delayed but should be taken in mid trimester unless there is a clinical contra-indication. If a patient declines to attend following an invitation for early repeat, this should be recorded in the patient’s notes.

### 14.6 Colposcopy in Pregnancy

- A woman who meets the criteria for colposcopy still needs colposcopy if she is pregnant, however, if low grade and High Risk HPV detected the colposcopist may choose to delay the colposcopy examination. The primary aim of colposcopy for pregnant women is to exclude invasive disease and to defer biopsy/treatment until the woman has delivered. Women seen in early pregnancy may require a further assessment in the late second trimester at the clinician’s discretion.

### 14.7 Screening and Management of Immunosuppressed women

- All patients who are Immunosuppressed must be managed in a centre with demonstrable skill and expertise, with sufficient access to patient numbers to maintain expertise. This would ordinarily be agreed between the hospital physician and the GP.
- All women aged 25-65 years developing renal failure requiring dialysis or transplant are expected to have attended for routine screening in the past and checks are specifically made to ensure they have had a test within the year pre transplant. Where required women should have a screening test performed at, or shortly after diagnosis. Subsequent screening can be as per national guidelines.
- There is no indication for increased surveillance in the following situations:
  - Women receiving cytotoxic chemotherapy for non-genital cancers
  - Women receiving long-term steroids
  - Women receiving oestrogen antagonists such as tamoxifen.
Such women should have cytological screening in accordance with national guidelines.

- All women newly diagnosed with HIV should have cervical surveillance performed by, or in conjunction with, the medical team managing the HIV infection. Annual cytology should be performed subsequently. The age range screened should be the same as for HIV negative women.

14.8 Complaints

Any complaint relating to Cervical Screening should be forwarded to the Patient Advice and Liaison Services (PALS). PALS will liaise with the relevant department/s.

14.9 Incident Reporting to NHS England Midland and East (Central Midlands) Screening and Immunisations Team

As a result of incorrect information provided to women regarding their screening status, and subsequent history the Screening Quality Assurance Service (SQAS) have requested that Hertfordshire PCSS team keeps a record of all such incidents and reports them to the Screening and immunisation team on a monthly basis unless clinical input is required. Primary Care Service has the responsibility to contact the Practice or laboratory if there is concern over the information provided.

Any incidents in the Screening Programme should be managed in line with NHSCSP Document No 11 on Managing Incidents: [www.cancerscreening.nhs.uk/cervical/publications/pm-07.html](http://www.cancerscreening.nhs.uk/cervical/publications/pm-07.html)

15. SCREENING SERVICES

The Screening Services Team is made up as follows

<table>
<thead>
<tr>
<th>Contact</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Eyre, Registration Manager, Hertfordshire PCSS</td>
<td>01707 369733</td>
</tr>
<tr>
<td>Sharon Varney, PCSS Screening Manager</td>
<td>01707 369730</td>
</tr>
<tr>
<td>Susan Marsden NHS England Screening Manager</td>
<td>01138248869</td>
</tr>
</tbody>
</table>

Routine enquiries, for example checking sample details can be directed to any of the VDU Operators. More specific queries and questions on follow-up of test results can be directed to Sharon Varney. Susan Marsden deals with questions relating to policy, procedures and new services.

PCSS are unable to discuss results directly with women, who will be referred back to their surgery.
16. MULTI-DISCIPLINARY CERVICAL SCREENING PROGRAMME MANAGEMENT BOARD

The members of the above group give professional advice and where appropriate represent their colleagues or organisations:

- Commissioners representative
- Sampler taker representative
- Colposcopy representative
- Laboratory representative
- QA representative
- CCG representative
- LMC representative
- Call/Recall representative
- Training representative
APPENDIX 1: CERVICAL SAMPLE TAKING GUIDELINES (Source: NHSCSP 2010)

All gynecological Cytopathology samples for LBC must be sent in the ‘Thin Prep Pap Test’ sample vial, where processing takes place within the region.

The LBC broom is specifically designed to collect ectocervical and endocervical cells when used correctly:

- Insert the central bristles of the broom into the os deep enough to allow the shorter bristles to fully contact the ectocervix
- Push the broom gently and rotate it 5 times in a clockwise direction

Rinse off the sample immediately in the Preservcyt® solution vial – push the broom against the bottom of the vial 10 times forcing the bristles to bend apart

Leaving the broom in the Preservcyt® solution vial, swirl it with the thumb and forefinger vigorously to further release any remaining material

- Inspect the broom to ensure that no material remains attached; the broom may now be discarded in the clinical waste bin
- Make sure to tighten the Preservcyt® solution and sample vial cap so that the black line on the cap passes the black line on the vial
Record the patient name, DOB, NHS number and date taken on the Preservcyt® solution and sample vial.

Complete the HMR101 request form – download pre populated version from open Exeter

- Place the labeled vial and request form in a marsupial bag for collection.

**FACTORS AFFECTING SAMPLE and REPORT QUALITY**

- Incorrect sample taking
- Ensure the sample is placed into the Preservcyt® solution vial immediately
- Hormonal cycle – around mid-cycle is the best time to take the sample
- Infections / heavy discharge may result in an inadequate sample (cells may be obscured by polymorphs)
- Correct and legible completion of request form (insufficient information / errors will result in the return of sample and form to sender for completion / correction)
- The provision of relevant and up to date clinical history (e.g. previous abnormal cervical cytology and colposcopy) assists the laboratory in determining the correct recall for the patient
- It is recommended that samples are collected without lubricant or if absolutely necessary use of lubricant is kept to a minimum and well away from the tip of the speculum. Any lubricant used must be water based such as KY Jelly and the sample taker should ensure the broom and vial are not contaminated with the lubricant once the sample has been taken as they are likely to get an inadequate result.
APPENDIX 2: HERTFORDSHIRE CALL/RECALL

