National Overview ~ *November 2003*

# Cervical Screening

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# Introduction and Acknowledgements

NHS Quality Improvement Scotland was established as a Special Health Board on 1 January 2003 as a result of bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS Quality Improvement Scotland is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

A part of this remit is to develop and run a national system of quality assurance (QA) of clinical services. For each service, NHS Quality Improvement Scotland establishes a project group to:

- develop and consult on the standards and self-assessment framework;
- oversee the process of external peer review; and
- report findings to the NHS Quality Improvement Scotland Board.

The Cervical Screening Project Group was established in June 2001 under the chairmanship of Dr Jocelyn Imrie OBE, Medical Advisor for Quality Assurance in the Scottish Cervical Screening Programme (SCSP). Membership of the Group is given in Appendix 1.

The *Clinical Standards for Cervical Screening* were developed by this Group and published in September 2002 following extensive consultation. Copies of the standards are available on request from NHS Quality Improvement Scotland or on the website (www.nhshealthquality.org).

Peer review visits to all cervical screening services in Scotland were conducted between January 2003 and August 2003 to assess performance against the standards. A local report on each service visit, including a detailed assessment of performance against each standard, has also been published and is available on the website or on request from NHS Quality Improvement Scotland.

This report presents an overview of cervical screening services in Scotland, reporting on performance nationally against the standards and including relevant examples of local initiatives.

NHS Quality Improvement Scotland gratefully acknowledges the work of the Cervical Screening Project Group for overseeing the project from its inception to the publication of this report. In addition, the contribution made by every member of the peer review teams was crucial to the success of the visit programme.

To those NHSScotland staff who contributed to the peer review visit, NHS Quality Improvement Scotland wishes to record its thanks. In particular, thanks are due to the designated SCSP representatives and screening co-ordinators who were responsible for preparing locally for peer review visits, and for the compilation of comprehensive self-assessment material prior to visits.

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# Executive Summary

## Introduction

Cervical cancer is one of the very few cancers that is preventable. Over 40 years ago a pathologist, Dr George Papanicolaou, found that by taking a sample of the cells from the surface of the cervix, it was possible to identify abnormal cells that, left untreated, could develop into cervical cancer. The test, known as a smear test is simple, low technology and low cost. It can be carried out in almost any healthcare setting by a range of trained healthcare professionals. Treatment is also straightforward and usually completed in a one-off session that does not require an anaesthetic or a stay in hospital.

As cervical cancer is the second most common cancer in women aged under 35, the development of a test that can prevent it was a crucial advance in medical science, particularly as that test could easily be offered to anyone at risk of the disease. Organised screening for cervical cancer was first introduced in Scotland in the 1960s, when two local programmes were set up, one in Tayside and one in Grampian. These local programmes paved the way for the introduction of a national, Scotland-wide programme that was introduced in 1987, inviting all women aged 20-60 to make an appointment to have a smear at least once every 5 years. Since then, over 6.5 million smears have been taken and of the 1.4[1] million women eligible for screening, over 87% have been screened in the last 5 years. Most importantly, around 250 cases of cervical cancer are prevented each year, and the incidence, or number of cases, has fallen by 32% in Scotland (1986-1999)[2]. This is mirrored by a 43% reduction in the number of deaths from the disease, falling from 199 to 113 (1986-2001)[3].

## Cervical Screening and Quality Assurance

Whilst each part of the process of screening is relatively straightforward, bringing them all together as an effective, organised programme is more complex, particularly due to the number of different people involved. With over 1.4 million women to be invited over 5 years, and reminded as necessary, over 1,500 people taking smears, 450,000 smears processed each year, and treatment provided to women in over 20 centres, there are real challenges involved in making sure the right part of the process happens at the right time, and with the right result. Cervical screening has been dogged by problems over the years, mainly due to women receiving a normal result when in fact there were probably abnormal changes in their cells at the time of their smear. As the outcome of such errors may be development of a serious disease, the quality assurance of every step of the way is essential. When problems have been investigated, it has usually been found that there were a number of organisation/systems issues that, when combined, had poor outcomes. These included problems with issuing invitations and results, staff shortages, and

1. Information and Statistics Division (ISD), 2002.
2. Cancer of the Cervix Uteri, (Scotland) Trends in Incidence, (ISD), 2002.
3. Cancer of the Cervix Uteri, (Scotland) Trends in Mortality, (ISD), 2002.

ineffective monitoring. The challenge, therefore, is to make sure that as far as possible, every stage of the screening process is covered by systems that reduce and manage any risk of error.

Quality assurance of cervical screening is not new. Since the Scottish Cervical Screening Programme (SCSP) was established, there have been a number of standards and systems in place to make sure that quality is maintained and improved. This is particularly true in the laboratory setting where stringent quality control has traditionally been in place. The SCSP is nationally co-ordinated by NHSScotland Screening Programmes, part of the National Services Division (NSD) of the Common Services Agency (CSA), which promotes the sharing of good practice and the development of common protocols and procedures.

In June 2001, the remit of the Clinical Standards Board for Scotland (now part of NHS Quality Improvement Scotland) was extended to include the independent review of the quality of the cervical screening programme in Scotland. The first step towards this was the development of a set of standards that drew together the various standards already in place, and built upon the experience and expertise of those providing cervical screening, and those using these services. A multidisciplinary project group was set up to take this forward, and the standards it produced focus on the key elements of the programme that have a direct impact on the quality of care a woman receives on her journey through the screening process. Standards were set in the following five areas:

- A **general** standard, covering the way in which the service is provided, including accountability and monitoring arrangements.
- **Call-recall and failsafe**, covering the issuing of invitations and reminders, and the systems in place to make sure women are not 'lost' to the system.
- **Smear-taking**, including training, environment and equipment, and technique.
- **Laboratory reporting**, which relates to reporting of the smears.
- **Colposcopy**, the investigation and treatment women receive if problems are picked up.

These standards were developed after extensive consultation, and this was followed by the first ever Scotland-wide quality review of cervical screening services. This executive summary highlights the key features of this review, describing the strengths and challenges identified across the five areas in which standards have been set.

## Summary of Findings

Generally, a high standard of cervical screening is provided across the country, and many examples of good practice were identified. However, there was considerable variation in the way in which performance is monitored, both locally and nationally, and this made it difficult on occasion to assess performance. More detailed feedback on the criteria and standards can be found in Chapter 2.

## General (Standard 1)

NHS Boards are responsible for making sure that high quality screening services are provided to women in their area. As this involves a range of different services delivered by a number of organisations in a variety of NHS settings, co-ordination of these activities lies at the heart of effective screening. Standard 1 states that each NHS Board should have a multidisciplinary co-ordinating team in place, including representatives of those involved in providing cervical screening, and those using the services.

## Strengths

- Multidisciplinary teams in place in every mainland NHS Board to co-ordinate and monitor cervical screening.
- A high level of support provided by public health specialists.
- Comprehensive information materials that have been developed with the public.
- Case review of every instance of invasive cervical cancer, and sharing of the knowledge gained and lessons learned.