Patient has a test, invitation date given

Test due, PNL issued to GP for checking

Invitation issued to woman from Call/Recall service

Attends for cervical screen at surgery, clinic or hospital

Cervical sample sent to Path lab for reporting

Normal Result
3 year recall
24½ - 49
5 year recall
50 - 64

Inadequate result
Repeat within 3 months

Abnormal HPV tested and/or referred to Colposcopy

Does not respond
Reminder issued 3 months later

Still does not respond
Non Responder Card issued 3 months after second letter

Re-enters the call/recall programme
Cycle starts again
APPENDIX 3: HOW TO PRE POPULATE AND PRE PRINT YOUR CERVICAL CYTOLOGY REQUEST FORMS FROM OPEN EXETER

1. All users, to access Open Exeter, to print out a request form which carries the last 10 cervical smear results. This means Laboratory staff will not have to decipher handwriting and the correct patient management can be given.

2. Instructions to use the Open Exeter to print HMR101 cervical screening sample request form:
   - If you do not already have access or have any difficulty accessing Open Exeter database please contact your practice manager.
   - Log into Open Exeter
   - Search for your patient by name or NHS number
   - From the menu on the top left of the screen, choose HMR101 form A5 PDF (2009). DO NOT choose any of the other options as they will be the wrong format and will not have the full patient history
   - Click Continue
   - The form will be displayed on screen
   - Choose Print
   - At the connected printer screen the following options must be selected/changed:
     - Page Scaling = None
     - Auto-rotate and centre – uncheck this box
   - Click OK. When this is done, the form will print at the top half of an A4 sheet
   - Complete box numbers 13 to 20 and sign the form
   - Important - Don’t forget to add the date of the cervical screening test
   - Check that the details on the pot
     - First name
     - Last name
     - Plus NHS number or date of birth match those on the form
   - Finally, send the sample to the laboratories as soon as possible.

For other queries contact the Cytology Department at Watford General Hospital (01923 217617) or Addenbrookes Hospital (01223 245151)
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<td>Hospital, clinic, or ward</td>
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<td>Name of sender</td>
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**CLINICAL REPORT**

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<td>Reason for test</td>
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**CYTOLOGY REPORT**

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**NDP Code**

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</table>

**Signature**

Date
APPENDIX 4: CERVICAL SCREENING PROGRAMME “OUT OF PROGRAMME” AND MISLABELLED SAMPLES

CERVICAL SAMPLES SHOULD ONLY BE TAKEN ON WOMEN WHO HAVE RECEIVED AN INVITATION LETTER OR WHO HAVE REACHED THE STATUS OF A NON-RESPONDER

CERVICAL SAMPLES SHOULD NOT BE TAKEN ON:
- WOMEN UNDER 24.5 YEARS OLD, UNLESS THEY HAVE HAD PREVIOUS SAMPLES
- WOMEN OVER 64 YEARS OLD AND CEASED FROM RECALL
- WOMEN WITH SYMPTOMS AND/OR AN APPARENTLY ABNORMAL CERVIX IF THEY HAVE NOT BEEN INVITED FOR SCREENING. SEE GUIDELINES FOR SYMPTOMS IN THE UNDER-25s:
- AND MAP OF MEDICINE FOR THE OVER 24s:
  - http://eng.mapofmedicine.com/evidence/map/abnormal_vaginal_discharge1.htm
- WOMEN WHO ARE ON NORMAL RECALL AND PRESENT MORE THAN 3 MONTHS EARLY (IF ON 3-YEARLY RECALL) OR 6 MONTHS EARLY (IF ON 5-YEARLY RECALL)

THESE SAMPLES WILL BE DISCARDED

MISLABELLED SAMPLES

WE REQUIRE AT LEAST THREE OF FOUR MAJOR IDENTIFIERS ON VIAL AND FORM: SURNAME, FORENAME, DATE OF BIRTH AND NHS NUMBER

Minor discrepancies
- Surname or forename differs between vial and form because of one letter
- NHS no. or date of birth differs by one digit
- Transposition of two letters or digits, eg “01” instead of “10”

SAMPLES WITH ONE MINOR DISCREPANCY WILL BE PROCESSED

Major discrepancies
- Unlabelled vials
- Absence of one of the three identifiers on either form or vial
- Substantial mismatch of one identifier between form and vial
- Two or more minor discrepancies

SAMPLES WITH A MAJOR DISCREPANCY WILL BE DISCARDED

All rejected samples will be clearly reported directly to the sample taker with the reason for rejection

It is the sample taker’s responsibility to contact the woman and explain the situation

The laboratory will destroy the sample (vial)

Using pre-printed Open Exeter forms will enable you to check that the test is due and that the address is correct to ensure the woman receives her letter.
APPENDIX 5: CERVICAL SCREENING CEASING TEMPLATE. PLEASE ENSURE THIS LETTER IS RETURNED TO THE FOLLOWING ONCE SIGNED:

[Surgery Address]  

Dear

Women aged 25 to 49 are invited for cervical screening every three years, and women aged 50 to 64 are invited every five years. The risk of developing cervical cancer can be significantly reduced by having regular screening.

I understand that you do not wish the NHS Cervical Screening programme to invite you for future screening tests. I enclose the leaflet ‘NHS Cervical Screening: helping you decide’ which explains the benefits and disadvantages of cervical screening, and the importance of screening in reducing deaths from cervical cancer. If you need further information please do not hesitate to contact your General Practitioner (GP).

We need your written instruction to remove your name from the list of women invited for cervical screening. I would be grateful, therefore, if you could **sign and return** the lower part of this letter to confirm that you do not wish to receive any future invitations to be screened for cervical cancer or any further information about the NHS Cervical Screening Programme.