## Challenges

- Involving the public in every aspect of screening, particularly on multidisciplinary co-ordinating groups.
- Making sure that dedicated, specialist public health support is in place at NHS Board level.
- Reviewing and updating the basic national service specification that all NHS Boards should be working to.
- Introducing arrangements to support the monitoring of cervical screening services, including the information women receive, and the way in which they receive it.

## Recommendations

NHS Boards should:

- Maintain and build on public involvement at every stage.
- Clearly define specialist public health sessions, and identify protected time to make sure these are available.
- Make sure that monitoring arrangements are in place where elements of the screening programme, such as laboratory services, are commissioned from other NHS Boards.

NSD should:

- Review and update the basic national service specification, in collaboration with NHS Boards.

## Call-Recall and Failsafe (Standard 2)

The SCSP aims to invite all eligible women (those aged 20-60) to make an appointment to have a cervical smear at least once every 5 years. If a woman does not respond within 3 months, she is sent a reminder, followed by a further reminder 3 months after that. If she still does not respond, she is returned to the recall system and called again 3 years after the date of the first call for screening. This is known as call-recall and depends on a well-maintained, accurate population register that holds details on every woman registered with a GP, and if possible, pointing to those who have their healthcare provided in other ways such as long-stay care.

In Scotland, there is a well-established population register known as the Community Health Index (CHI). This is used for call-recall in a variety of healthcare programmes including immunisation and breast screening. It is also used to administer GP practice payments and considerable effort has been invested in making sure it is accurate. While this robust baseline index of eligible women is available, call-recall arrangements in Scotland are complicated by the fact that there are three different systems in use:

1. One of the two 'national' call-recall systems: the Cervical Cytology Screening (CCS) system or the Online Cervical Cytology Uptake and Recall System (OCCURS), administered through a regional (NHS Board-wide) call-recall office.

2. A GP practice-based system.

3. A mix of both systems, using the 'national' system lists as a cross-check for the practice lists.

Having different systems in place presents real problems for monitoring many aspects of cervical screening, as NHS Boards cannot directly collect information about GP activity without feedback from GPs. Further, NHS Boards may not be aware of which letters are in use, how and what information is provided, and how results are given. Whilst uptake rates are high, with over 87% of women invited attending for screening, there is a need to be able to monitor how this is achieved, and also to make best use of the considerable investment that is made in developing information materials, including invitation and results letters. This has already been recognised, and NHSScotland has invested in the development of a national call-recall system, the Scottish Cervical Call-Recall System (SCCRS), that is targeted for implementation across Scotland from 2006. This links screening offices with GP practices and laboratories, and will support both call-recall and failsafe, and follow-up arrangements.

## Strengths

- High uptake rates across Scotland.
- Evidence of robust protocols in use to follow up women who do not attend or those who have a non-negative result.

## Challenge

- Monitoring of call-recall and failsafe activity in GP practices that do not participate in one of the national call-recall systems, particularly during the period before the new SCCRS system is rolled out.

## Recommendations

- The development and roll-out of SCCRS should be completed as soon as possible.
- Contingency arrangements should be made to cover the period before the new system is in place. In particular, any updates required to ensure women are screened appropriately should be made to the existing systems.

## Smear-taking (Standard 3)

Monitoring this standard presented some problems, simply because of the sheer numbers of smear-takers, practices and clinics. There are over 1,000 GP practices alone, and many more smear-takers. Making sure that they all had the required training, including communication skills, and that the screening environment was private and comfortable, was simply not possible. It was agreed that a possible way of monitoring could be through the Practice Accreditation Scheme that is run by the Royal

College of General Practitioners (RCGP). The Scottish Executive Health Department has set a target of January 2005 for all practices to be accredited. Several NHS Boards reported on local arrangements to review GP premises, and recent funding has been released to support the upgrading and development of premises.

It was also difficult to monitor how quickly results are sent out after smear tests are taken. Where this could be monitored, very few NHS Boards were able to evidence that they met the required standard of sending women their smear test results within 4 weeks.

## Strengths

- Cervical screening is widely available to women in Scotland.
- Many smear-takers have attended accredited smear-taking courses, which include communication skills training.

## Challenges

- Monitoring the facilities for smear-taking.
- Improving the time between taking the smear and sending out the results.
- Ensuring that all women get their results in writing, as well as backing this up as required. This is particularly important if the result is non-negative.

## Recommendations

- NHS Boards should use the introduction of the new screening technique, liquid based cytology (LBC) as a training opportunity for smear-taking, (see Standard 4).
- Results should be sent out within 4 weeks of taking the smear.
- Closer co-operation should be developed between primary care and the RCGP to avoid duplication of assessment visits.

## Laboratory Reporting (Standard 4)

Cytology laboratories in Scotland have long upheld very high professional standards, and all have current Clinical Pathology Accreditation (CPA). This has not been easy to achieve and maintain over the last 15 years, mainly due to staffing shortages. However, the commitment to ensure that services meet set standards has been evident throughout Scotland, and laboratory staff meet together regularly to review performance. Scotland has led the way in introducing a technical External Quality

Assurance (EQA) scheme which aims to improve the consistency of sample staining, and also has two schemes for those reporting smears: a national proficiency-testing scheme and a slide circulation scheme.

The proficiency-testing scheme is run as a regular test in exam conditions when staff in a laboratory report on a test set of smears within a given time. The results are then scored and laboratory and personal profiles are provided. It is run independently, is nationally funded, and has provided a very useful way of identifying teaching needs or reporting challenges. The slide circulation scheme is educational, and provides teaching sets of 'difficult' or interesting slides. These are usually examples of smears or conditions that are not seen very often or where there is known variability in reporting. Laboratories report on these teaching sets, and the answers are then sent out for them to compare with their responses. All laboratories are invited to submit material, and the scheme is dependent on this.

All smears in Scotland are reported by a trained cytoscreener, and every report is checked. Abnormal smears are referred to a consultant for a further review. However, over the last 5 years there have been serious staffing pressures. It takes 2 years to fully train a cytoscreener and, as the checks in place cannot be overridden, staff shortages inevitably lead to longer reporting times. While this may cause anxiety for women, the safety measures in place in laboratories are considered the main priority, although all laboratories are actively exploring ways of addressing this. Some have transferred part, or all, of their reporting to another Scottish laboratory, whilst others are using private laboratories to assist with workload and reduce reporting times, rather than struggle with reporting a limited number of smears. Over time, the challenge will be to distribute reporting among laboratories to ensure that quality is maintained and volume is manageable.

Another major initiative that has been introduced since the NHS Quality Improvement Scotland cervical screening standards were developed, is the introduction of a new smear-taking and slide preparation technique known as liquid based cytology or LBC. Using LBC has been shown to reduce the number of smears that are reported as unsatisfactory, thus reducing both laboratory workload and anxiety for women who may otherwise have needed repeat smears.

## Strengths

- Long-held, high quality standards are in place in all Scottish laboratories.
- All normal smear reports are double-checked, and any non-negative smear reports are medically reviewed. Where there is a big difference between the smear result and the result of any biopsy (tissue) taken at colposcopy, there is a review of the recent smear history.

## Challenges

- Balancing workload individually and within laboratories. The challenge is to report enough to maintain skills, but not to report so many that the finer interpretative skills are blunted.
- Reducing reporting times.

## Recommendations

- Individual and laboratory workload should be regularly reviewed. Action should be taken where these are outwith the set standards, or where performance is outwith acceptable ranges, and the outcome of this should be monitored.
- Smear reports should be issued within 4 weeks of the date the smear is taken.
- The way in which laboratory resources are used across Scotland should be reviewed to make sure that these are used effectively.

## Colposcopy (Standard 5)

Women with non-negative smears are referred for further investigation and, where necessary, for a diagnosis and treatment. This investigation is called colposcopy and is carried out by trained medical and nursing staff (colposcopists) using an instrument called a colposcope. This magnifies and illuminates the cervix allowing the colposcopist to identify any abnormal areas, and take further tests as necessary. Treatment can also be carried out at the same time. As most women referred to colposcopy have no symptoms, it is important that they are given information that explains what to expect, and why this further investigation is important.

Attendance at colposcopy clinics is often poor, and as there are also long waiting lists for appointments, further work on this is required. While the colposcopy service takes responsibility for following up its patients until they are ready to be returned to routine recall, it is not always easy to persuade women to return for follow-up if they believe they have

been successfully treated. There is a known shortage of trained colposcopists, and nursing cover at these clinics is often stretched and shared between other services. Because of this, it is important that primary care and laboratories have clearly agreed referral policies that make sure only those who are likely to need further investigation and treatment are referred. One of the main issues is the referral of women who present with symptoms outwith the cervical screening programme, and the referral of women with unsatisfactory smears who may only need another smear taken, but who experience significant anxiety due to this referral.

Another major challenge identified was the problem faced across this service with monitoring performance. The British Society for Colposcopy and Cervical Pathology (BSCCP) has specified a core audit data set, and whilst a system was developed to support the collection and monitoring of this information, it has been dogged by resource issues and is largely without any committed technical, administrative or analytical support.

## Strengths

- Colposcopy services provide excellent information for women, and the staff have strong communication skills.
- The introduction of nurse colposcopists in some areas.

## Challenges

- Reducing waiting times for colposcopy appointments.
- Optimising clinic appointments to take account of non-attendance and prioritisation.
- Making sure that there is adequate, dedicated nursing cover for clinics, and that opportunities for role extension are fully explored.
- Monitoring performance against BSCCP standards.

## Recommendations

NHS Boards should:

- Review referral patterns. In particular, there should be a review of which patients are sent to colposcopy, and more focused monitoring of unsatisfactory smear rates and inappropriate referrals for clinical reasons.
- Put in place clear protocols to make sure that urgent referrals are prioritised, and that ‘short notice’ arrangements are in place to tackle appointment slots ‘lost’ through non-attendance. Consideration should

be given to reminding all women of their colposcopy appointment, possibly through primary care. This can be particularly valuable where there are long waiting times for appointments.

- Make sure that adequate and dedicated nursing cover is in place to ensure the safe and effective running of colposcopy clinics.
- Provide the staff required to collect data locally, and to support colposcopy clinics in monitoring their services and addressing any issues identified.

NSD should:

- Secure funding for the development of an information system that collects BSCCP data to monitor colposcopy services, and provide a central reporting system and analysis of these data.

## In Summary

Cervical screening services in Scotland are of high quality and are used by the majority of women. Monitoring of these services is challenging, due to the different systems in use, and in some instances, there are no standard systems in place. Every review team commented on the high awareness of those providing these services: they are aware of the standards they strive to meet; the service they provide; the needs of those using the service; and the need to build on their success to date. Much has been achieved since the national cervical screening programme was introduced in 1986, and the challenge is to maintain the reduction in the number of cases of cervical cancer and in the number of deaths from the disease.

Many changes also face the service: the setting up of unified NHS Boards that will bring Primary Care and Acute Trusts together under one system; the introduction of the new General Medical Services (GMS) contract that will change GP accountability, and the way in which the quality of services they provide is monitored; the introduction of LBC; and, most importantly, the introduction of SCCRS, which should 'join up' many parts of the process that cannot currently interact easily.

The NHS Quality Improvement Scotland review of the Scottish Cervical Screening Programme found a service keen to change, and open to different ways of doing things. The review teams had a strong sense that this is a trademark of a committed service that looks to the future, and is not afraid to accept challenges and changes.