The screening department will send you written confirmation when your name has been removed from the screening list.

If you wish to restore your name to the screening list at any time, please contact your GP. You may wish to keep the top part of this letter for future reference.

Yours sincerely,
Practice nurse/ Doctor

------------------------------------------------------------------------------------------------------------------------------------------

To:

Please do not send me any further invitations to participate in the NHS Cervical Screening Programme. I assume full responsibility for this decision and confirm that I have understood the leaflet ‘NHS Cervical Screening: helping you decide’ which explains the benefits and disadvantages of cervical screening and the importance of screening in preventing cervical cancer and reducing deaths from it.

I understand that my name can be restored to the screening list at any time at my request to my GP.

Name:                                      Date of birth:
Address:                                   
NHS No.:                                   Signed:                          Dated:
APPENDIX 6: NHS Cervical Screening Programme Protocol Algorithm for HPV Triage and TOC,

NHS Cervical Screening Programme
Screening Protocol Algorithm for HPV Triage and TOC

Screening test result

- Inadequate: Repeat at 3 months
- ?Glandular neoplasia (non cin) or Negative Routine Recall
- Borderline-Squamous/Borderline-Endocervical or Low Grade Dyskaryosis
  - HPV tested
- High grade dyskaryosis or worse or other indication for referral
  - Colposcopy referral

HPV Negative Routine Recall

HPV test inadequate or unreliable
- Cytology = Borderline (2)
  - Repeat in 6m with HPV test only if Neg/Border/Low grade

HPV Positive Colposcopy Referral

< CIN 1 or Untreated CIN
- Cytology Follow-up or Recall

Repeat test result

- Cytology Neg (2)/Borderline (2)/Low grade dyskaryosis; HPV Negative Routine Recall
- Cytology Neg (2)/Borderline (2)/Low grade dyskaryosis; HPV Positive Colposcopy Referral
- Cytology High grade or worse (no HPV test required)
  - Colposcopy Referral

< CIN 1
- Cytology Neg (2)/Borderline (2)/Low grade dyskaryosis Routine Recall
- Untreated CIN 1
  - Cytology Follow-up at 12m
  - Continued on page 2
- CIN 1/2/3
  - Treatment Invite for 6m test of cure
  - Continued on page 3
- CGIN
  - Treatment Invite for 6m test
  - Continued on page 4

July 2014

1 of 5
Management of Untreated CIN 1

Untreated CIN 1
Cytology Follow-up at 12m

Follow up test

- Cytology Bond (2)/Low grade dyskaryosis; HPV test inadequate
  Repeat at 3 months
- Cytology Neg (2)/No HPV test required
  Repeat at 12 months
- Cytology Bond (2)/Low grade dyskaryosis; HPV Negative
  3 Year Recall
- Cytology Bond (2)/Low grade dyskaryosis; HPV Positive
  Colposcopy/Referral
- Cytology High grade dyskaryosis or worse (No HPV test)
  Colposcopy/Referral

Follow up test (i)

- Cytology Neg (2)/no HPV test required
  Routina Recall
- Restart screening protocol algorithm

(i) The management of women with abnormal cytology at this second 12 month follow up test will mirror that at the first 12 month repeat test.
Test of Cure Following Treatment for CIN

CIN 1/2/3 -> Treatment
Invite for 6m test of cure

Test of cure

- Cytology Neg (2) / Bord
  - (2) Low grade dyskaryosis
  - HPV test inadequate
  - Repeat at 3 months

- Cytology Neg (2) / Bord
  - (2) Low grade dyskaryosis
  - HPV Negative
  - 3 Year Recall

- Cytology Neg (2) / Bord
  - (2) Low grade dyskaryosis
  - HPV Positive
  - Colposcopy Referral

- Cytology High grade dyskaryosis or worse
  - (No HPV test)
  - Colposcopy Referral

Follow up test

See note (8)

Restart screening protocol algorithm

(ii) Women referred back to colposcopy (at TOC following treatment for CIN) due to borderline, low-grade dyskaryosis or negative cytology, who are HR-HPV positive, and who then have a satisfactory and negative colposcopy, can be recalled in 3 years.

July 2014
Cancer Screening Programmes

Management of women adequately treated for CGIN

CGIN -> Treatment (iii) - invite for 6th test

Test of cure

with or without colposcopy
(local preference)

Cytology Neg (2); HPV test inadequate
Repeat at 3 months

Cytology Neg (2); HPV Positive
Colposcopy referral if not already performed.
Normal colposcopy - repeat test at 12 months

Cytology Neg (2); HPV Negative
Repeat at 12 months

Cytology abnormal
Colposcopy referral if not already performed.
Complete 10 year cytology follow up

Test of cure

Cytology Neg (2); HPV Positive
Colposcopy referral if not already performed.
Normal colposcopy - repeat test at 12 months

Cytology Neg (2); HPV Negative
3 year recall

Follow up test

Restart screening protocol algorithm

(iii) Women who have been adequately treated (complete excision margins) for CGIN or SMILE will follow the management in this protocol algorithm. Women receiving annual surveillance tests following treatment for CGIN or SMILE in the past may also be tested in line with this policy at their next two tests. Women treated for cervical cancer are excluded from this management policy.

July 2014
Notes

Non-cervical neoplasia is treated as negative for CSP management.

(2) Used to denote both categories of negative result (negative and glandular neoplasia (non cervical)) or both categories of borderline result (borderline change in squamous cells and borderline change in endocervical cells.)