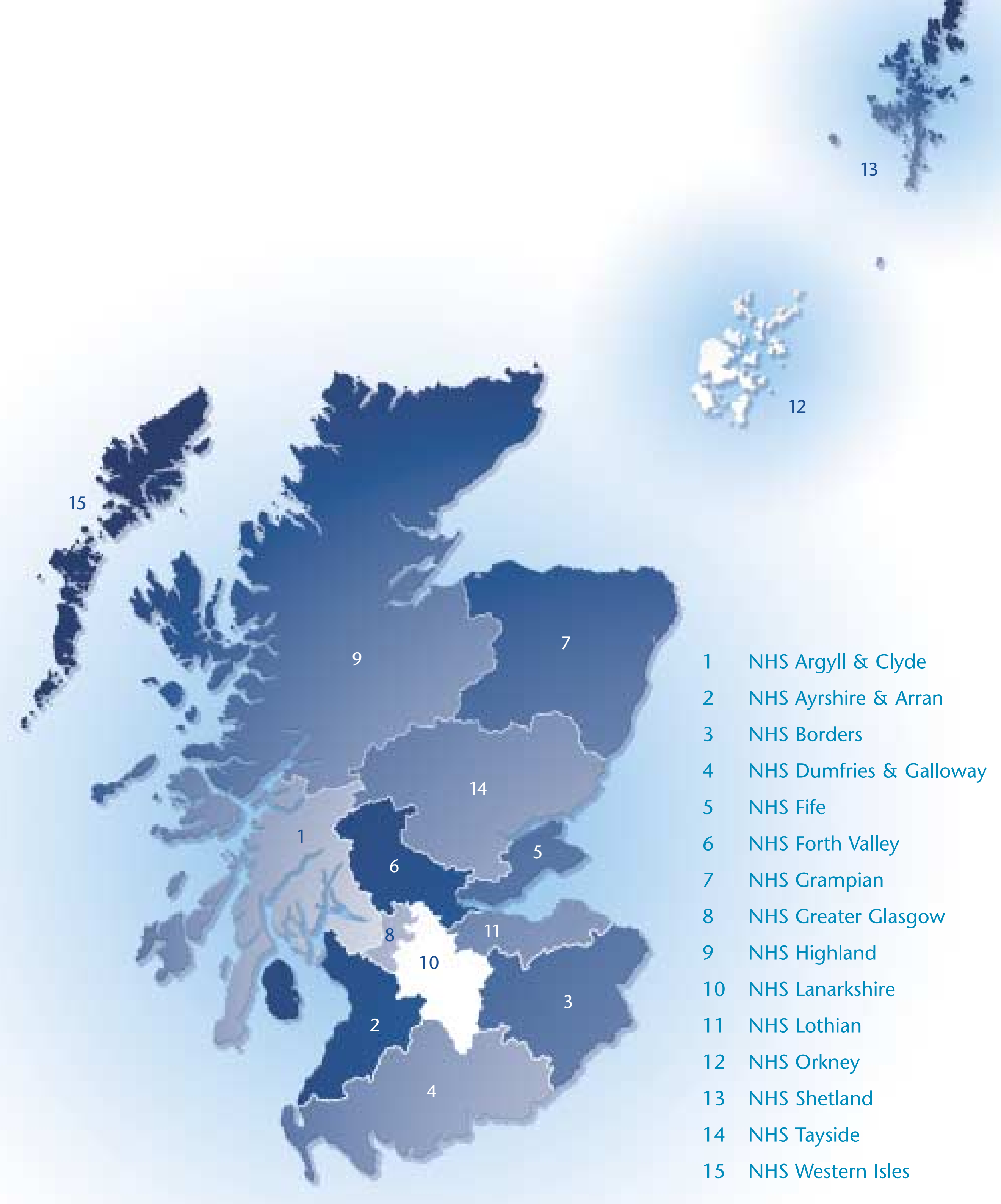
Chapter 1

# Setting the Scene

- List of NHSScotland Cervical Screening Services
- The NHS Quality Improvement Scotland Approach to Assessment
- Background to the Clinical Standards for Cervical Screening
- Introduction to Cervical Screening
- The NHS Quality Improvement Scotland Standards and Your Care
- Frequently Asked Questions
- Useful Contacts

# 1. Setting the Scene

## 1.1 List of NHSScotland Cervical Screening Services



The following cervical screening services were reviewed during January 2003 - August 2003. Local reports, containing findings of each individual peer review visit and assessment against the standards, are available on the website (www.nhshealthquality.org) or in print format from NHS Quality Improvement Scotland.

| **Local Report Area:**<br>Total Population[4]<br>Estimated Target Population (eligible women aged 20-60)[5]<br>Cervical Screening Uptake Rates[6] (percentage of eligible women screened every 3.5-5.5 years) | **NHS Board Area Visited** |
|---|---|
| **1. Argyll & Clyde**<br>418,750<br>113,785<br>80.7% (3.5 years)<br>85.8% (5.5 years) | NHS Argyll & Clyde |
| **2. Ayrshire & Arran**<br>367,060<br>98,852<br>84.5% (3.5 years)<br>88.9% (5.5 years) | NHS Ayrshire & Arran |
| **3. Borders**<br>107,400<br>27,741<br>87.4% (3.5 years)<br>90.3% (5.5 years) | NHS Borders |

4. Information and Statistics Division (ISD), 2002.
5. As above.
6. As above.

| Local Report Area | NHS Board Area Visited |
| --- | --- |
| **4. Dumfries & Galloway**<br>147,310<br>36,627<br>88.4% (3.5 years)<br>92.1% (5.5 years) | NHS Dumfries & Galloway |
| **5. Fife**<br>350,620<br>93,378<br>79.4% (3.5 years)<br>85.2% (5.5 years) | NHS Fife |
| **6. Forth Valley**<br>279,370<br>75,086<br>82.8% (3.5 years)<br>88.2% (5.5 years) | NHS Forth Valley |
| **7. Grampian**<br>523,290<br>144,630<br>85.4% (3.5 years)<br>89.6% (5.5 years) | NHS Grampian |
| **8. Greater Glasgow**<br>866,080<br>257,630<br>77.7% (3.5 years)<br>82.3% (5.5 years) | NHS Greater Glasgow |
| **9. Highland**<br>208,140<br>55,127<br>85.6% (3.5 years)<br>89.3% (5.5 years) | NHS Highland |

| Local Report Area | NHS Board Area Visited |
|---|---|
| **10. Lanarkshire**<br>552,910<br>155,185<br>80.7% (3.5 years)<br>85.4% (5.5 years) | NHS Lanarkshire |
| **11. Lothian**<br>779,100<br>236,202<br>81.2% (3.5 Years)<br>85.1% (5.5 years) | NHS Lothian |
| **12. Orkney**<br>19,210<br>4,801<br>90.7% (3.5 years)<br>93.0% (5.5 years) | NHS Orkney |
| **13. Shetland**<br>21,940<br>5,536<br>88.6% (3.5 years)<br>91.6% (5.5 years) | NHS Shetland |
| **14. Tayside**<br>387,420<br>100,124<br>80.9% (3.5 years)<br>87.1% (5.5 years) | NHS Tayside |
| **15. Western Isles**<br>26,200<br>6,311<br>84.1% (3.5 years)<br>87.5% (5.5 years) | NHS Western Isles |

## 1.2 The NHS Quality Improvement Scotland Approach to Assessment

NHS Quality Improvement Scotland uses a methodology which draws upon other quality assurance models to enable it, in partnership with healthcare professionals and members of the public, to develop standards for clinical services and to assess performance across NHSScotland against these standards.

Further information and definitions of the terms used in the standards and in the assessment of performance are contained in Appendix 2.

### Assessment Categories

Each review team assesses performance using the categories 'met', 'not met' and 'not met (insufficient evidence)', as detailed below:

- '**Met**' applies where the evidence demonstrates the standard and/or criterion is being attained.
- '**Not met**' applies where the evidence demonstrates the standard and/or criterion is not being attained.
- '**Not met (insufficient evidence)**' applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category '**not applicable**' is used where a standard and/or criterion does not apply to the service under review.

## 1.3 Background to the Clinical Standards for Cervical Screening

In June 2001, the remit of the Clinical Standards Board for Scotland (now part of NHS Quality Improvement Scotland) was extended to include the independent review of performance against standards for the Scottish Cervical Screening Programme, in line with the commitments in *Our National Health: A Plan for Action, a Plan for Change* (2000). Since January 2003, this work has been taken forward by NHS Quality Improvement Scotland.

NHS Quality Improvement Scotland has three key areas of responsibility relating to the quality assurance of cervical screening:

- carrying out the rolling programme of independent, multidisciplinary review visits in Scotland to assess the performance of cervical screening services against UK standards;

- the ongoing development and endorsement of revisions of Scottish cervical screening standards, including integration with NHS Quality Improvement Scotland cancer standards; and

- overseeing and developing the strategic quality assurance component of uni-professional and multi-professional audit groups for the screening programme.