★ colposcopy referral without HPV test.
Best Practice Guidance for the Management of Women with a ‘Lack of Capacity’ within the NHS Cervical Screening Programme

On behalf of:
Primary Care Service
Charter House
Parkway
Welwyn Garden City
Herts AL8 6JL
| Contents |
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| 1. Purpose of the Document | 3 |
| 2. Defining ‘Lack of Capacity’ | 3 |
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| 4. Who can make a Best Interest Decision? | 4 |
| 5. Advance Decision Making | 5 |
| 6. Managing a Request to Cease under ‘Lack of Capacity’ | 5 |
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| Appendix II: Template letter to be returned by GP when a decision has been made to cease or defer a woman with learning disabilities | 8-9 |
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3. Best Interest Decisions

A best interest decision is an act done or decision made for or on behalf of a person who lacks capacity which is deemed in that person’s best interests. The Mental Capacity Act recommends the following factors be considered when deciding what is in a person’s best interests:

- Encourage participation in decision making.
- Identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
- Try to find out the views of the person who lacks capacity, including past wishes, religious/cultural values and other factors.
- Avoid discrimination with relation to age, appearance, condition behaviour.
- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- Not be motivated in any way by a desire to bring about the person’s death. They should not make assumptions about the person’s quality of life.
- Consult people for their views about the person’s best interests and to see if they have any information about the person’s wishes and feelings, beliefs and values.
- Avoid restricting the person’s rights.

All the above should be considered when making a best interest decision both in relation to ceasing a woman from the NHS Cervical Screening Programme and when considering treatment required.

4. Who can make a Best Interest Decision?

The following individuals are capable of making a Best Interest Decision on behalf of the woman:

- An individual in whom the woman has invested a Lasting Power of Attorney
- A Deputy appointed by the Court of Protection
- A responsible healthcare professional as part of a care team

Care Teams can make the decision to cease a woman under the Mental Capacity Act, by means of a Best Interest Decision.

In relation to participation in the screening programme the decision can be taken by the professional responsible for the woman’s health care (usually her GP), who should also consult with any or all formally appointed decision-makers, and usually a member of the local learning disability partnership (if one is involved in the care of the individual).

The care team is expected to consult the family and close friends of the woman or use an Independent Mental Capacity Advocate to ensure all relevant information and opinions are taken into account. On occasions where a care team is charged with making this decision it is important that the process is well documented for future reference.

This must include the decision taken, the information reviewed, how the care team came to the decision and the individuals consulted. Appendix 1 of this document provides the relevant forms for completion.
The Independent Mental Capacity Advocate service provides independent safeguards for people who lack capacity to make certain important decisions including those around serious medical treatment and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.

The role of an Independent Mental Capacity Advocate (IMCA) is not to take a Best Interest Decision on behalf of woman but is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to see relevant healthcare and social care records. Under the terms of the Act an IMCA must be instructed whenever an NHS body is proposing to provide “serious medical treatment”.

In the case of the Cervical Screening Programme this is likely to relate to treatment issues that arise from the detection of abnormalities following screening.

5. Advance Decision Making

Where a woman has previously made an advance decision in relation to the Cervical Screening Programme while they had the capacity to do so, their advance decision should be respected when they lack capacity. Even on those occasions where it is felt that the decision to refuse treatment/participation is not in their best interests this advance decision should be adhered to.

The GP holding documentation relating to a woman’s advance decision will notify the Screening Programme in writing.

6. Managing a Request to Cease under ‘Lack of Capacity’

A request to cease or defer a woman under the Mental Capacity Act may be received in a number of ways e.g. at Prior Notification stage, at Invitation stage via a telephone call or a letter or at Non-Responder stage. All requests should be managed in a uniform way in accordance with the flow chart in Appendix 5.

The Screening Office will send the letter and forms provided in Appendix 1 to the individual requesting to cease or delay along with the supporting leaflets ‘Making decisions - A guide for people who work in health and social care’ and ‘An easy guide to screening for women with learning disabilities’.

The letter and leaflets are intended to encourage women to continue to receive invites, and refers them to the local disability team. On receipt of the completed forms the Call Recall Screening Office Manager will take the appropriate action and retain the document indefinitely.

The Screening Office Manager will produce an audit annually for women ceased under the Mental Capacity Act. This audit will be shared with the Public Health Lead.

7. Documentation

The Screening Office Manager must retain copies of all documentation on behalf of the Primary Care Trusts as part of the management of the Call/Recall programme.

It is recommended that a log be used to record all information and that a file be compiled for each request.
These should be kept in a lockable cabinet or held electronically on a secure area of the relevant Trust IT system.

8. References / Useful Links


APPENDIX I: LETTER TO GP REGARDING A REQUEST TO CEASE OR DEFER DUE TO LACK OF MENTAL CAPACITY

«GP_name» «GP_code»
«Surgery_name»
«address1»
«postcode1»

Date

Dear «GP_name»

Re: «Title» «Forename» «Surname»: «NHS_Number» DOB «Date_of_Birth_».

We have received a communication from «Communication_from_» requesting not to invite the above named patient to the NHS Cervical Screening Programme. It has been indicated that this woman is classed as having a lack of capacity, and that you have made this request in your capacity as the responsible healthcare professional following discussion with the patient’s care team.

Using guidance from the Mental Capacity Act we have devised local guidance to assist screening practitioners and carers when consenting on behalf of patients for who it has been agreed the cervical screening process may be inappropriate.

Current guidance states that people participating in cancer screening should do so with the knowledge of the inherent benefits and disadvantages of the process. This is to enable individuals to make an informed choice about whether or not to take up their screening invitation.

I enclose the leaflets ‘Making decisions - A guide for people who work in health and social care’ and ‘An easy guide to Cervical Screening for women with learning disabilities’. Evidence suggests that the number of women with disabilities who are accessing the screening programmes is significantly smaller than the non-disabled population.

It is important to establish what additional or different support and preparation may be needed to enable women who lack capacity to access screening programmes. Further information can be found on the National Cancer website www.cancerscreening.nhs.uk

In every case the appropriate actions need to have been completed to indicate you have complied with current guidance. Please complete one of the forms attached and return to this office.