As a first step in addressing the development of standards for cervical screening, a multidisciplinary project group was appointed. This included healthcare professionals and members of the public, and was led by Dr Jocelyn Imrie OBE, Medical Advisor for Quality Assurance in the Scottish Cervical Screening Programme (SCSP). The Project Group first met in August 2001 and its membership is given in Appendix 1.

The remit of the Cervical Screening Project Group was to:

- develop robust core national standards in relation to the Scottish Cervical Screening Programme;

- recommend a review process; and

- provide a baseline report on performance against standards in Scotland.

The *Clinical Standards for Cervical Screening*, published in September 2002 (available from the NHS Quality Improvement Scotland website), focus on key elements that have a direct impact on the quality of care a woman receives on her journey through the screening process.

Using these standards, a programme of peer review was undertaken to the 15 NHS Boards in Scotland between January 2003 and August 2003, involving both healthcare professionals and lay representatives.

## 1.4 Introduction to Cervical Screening

Cervical screening was introduced in the UK in the 1960s when a number of local screening programmes were implemented. By the 1980s, many programmes had been developed on an ad hoc basis, but it was recognised that this was not an effective way to manage a population-based screening programme. There were also concerns that those women who were at greater risk of developing cervical cancer were not being screened, and that some who were screened were not being followed up appropriately.

In 1987, the Scottish Cervical Screening Programme was set up when the Scottish Home and Health Department required all Scottish NHS Boards to introduce computerised call-recall systems and to meet certain quality standards. The NHS Boards were required to complete calling the first 'round' of women by 1991 and, since then, the programme has continued to develop. The aim of the SCSP is to reduce the number of women who die from cervical cancer (mortality).

The current policy in Scotland is that eligible women aged 20-60 are invited to have a free cervical smear test at least once every 5 years. In practice, all Scottish NHS Boards invite women every 3 years. Currently, approximately 400,000 women attend for a cervical smear test each year, and over 439,678[7] smears are processed annually. Of the 1.4 million women eligible for screening, over 86% have been screened in the last 5 years, and it is estimated that up to 250 cases of cervical cancer are prevented each year. Since 1986, the incidence of invasive cervical cancer has fallen by 32% in Scotland, and there has also been a 43% reduction in deaths from the disease. This is largely due to cervical cancers being prevented by the detection of pre-cancerous changes in the cervix, by cervical screening, and effective treatment of these changes.

### Basic Facts about Cervical Screening

Cervical screening is a way of preventing cancer of the cervix by detecting and treating abnormal changes in a woman's cervix which, if left untreated, may develop into invasive cervical cancer. The first stage in cervical screening is a smear test, which is a simple procedure, often carried out by GPs or, more commonly, their practice nurses.

Cervical screening is not a test for cancer. It detects possible abnormalities, or changes in cells, which may develop into cancer if they are not treated. Almost all changes detected by screening are successfully treated.

7. Cervical Cytology Workload Statistics, ISD, year ending 31 March 2003.

### What is a Cervical Smear Test?

Cells from the surface of the cervix, or 'neck of womb', are collected and sent to a specialist laboratory. The cells are then examined under a microscope to see if any of them appear abnormal.

The examination of cervical smears is a highly skilled process. Like most medical tests, the test is not 100% accurate. However, having a regular smear test means that any changes are more likely to be picked up.

If the smear test shows some minor abnormality this does not mean that cancer is present. Often, these will return to normal on their own. However, if the smear result shows slightly more marked changes which do not return to normal on their own, a further investigation will be required. This investigation is called colposcopy.

### What is Colposcopy?

Colposcopy enables the cervix to be examined more closely. An instrument called a colposcope is used, which looks like a pair of binoculars on a stand. This allows the doctor or nurse colposcopist to examine more closely any changes on the cervix. The colposcope does not go inside the body.

The SCSP is organisationally very complex and many healthcare staff are involved in providing this service. They include: the doctors and nurses who take the smear tests in GP surgeries and community clinics; the laboratory staff who interpret and report the smears; clinicians who treat abnormal changes; and the people who run the computer systems. Each NHS Board also has a nominated person responsible for its cervical screening programme (screening co-ordinator), and NHS Quality Improvement Scotland has appointed a medical advisor who is responsible for assuring the quality of the SCSP.

The SCSP is now well established and good systems are in place to ensure that a high quality of service is being delivered to women across the country.

## 1.5 The NHS Quality Improvement Scotland Standards and Your Care

### Questions You Might Want to Ask

The cervical screening standards have been summarised overleaf and are shown in blue. Each standard is followed by relevant questions you might want to ask about your care.

## General

*An effective cervical screening service is available and offered in NHS Boards.*

- Who is responsible for organising the cervical screening service in my area?
- How will I know when I am due a smear test?
- Where do I go for a smear test?

*All communication with users of the cervical screening service is clear and relevant.*

- How will I get information about cervical screening?
- What information is available to help me if I do not speak/read English? How can I access a translator?
- What information is available to help me if I am sensory impaired?
- How can I make a comment or complaint about the service?

## Call-Recall and Failsafe

*Effective arrangements are in place to ensure that all eligible women are invited for screening once every 5 years.*

- When and how will I be invited for screening?
- I have recently moved to Scotland. Can I have a cervical smear test?
- I am not registered with a GP. Where can I have a smear test?

*Women who remove themselves from the cervical screening programme remain on the call-recall system and have the opportunity to be reinstated at a later date.*

- Can I opt out of the cervical screening programme?
- I have changed my mind about screening. Can I still have a smear test?

## Smear-taking

*All women are given an explanation of how and why the smear test will be taken before and when they attend.*

- What information is available to me before I attend for a smear test?
- Who will explain the process to me?
- Who carries out the smear test?

*All women receive their smear test result timeously, in a format that takes account of their cultural, educational and physical needs.*

- When and how will I get my results?
- What happens after I have received my results?
- What happens if I need further investigation/follow-up tests?

## Laboratory Reporting

*There is timely issue of laboratory results to smear-takers.*

- How long does it take for the laboratory to report my smear test?

*All staff who carry out screening of smear slides and/or reporting smears are either in a recognised training programme or have successfully completed this.*

- Who works in the laboratory and what qualifications do they have?

## Colposcopy

*There is early colposcopy assessment for all women referred for investigation of an abnormal smear.*

- How long will I have to wait for an appointment?
- Can I change my appointment time?
- What happens if I miss my appointment?

*A professional and efficient colposcopy service requires good communication.*

- When will I get my results?
- What will happen after I get my results?

## 1.6 Frequently Asked Questions

*Q. What is cervical screening?*

A. Cervical screening is not a test for diagnosing cervical cancer. It is a test to check if the cells that make up the neck of the womb (the cervix) are developing normally. For 9 out of 10 women the test results show that everything is fine. But for others, the test shows changes in the cells that can be caused by many things. Most of these changes will not lead to cervical cancer.