We are required to hold confirmation in writing, signed by the sample taker, GP and the patient’s normal carer to support this decision to stop or defer invitations for cervical screening for women who are classed as having a lack of capacity.

Yours sincerely
Primary Care Services Screening Manager

APPENDIX II: TEMPLATE LETTER TO BE RETURNED BY GP WHEN A DECISION HAS BEEN MADE TO CEASE OR DEFER A WOMAN WITH LEARNING DISABILITIES.

Women with learning disabilities

In the case of women with learning disabilities who live in the community, it is preferable that the general practitioner and, if appropriate, the carer(s) give advice on what suitable provision and care can be arranged.

For women who live in a care facility, it is essential that carers are informed about the screening procedure so that they can advise on suitable provision and care and also help to communicate effectively and sensitively with the woman.

Experience in the screening programme suggests that some women with learning disabilities are unable to understand and comply with the screening procedure, and they may also find it distressing. In such cases, screening staff must act in accordance with reasonable practice.

If a woman is unable to articulate consent to screening, behavioural consent to procedure may be accepted. Behavioural consent is implied if a woman cooperates with the screening procedure without displaying signs of any undue anxiety or distress.

It is important that carers or family members who understand how the woman communicates her feelings are able to give guidance to the screening practitioner. If a woman withdraws consent either verbally or behaviourally during the screening examination, this should be accepted as withdrawing consent on that occasion and the screening procedure should be stopped.

It is important for screening staff to recognize that refusal on one occasion to undertake or complete a screening examination does not necessarily indicate that a woman should be permanently removed from the recall programme. Unless the woman (if possible), a screening practitioner or a carer decides that any future screening would be impossible or not in the woman's best interests, she should be kept in the recall programme and another invitation for screening issued at the appropriate interval.

In every case the appropriate actions need to have been completed to indicate you have complied with current guidance. Please indicate which option has been decided in this case i.e. cease permanently or defer on this occasion, action the appropriate box that applies for the above patient:
Patient details: «Forename» «Surname»: «NHS_Number» DOB «Date_of_Birth».

☐ Cease from the National Cervical Screening Programme Permanently

☐ Defer on this occasion, please recall on …………………………………..

I confirm that this decision has been taken in line with the MCA and Regional guidance and that all discussions have been documented in the patient’s records.

This should be signed by at least 2 members of the care team

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<thead>
<tr>
<th></th>
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<tbody>
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<td>Sample Taker</td>
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<td>Carer</td>
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Please keep a copy for your records and send the original copy to:
Primary Care Services
Charter House
Parkway
Welwyn Garden City
Herts
AL8 6JL
APPENDIX III: TEMPLATE LETTER TO BE RETURNED BY GP WHEN A DECISION HAS BEEN MADE TO CEASE OR DEFER A WOMAN WHO LACKS MENTAL CAPACITY.

Women who lack mental capacity

The decision on whether to attempt screening should be taken by screening staff in consultation with the woman (if this is possible). The woman’s family, a carer or close friend may also provide input into the decision where practicable and appropriate.

Screening of a woman incapable of giving (or withdrawing) consent either verbally or behaviourally should only be undertaken in her best interests. ‘Best interests’ go beyond medical interests, and include factors such as previous wishes or beliefs (e.g., before a loss of capacity to express these), current wishes, general well-being, and spiritual or religious welfare.

A Best Interests Decision can be made by screening staff, a GP or other health professional, carer, or a family member. Someone nominated under a Lasting Power of Attorney or any deputy appointed by the Court of Protection can make care and treatment decisions, which must be accepted as if made by the individual lacking capacity. However, the decision must still be made according to the same processes of any other person acting in the individual’s best interests.

It should be remembered that the individual responsible for the decision to proceed with (or withhold) screening in someone’s best interests must be able to justify the decision should it be challenged. To this end, any decision to screen or withhold screening due to a Best Interests Decision should be clearly documented, including detailed information on why the decision was considered to be in the individual’s best interests.

Screening practitioners should adhere to the requirements of the Mental Capacity Act 2005 (MCA), and correspondingly have regard to the MCA’s Codes of Practice. The British Medical Association has provided appropriate guidance, The Mental Capacity Act – Guidance for Health Professionals, which is available to download at www.bma.org.uk.

In every case the appropriate actions need to have been completed to indicate you have complied with current guidance.

Please indicate which option has been decided in this case i.e. cease permanently or defer on this occasion action the appropriate box that applies for the above patient:
Patient details: «Forename» «Surname» «NHS_Number» DOB «Date_of_Birth».

□ Cease from the National Cervical Screening Programme Permanently

□ Defer on this occasion, please recall on ...........................................

I confirm that this decision has been taken in line with the MCA and Regional guidance and that all discussions have been documented in the patient’s records.

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This should be signed by at least 2 members of the care team

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Please keep a copy for your records and send the original copy to:
Primary Care Services
Charter House
Parkway
Welwyn Garden City
Herts
AL8 6JL
APPENDIX IV: TEMPLATE LETTER SENT TO THE PATIENT WHEN A DECISION HAS BEEN MADE TO CEASE HER FROM THE CERVICAL SCREENING PROGRAMME. LETTER SENT BY THE LOCAL PRIMARY CARE SERVICE SCREENING DEPARTMENT

Woman ceased from the Programme due to Lack of Capacity

Dear Name,

Cervical Screening Programme

This letter is being sent for the information of your carer, your family, the person invested with lasting Power of Attorney or your Deputy appointed by the Court of Protection.

We have received documentation requesting that we withdraw your name from the National NHS Cervical Screening Programme. In line with this notification we have removed your name from the list of eligible women. We are writing to inform you that you will not receive any further invitations to attend for cervical screening from us.

Please remember that the risk of cervical cancer can be significantly reduced by having regular routine screening tests. If you require any further information please do not hesitate to contact your GP or Practice Nurse.

We would be pleased to restore your name to the screening list at any time should you wish and you may be screened at any time at your request by contacting your GP or Practice Nurse.

I have informed your GP that you have been permanently removed from the cervical screening programme. You may wish to retain this letter for future reference.

Yours sincerely

Screening Manager
Primary Care Service

Your NHS number is:
Patient details: «Forename» «Surname»: «NHS_Number» DOB «Date_of_Birth_».

- Cease from the National Cervical Screening Programme Permanently
- Defer on this occasion, please recall on …………………………………..

I confirm that this decision has been taken in line with the MCA and Regional guidance and that all discussions have been documented in the patient’s records.

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Please keep a copy for your records and send the original copy to:
Primary Care Services
Charter House
Parkway
Welwyn Garden City
Herts
AL8 6JL
Request received at the database from an individual other than the patient to cease or defer recall

Letter & documents defined in Appendix 2 sent to registered GP or carer by the screening manager

Screening manager defers recall by using admin options for a period of 4 months. This is to allow the care team time to hold appropriate discussions and make a decision

Care Team discussion take place and decision made. Decision process documents in Patients medical records

Care Team decision to defer recall until a specified date or no longer than the routine Next Test due date (3 or 5 years dependant on age)

Letter defined in Appendix 2 or 3 submitted to Screening Manager

Recall date reset as specified reason given as Code 5

Deferring under this category can only take place once during a 3/5 year period depending on age

Care Team decision to Cease Recall

Letter defined in Appendix 2 or 3 submitted to Screening Manager

Recall ceased by Screening Manager as code 99 – The Mental Capacity Act

Notification from Care team of a decision to continue with screening or no letter returned to Screening Manager in the 4 month period.

Invitations will re commence at the end of the deferral period

Letter sent to Patient and notification to GP informing them of the action taken

Letter sent to Patient and notification to GP informing them of the action taken
Tests are coded (result code, infection code, action code) using the coding schemes described below. Results where there is no infection code are shown using a ‘-’. E.g. 1-S for inadequate, no infection reported, refer for colposcopy.

<table>
<thead>
<tr>
<th>Letter type</th>
<th>Letter purpose/content</th>
<th>Result code</th>
<th>Infection code</th>
<th>Action code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result</td>
<td>negative (not HPV tested); routine recall</td>
<td>2</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>negative (not HPV tested); cease due to age</td>
<td>2</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>negative (not HPV tested); early recall</td>
<td>2</td>
<td>-</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>inadequate; 3 month recall</td>
<td>1</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>inadequate; refer for colposcopy</td>
<td>1</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>negative cytology but non-cervical ?glandular neoplasia (not HPV tested); routine recall</td>
<td>Ø</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>negative cytology but non-cervical ?glandular neoplasia (not HPV tested); routine recall</td>
<td>Ø</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>high grade dyskaryosis (severe) (not HPV tested); refer for colposcopy</td>
<td>4</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>high grade dyskaryosis ?invasive squamous carcinoma (not HPV tested); refer for colposcopy</td>
<td>5</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>?glandular neoplasia of endocervical type (not HPV tested); refer for colposcopy</td>
<td>6</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>high grade dyskaryosis (moderate) (not HPV tested); refer for colposcopy</td>
<td>7</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>negative cytology but non-cervical ?glandular neoplasia (not HPV tested); early recall</td>
<td>Ø</td>
<td>-</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>negative cytology but non-cervical ?glandular neoplasia (not HPV tested); refer for colposcopy</td>
<td>Ø</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>low grade dyskaryosis (not HPV tested); early recall</td>
<td>3</td>
<td>-</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>low grade dyskaryosis (not HPV tested); refer for colposcopy</td>
<td>3</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>low grade dyskaryosis (HPV negative); routine recall</td>
<td>M</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>low grade dyskaryosis (HPV negative); cease due to age</td>
<td>M</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>low grade dyskaryosis (HPV negative); early recall</td>
<td>M</td>
<td>Ø</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/squamous (not HPV tested); early recall</td>
<td>8</td>
<td>-</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/squamous (not HPV tested); refer for colposcopy</td>
<td>8</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/squamous (HPV negative); routine recall</td>
<td>B</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>borderline/squamous (HPV negative); cease due to age</td>
<td>B</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/squamous (HPV negative); early recall</td>
<td>B</td>
<td>Ø</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/endocervical (not HPV tested); early recall</td>
<td>9</td>
<td>-</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/endocervical (not HPV tested); refer for colposcopy</td>
<td>9</td>
<td>-</td>
<td>S</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/endocervical (HPV negative); routine recall</td>
<td>E</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>borderline/endocervical (HPV negative); cease due to age</td>
<td>E</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>borderline/endocervical (HPV negative); early recall</td>
<td>E</td>
<td>Ø</td>
<td>R(m)</td>
</tr>
<tr>
<td>Result</td>
<td>negative cytology but non-cervical ?glandular neoplasia (HPV negative); routine recall</td>
<td>G</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>negative cytology but non-cervical ?glandular neoplasia (HPV negative); cease due to age</td>
<td>G</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>Result</td>
<td>negative cytology but non-cervical ?glandular neoplasia (HPV negative); 3-year recall</td>
<td>G</td>
<td>Ø</td>
<td>R(36)</td>
</tr>
<tr>
<td>Result and cease/age</td>
<td>Result</td>
<td>Cervical/glandular neoplasia</td>
<td>HPV</td>
<td>Recall</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------</td>
<td>-----------------------------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>negative (HPV negative); routine recall</td>
<td>negative cytology but non-cervical glandular neoplasia (HPV negative); refer for colposcopy</td>
<td>G</td>
<td>Ø</td>
<td>S</td>
</tr>
<tr>
<td>negative (HPV negative); 3 year recall</td>
<td>negative cytology but non-cervical glandular neoplasia (HPV positive); refer for colposcopy</td>
<td>G</td>
<td>9</td>
<td>S</td>
</tr>
<tr>
<td>negative (HPV positive); refer for colposcopy</td>
<td>negative cytology but non-cervical glandular neoplasia (HPV result unavailable); 3 month recall</td>
<td>G</td>
<td>U</td>
<td>R(3)</td>
</tr>
<tr>
<td>negative (HPV result unavailable); early recall</td>
<td>negative (HPV result unavailable); refer for colposcopy</td>
<td>G</td>
<td>U</td>
<td>S</td>
</tr>
<tr>
<td>negative (HPV result unavailable); routine recall</td>
<td>negative (HPV negative); cease due to age</td>
<td>N</td>
<td>Ø</td>
<td>A</td>
</tr>
<tr>
<td>negative (HPV negative); 3 year recall</td>
<td>negative (HPV negative); refer for colposcopy</td>
<td>N</td>
<td>Ø</td>
<td>S</td>
</tr>
<tr>
<td>negative (HPV positive); refer for colposcopy</td>
<td>negative (HPV result unavailable); early recall</td>
<td>N</td>
<td>U</td>
<td>R(m)</td>
</tr>
<tr>
<td>negative (HPV result unavailable); early recall</td>
<td>low grade dyskaryosis (HPV negative); refer for colposcopy</td>
<td>M</td>
<td>Ø</td>
<td>S</td>
</tr>
<tr>
<td>low grade dyskaryosis (HPV positive); refer for colposcopy</td>
<td>low grade dyskaryosis (HPV result unavailable); early recall (3 months)</td>
<td>M</td>
<td>U</td>
<td>R(3)</td>
</tr>
<tr>
<td>low grade dyskaryosis (HPV result unavailable); refer for colposcopy</td>
<td>low grade dyskaryosis (HPV result unavailable); early recall</td>
<td>M</td>
<td>U</td>
<td>S</td>
</tr>
<tr>
<td>borderline/squamous (HPV negative); refer for colposcopy</td>
<td>borderline/squamous (HPV positive); refer for colposcopy</td>
<td>B</td>
<td>Ø</td>
<td>S</td>
</tr>
<tr>
<td>borderline/squamous (HPV result unavailable); early recall</td>
<td>borderline/squamous (HPV result unavailable) refer for colposcopy</td>
<td>B</td>
<td>U</td>
<td>R(m)</td>
</tr>
<tr>
<td>borderline/squamous (HPV result unavailable) refer for colposcopy</td>
<td>borderline/endocervical (HPV negative); refer for colposcopy</td>
<td>E</td>
<td>Ø</td>
<td>S</td>
</tr>
<tr>
<td>borderline/endocervical (HPV positive); refer for colposcopy</td>
<td>borderline/endocervical (HPV result unavailable); early recall</td>
<td>E</td>
<td>U</td>
<td>R(m)</td>
</tr>
<tr>
<td>borderline/endocervical (HPV result unavailable); early recall</td>
<td>borderline/endocervical (HPV result unavailable); refer for colposcopy</td>
<td>E</td>
<td>U</td>
<td>S</td>
</tr>
</tbody>
</table>
NHSCSP ABC3 RESULT, INFECTION AND ACTION CODES