*Q. Why should I go for a smear test?*

A. Cervical cancer can often be prevented. Cervical screening can act as an early warning sign indicating that there is a possibility that cancer may develop in the future. If the smear test shows abnormalities, these can usually be simply and effectively treated.

*Q. Where should I go for a smear test?*

A. Smear tests are usually taken at GP surgeries by a specially trained practice nurse, or by a doctor. However, you may also choose to have your smear test taken at a family planning clinic or well woman clinic.

*Q. What happens during a smear test?*

A. The test takes just a few minutes. The doctor or nurse will ask you to lie down on a couch. They will then gently put a small instrument (speculum) into your vagina to hold it open. A smooth wooden or plastic spatula is used to collect a few of the cells from the cervix. Alternatively, a small brush may be used to collect the cells. The cells are carefully spread across a glass slide, which is then sent to the laboratory where it will be examined under a microscope. A new technique called liquid based cytology (LBC) is being introduced. Using LBC, the cells are collected by a brush and transferred into a small jar containing preservative fluid, which is sent to the laboratory.

*Q. When do I get my results?*

A. When you have the test, the doctor or nurse will tell you how, where and approximately when you will get your results. Make sure you have received this information before you leave the surgery or clinic.

*Q. How effective is cervical screening?*

A. No screening test can be 100% accurate. However, attending regularly for screening can increase the chance of any changes in the cervix being detected early.

*Q. What do the different results mean?*

A. Most women receive a normal result, which means that the risk of developing cervical cancer is small. You do not need to have any extra smear tests until you are invited 3 years later, or unless you notice any abnormal symptoms in the meantime.

An unsatisfactory result means that the laboratory cannot assess the smear to its satisfaction. This is quite common and there may be many reasons for this. It does not mean that there are any abnormalities, but that not enough cells were seen to be able to give a result with confidence. A repeat smear test is usually taken in the following weeks.

Sometimes the smear test result shows that you have an infection. This can be easily treated. If there are no abnormal cell changes, you do not need to have any extra smear tests until you are next invited.

About 5% of all smear tests show an abnormality. These are graded as mild, moderate or severe.

*Q. What happens if I receive an abnormal result?*

A. Abnormal results are not unusual. The smear test is designed to pick up even minor abnormalities. It is important that they are monitored at an early stage and, if necessary, investigated further. If the abnormality is very minor they will frequently return to normal without treatment. In these cases, your doctor will ask you to return for another smear test in a few months time to check whether the abnormalities are still present, or whether they have returned to normal.

If your smear test indicates that the abnormalities are moderate or severe, your doctor will refer you to hospital for a colposcopy examination.

*Q. What is a colposcopy examination?*

A. A colposcopy examination involves looking at the cervix using a special microscope (colposcope), which looks like a large pair of binoculars. This does not touch or go inside you. The doctor will gently put a special tube (speculum) into your vagina to hold it open (similar to having a smear test). A special solution will be applied to your cervix, to highlight any areas of abnormality. The doctor will then use the colposcope to see where the abnormalities are and what they look like. The examination only takes about 15 minutes, and a nurse stays with you throughout.

*Q. If I have a colposcopy examination, will I need any treatment?*

A. During colposcopy, a small sample of cells (biopsy) may be taken from the abnormal area. This should not hurt. The biopsy is sent away to the laboratory to be examined, and you will receive the results at your next clinic appointment. Sometimes treatment is not needed, and the doctor will monitor you to ensure that there are no further problems. This may involve going back for further colposcopy examinations, or having more frequent smear tests until the doctor is satisfied that everything is normal.

If treatment is needed, the doctor will decide whether to treat minor abnormalities at your first appointment, or whether to carry out treatment at another appointment, once the biopsy result is known. If treatment has already been given, the biopsy result will confirm whether the treatment was appropriate. If treatment has not been given, the biopsy result will help the doctor decide the best form of treatment.

If treatment is required, this will be discussed with you. Most treatment takes just a few minutes, and can be done at an out-patient clinic using local anaesthetic. Most women feel no pain, although some experience cramps, like period pain.

*Q. What will happen after treatment?*

A. After treatment, the doctor will monitor you, to ensure that treatment has been successful, and that there are no further problems. It is likely that you will need to go back to the colposcopy clinic for a follow-up examination. A repeat smear test may also be taken to ensure that all abnormal cells have been removed. After you are discharged from the colposcopy clinic, you will be referred back to your GP, well woman clinic or family planning clinic for further smear tests. For a time, these will usually be more frequent than is normal, to ensure that the abnormalities do not return.

## 1.7 Useful Contacts

The following organisations will provide information about cervical screening. Practice nurses, GPs and other healthcare professionals taking smear tests can also provide you with information.

**1. NHSScotland Screening Programmes**
National Services Division
Common Services Agency
Room C030
Trinity Park House
South Trinity Road
EDINBURGH
EH5 3SF

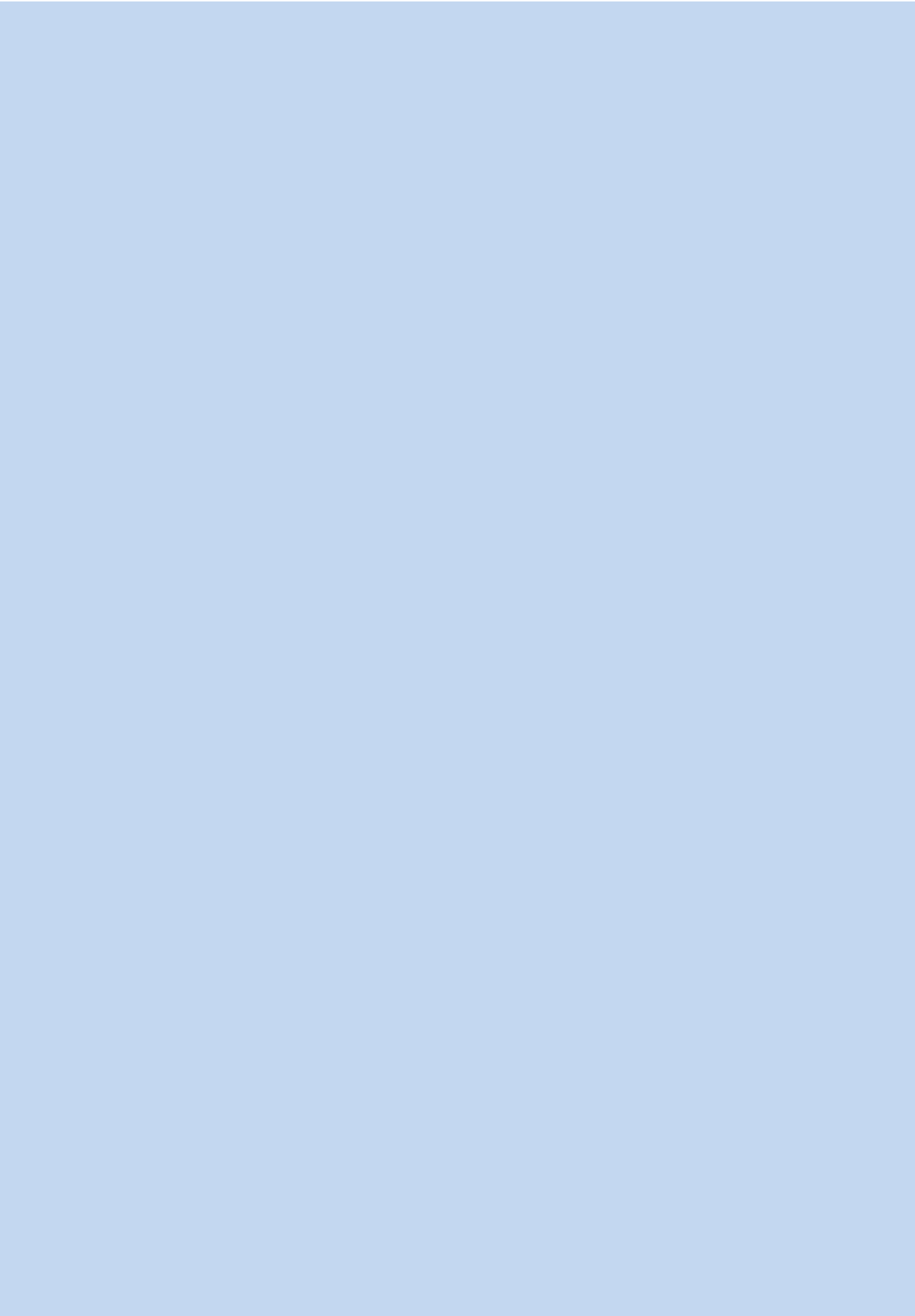
Tel: 0131 551 8136
www.show.scot.nhs.uk/nsd/screening/
www.show.scot.nhs.uk/nsd/screening/pdf/cervguide.pdf