CYTOLOGY RESULT CODES

<table>
<thead>
<tr>
<th>Code without Hr-hpv test result</th>
<th>Code with hr-hpv Test result*</th>
<th>Cytology result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ø</td>
<td>G</td>
<td>?Glandular neoplasia (non-cervical) i.e. negative cervical cytology</td>
</tr>
<tr>
<td>1</td>
<td>n/a</td>
<td>Inadequate</td>
</tr>
<tr>
<td>2</td>
<td>N</td>
<td>Negative</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>Low grade dyskaryosis</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>High grade dyskaryosis (severe)</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>High grade dyskaryosis ?invasive squamous carcinoma</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>?Glandular neoplasia of endocervical type</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>High grade dyskaryosis (moderate)</td>
</tr>
<tr>
<td>8</td>
<td>B</td>
<td>Borderline change in squamous cells</td>
</tr>
<tr>
<td>9</td>
<td>E</td>
<td>Borderline change in endocervical cells</td>
</tr>
</tbody>
</table>

*Note that cytology results of G, N, M, B and E must be accompanied by a valid HR-HPV result code.

HR-HPV infection codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>No infection reported</td>
</tr>
<tr>
<td>Ø</td>
<td>HPV tested: negative</td>
</tr>
<tr>
<td>9</td>
<td>HPV tested: positive</td>
</tr>
<tr>
<td>U</td>
<td>HPV test unavailable/unreliable</td>
</tr>
</tbody>
</table>

Action codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Routine recall (3 or 5 years according to age)</td>
</tr>
<tr>
<td>R(m)</td>
<td>Repeat in number of months specified by laboratory</td>
</tr>
<tr>
<td>S</td>
<td>Suspend from recall system</td>
</tr>
<tr>
<td>H</td>
<td>No action</td>
</tr>
</tbody>
</table>
APPENDIX 9: NHS CERVICAL SCREENING PROGRAMME PUBLICATIONS

Current NHSCSP publications in numbered order (as at January 2013)