**2. NHS Cancer Screening Programmes**
The Manor House
260 Ecclesall Road South
SHEFFIELD
S11 9PS

Tel: 0114 271 1060
Fax: 0114 271 1089
E-mail: info@cancerscreening.nhs.uk
www.cancerscreening.nhs.uk/cervical/index.html

**3. NHS Health Scotland (formerly Health Education Board for Scotland)**
Woodburn House
Canaan Lane
EDINBURGH
EH10 4SG

Tel: 0131 536 5500
Fax: 0131 536 5501
www.hebs.scot.nhs.uk/dbtw-wpd/exec/dbtwpcgi.exe



Chapter 2

# National Performance Against the Standards

# 2. National Performance Against the Standards

This section presents the findings across Scotland in terms of performance against individual standards. A number of examples of innovative local solutions and areas of good practice are highlighted in boxes throughout the text. These examples are not exhaustive - every review team noted examples of good practice during visits, and these were often in place in more than one service. Challenges are also listed, and there remains scope for change and improvements in the process of cervical screening.

Feedback from those reviewed and review team members is sought after every visit, and nearly 130 people have responded. Those involved in the review process report that the opportunity to consider different ways of addressing shared issues, to highlight difficulties, and to obtain feedback has been particularly valuable. A number of suggestions received will also help NHS Quality Improvement Scotland to improve the process used for future reviews of the Scottish Cervical Screening Programme (SCSP).

Giving the public and the service the chance to review aspects of the way in which cervical screening is provided is a starting point for many activities, including:

- measuring good practice;
- disseminating good practice;
- stimulating multidisciplinary working;
- involving those who use the service; and, perhaps most importantly,
- ensuring that the provision of care is balanced by the monitoring of that care against key performance standards, and that the quality of care is continually improved.

During the review of the SCSP, the 12 NHS Boards and three Island NHS Boards across Scotland were reviewed to assess performance against the standards. This national overview summarises the local reports produced for each service. Accordingly, the findings presented reflect the number of instances where the standard criteria were met, based on the denominator of the 15 local reports.

## Information, Data Collection and Audit

The Information and Statistics Division (ISD) of the Common Services Agency publishes quarterly laboratory reporting profiles and annual cervical screening update rates for each NHS Board. However, it should be recognised that this process requires a significant level of data to be produced at local level.

Two ‘national’ computer systems are currently in place to manage call-recall: the Cervical Cytology Screening (CCS) system, and the Online Cervical Cytology Update and Recall System (OCCURS). While many GP practices fully participate in these national call-recall systems, some prefer to use their own systems. In NHS Boards where there is a lot of GP call-recall activity, it has resulted in difficulties in monitoring call-recall activity on an NHS Board-wide basis. A new national system, the Scottish Cervical Call-Recall System (SCCRS) is currently under development, and will be rolled out across the country, once completed. GP participation in this new system will be compulsory.

There are no robust systems available for monitoring data in the areas of primary care, where GP practices do not participate in one of the national call-recall systems, and colposcopy. While systems have been developed for collecting colposcopy data in some NHS Boards, it is often difficult to retrieve these data, and they were reported to be unreliable.

Within the laboratories, a slide circulation scheme is in operation, to ensure that clinical laboratory results are accurate, reliable, and comparable. The scheme is educational and provides teaching sets of ‘difficult’ or interesting slides. These are usually examples of smears or conditions that are not seen very often, or where there is known variability in reporting. Laboratories report on these teaching sets, and individual screeners submit anonymised responses. The answers are then sent out for them to compare with their responses. In addition, the national proficiency-testing scheme is a quality assurance programme that aims to promote consistency in reporting across the country, support the development of skills, and enhance the confidence of cervical cytopathology staff in their reporting practice.

These quality assurance schemes are overseen by NSD, as is the central production of national programme information, including information leaflets. These information leaflets are available to all NHS Boards. While some Boards choose to use the national information leaflets, others have developed local leaflets based on the text from the national leaflets. Women across Scotland are therefore likely to receive uniform information, which contains the core elements as identified by the SCSP to enable informed choice.

While much work is underway to support monitoring within the service, this remains a major challenge for the SCSP. Data collection, technical support, analysis and audit are currently variable across the country, and require much personal input from dedicated individuals. This applies in particular to the colposcopy component of the service.

## 2.1 Standard 1: General

### Standard Statement 1(a)

***An effective cervical screening service is available and offered for NHS Board populations.***

### Essential Criteria

1(a)1. Every NHS Board has a multidisciplinary co-ordinating group with lay representation that meets at least annually and contributes to an annual report for the unified NHS Board.

This group is responsible for ensuring that effective cervical screening is offered and available to eligible women in their area in accordance with current NHSCSP/SEHD/CSBS guidance.

**This criterion was met in 10/15 NHS Boards.**

1(a)2. There is a designated consultant in public health medicine with responsibility for overseeing and monitoring the provision of cervical screening in their area which meets CSBS standards. (Responsibility may be delegated to key staff as appropriate.)