<table>
<thead>
<tr>
<th>Publication Number</th>
<th>Date</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSCSP Publication No. 10</td>
<td>April 1999</td>
<td>Histopathology reporting in cervical screening</td>
</tr>
<tr>
<td>NHSCSP Publication No. 11</td>
<td>November 1999</td>
<td>NHSCSP: Guidelines for Managing Incidents in the Cervical Screening Programme</td>
</tr>
<tr>
<td>NHSCSP Publication No. 15</td>
<td>May 2011</td>
<td>External Quality Assessment Scheme for Gynaecological Cytopathology v4</td>
</tr>
<tr>
<td>NHSCSP Publication No. 16</td>
<td>September 2003</td>
<td>Bench Aid for the Reporting of Cervical Histological Samples Associated with Abnormal Cervical Cytological or Colposcopic Investigations</td>
</tr>
<tr>
<td>NHSCSP Publication No. 17</td>
<td>September 2003</td>
<td>Ergonomic working standards for personnel engaged in the preparation, scanning and reporting of cervical screening slides</td>
</tr>
<tr>
<td>NHSCSP Publication No. 18</td>
<td>February 2004</td>
<td>Cervical Screening Call and Recall: Guide to Administrative Good Practice</td>
</tr>
<tr>
<td>NHSCSP Publication No. 19</td>
<td>April 2004</td>
<td>External Quality Assessment Scheme for the Evaluation of Papanicolaou Staining in Cervical Cytology, Protocol and Standard Operating Procedures</td>
</tr>
<tr>
<td>NHSCSP Publication No. 20</td>
<td>May 2010</td>
<td>Colposcopy and Programme Management: Guidelines for the NHS Cervical Screening Programme</td>
</tr>
<tr>
<td>NHSCSP Publication No. 21</td>
<td>December 2004</td>
<td>Guidelines on Failsafe Actions for the Follow-up of Cervical Cytology Reports</td>
</tr>
<tr>
<td>NHSCSP Publication No. 22</td>
<td>September 2005</td>
<td>the Aetiology of Cervical Cancer</td>
</tr>
<tr>
<td>NHSCSP Publication No. 23</td>
<td>April 2006</td>
<td>Taking Samples for Cervical Screening-a Resource Pack for Trainers</td>
</tr>
<tr>
<td>NHSCSP Publication No. 24</td>
<td>October 2006</td>
<td>Modelling the Impact of Referral Guideline Changes for Mild Dyskaryosis on Colposcopy Services in England</td>
</tr>
<tr>
<td>NHSCSP Publication No. 25</td>
<td>April 2006</td>
<td>Cervix chart for sample takers in primary care. (Available only to staff working in the NHS Cervical Screening Programme)</td>
</tr>
<tr>
<td>NHSCSP Publication No. 26</td>
<td>December 2006</td>
<td>Improving the Quality of Written Information Sent to Women about Cervical Screening: Evidence-based Criteria for the Content of Letters and Leaflets</td>
</tr>
<tr>
<td>NHSCSP Publication No. 27</td>
<td>December 2006</td>
<td>Improving the Quality of Written Information Sent to Women about Cervical Screening: Guidelines on the Content of Letters and Leaflets</td>
</tr>
<tr>
<td>NHSCSP Publication No. 28: December 2006</td>
<td>Audit of Invasive Cervical Cancers</td>
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</tr>
<tr>
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<td>-----------------------------------</td>
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<tr>
<td>NHSCSP Publication No. 29: March 2007</td>
<td>Time Dependent Response to Invitation for Cervical Screening</td>
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</tr>
<tr>
<td>NHSCSP Publication No. 30: October 2008</td>
<td>Guidelines for Quality Assurance Visits In The Cervical Screening Programme</td>
<td></td>
</tr>
<tr>
<td>NHSCSP Publication No. 31: February 2008</td>
<td>The Impact of Cervical Screening on Young Women: A Critical Review of the Literature</td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX 10: LABS AND COLPOSCOPY CONTACT DETAILS

<table>
<thead>
<tr>
<th>Hertfordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Call/Recall Centre</strong></td>
</tr>
<tr>
<td><strong>Primary Care Support Service Call/Recall Department</strong></td>
</tr>
<tr>
<td>3rd Floor, Charter House, Parkway, Welwyn Garden City, AL8 6JL</td>
</tr>
<tr>
<td>Phone: 01707 369730</td>
</tr>
<tr>
<td><strong>Screening samples</strong></td>
</tr>
<tr>
<td>Taken in GP Practices and Sexual Health Clinics by trained sample takers</td>
</tr>
<tr>
<td><strong>Cytology Laboratory</strong></td>
</tr>
<tr>
<td><strong>Watford General Hospital NHS Trust,</strong></td>
</tr>
<tr>
<td>Address: Vicarage Rd, Watford, Hertfordshire WD18 0HB</td>
</tr>
<tr>
<td>Tel: 01923 217742</td>
</tr>
<tr>
<td><strong>West Anglia Pathology Services</strong></td>
</tr>
<tr>
<td>Address: Pauline Copper Cytology Laboratory, Westbrooke House, 3 The Oaks, Fordham Road, Newmarket CB8 7XN</td>
</tr>
<tr>
<td>Tel: 01638 569160</td>
</tr>
<tr>
<td><strong>Colposcopy</strong></td>
</tr>
<tr>
<td><strong>Watford General Hospital NHS Trust,</strong></td>
</tr>
<tr>
<td>Address: Vicarage Rd, Watford, Hertfordshire WD18 0HB</td>
</tr>
<tr>
<td>Tel: 01923 217742</td>
</tr>
<tr>
<td><strong>Lister Hospital</strong></td>
</tr>
<tr>
<td>Address: Corey’s Mill Lane Stevenage Hertfordshire SG1 4AB</td>
</tr>
<tr>
<td>Tel: 01438 314333</td>
</tr>
<tr>
<td><strong>St Albans City Hospital</strong></td>
</tr>
<tr>
<td>Waverley Rd, St Albans, Hertfordshire AL3 5PN</td>
</tr>
<tr>
<td>Tel: 01727 897326</td>
</tr>
</tbody>
</table>