**This criterion was met in 13/15 NHS Boards.**

Although cervical screening is a national programme, it is the responsibility of each NHS Board to make sure that a cervical screening service is in place for eligible women in its area. This service is provided by many people in a variety of NHS settings, and co-ordination of service provision is essential if it is to be effective. Most Boards do have a multidisciplinary co-ordinating group in place, representing all the agencies involved and the general public, to oversee and monitor the provision and delivery of cervical screening in the area, although not every group includes members of the public. There is strong leadership in a number of Boards which reflects the responsibilities associated with the co-ordination of a complex programme. This requires the authority to make decisions, and to negotiate with, and influence, a wide range of people and services.

## Standard Statement 1(b)

***There is a service specification in place developed by, and including, all those involved in providing and monitoring cervical screening services in NHS Boards.***

### Essential Criteria

1(b)1. The service specification includes the following: audit, training, quality assurance, information for women, call-recall, smear-taking, smear reporting, follow-up and treatment.

**This criterion was met in 13/15 NHS Boards.**

1(b)2. NHS Boards have arrangements in place to ensure the specification is met and monitored on a regular basis.

**This criterion was met in 10/15 NHS Boards.**

A national service specification template has been developed which can then be used locally to explicitly state the service levels required, together with performance indicators and outcome measures that can be used to monitor cervical screening. This is particularly important for Boards that commission elements of the screening programme, such as laboratory services, from other Boards. Most Boards had a comprehensive service specification in place, and were able to demonstrate that it had been developed by those involved in the provision and monitoring of cervical screening services.

Regular monitoring of relevant outcome measures is essential to ensure that the services provided are of a high standard, and that these standards are maintained. Where service specifications were in place, not all Boards were monitoring services against these, or regularly reviewing the content of the specification to make sure it remained up to date and accurate. However, in several places, plans were already underway to address this.

## Standard Statement 1(c)

***All communication with the users of the programme is clear, informative, relevant and timeous.***

### Essential Criteria

1(c)1. The appropriate public are consulted when developing patient information about cervical screening.

**This criterion was met in 12/15 NHS Boards.**

1(c)2. Information leaflets and letters conform to current national guidelines (standards).

**Where evidence was available this criterion was met in 10/15 NHS Boards.**

1(c)3. All healthcare professionals communicating directly with the public undertake communication skills training.

**Where evidence was available this criterion was met in 7/15 NHS Boards.**

National information leaflets that have been extensively pre-tested are available and in use in many areas. However, a number of places have developed a range of in-house information (leaflets and letters), the content of which is not easily monitored, and it was not clear whether users of the service had been consulted during their development.

It was difficult for Boards to demonstrate that those taking smears or carrying out further investigations and treatment had undertaken communication skills training. While this was often available as part of other courses such as induction, and there is a communication skills module in many smear-taking courses, it was not possible to monitor uptake of these courses.

## Standard Statement 1(d)

***Case review and audit is undertaken to facilitate continuing improvement.***

### Essential Criterion

1(d)1. Screening histories of women developing invasive cancer are reviewed, and any areas in the Programme which require improvement are identified and addressed.

**This criterion was met in 12/15 NHS Boards.**

Most Boards review the screening histories of women with invasive cervical cancer, and valuable information about the way in which the service is provided has been collected. This information has shown that in most cases of cervical cancer, women have not taken up the opportunity of screening, and this has informed the development of targeted health promotion initiatives. Further, it has supported training where improvement is required, and also provides a valuable teaching opportunity.

### Strengths

- There is a high level of commitment to cervical screening at Board level, with all but one Board able to demonstrate that an identified individual is responsible for the co-ordination of the cervical screening programme.
- A wide range of information about cervical screening is available, much of which has been pre-tested with the public.
- There is comprehensive review of the screening history of women who develop invasive cervical cancer, which supports health promotion and training initiatives.

### Challenges

- Making sure that those responsible for co-ordinating the cervical screening programme at Board level have sufficient experience, authority and influence.
- Introducing arrangements to support the monitoring of cervical screening services, including the information women receive and the way in which they receive it.
- Ensuring that the public is represented on co-ordinating groups, and that annual reports on the service are widely circulated.
- Reviewing and updating the basic national service specification that all Boards should be working to.

## Recommendations

NHS Boards should:

- Make sure that monitoring arrangements are in place where elements of the screening programme, such as laboratory services, are commissioned from other NHS Boards. In this situation, the commissioning NHS Board has responsibility for making sure that the quality of services provided meets the service specification.
- Involve and include members of the public, both on co-ordinating groups and in the development of information materials about all aspects of cervical screening.

NSD should:

- Review the national service specification template. This should form the core of local specifications, which may also need to be reviewed.
- Develop a national standardised protocol for the audit of invasive cancers of the cervix.

## Examples of local initiatives

### NHS Ayrshire & Arran

The Steering Group makes use of the local media to raise the profile of the cervical screening programme in Ayrshire & Arran. The Group issues press releases to local newspapers informing them of the publication of the cervical screening annual report. The consultant in public health medicine is interviewed on the local radio to promote the cervical screening service and the findings of the annual report.

### NHS Greater Glasgow

The health promotion department used drama workshops, as a method of communicating with women in local communities with high levels of deprivation. The workshops were designed to encourage women to attend for a smear test, and addressed issues surrounding the importance of having smear tests and the dangers of cancer.

### NHS Shetland

The review team strongly commended the establishment of NHS Shetland 100, a register of local lay volunteers willing to be consulted on a range of health issues. NHS Shetland regards this group as a key sounding board, and patient and carer representatives have accepted NHS Shetland 100 as a practical method of raising issues and concerns they may have.

## 2.2 Standard 2: Call-Recall and Failsafe

### Standard Statement 2(a)

*Effective call-recall arrangements are in place to ensure all eligible women aged 20-60 are invited for screening at least once every 5 years.*

### Essential Criteria

2(a)1. All eligible women registered with a GP and on Community Health Index (CHI) have a written prompt to attend for screening at least once every 5 years, unless a current smear result is already on the call-recall module.

**This criterion was met in 9/15 NHS Boards.**

2(a)2. Arrangements are in place to offer screening to eligible women not registered on CHI or not accessible through their GP (eg long-stay institutions).

**This criterion was met in 12/15 NHS Boards.**

2(a)3. A minimum of 80% of women aged 20-60 are screened at least once every 5 years.

**This criterion was met in all 15 NHS Boards.**

2(a)4. A national protocol is in place for the management of non-attenders.

**This criterion was met in 12/15 NHS Boards.**

2(a)5. All staff involved in call-recall receive training in using the call-recall IT system before undertaking unsupervised work.

**This criterion was met in 11/15 NHS Boards.**

2(a)6. Screening uptake at GP practice level is monitored and supportive action taken where targets are not achieved.

**This criterion was met in all 15 NHS Boards.**

## Desirable Criteria

2(a)7. A minimum of 80% of women aged 20-60 are screened every 3 years.

**This criterion was met in 13/15 NHS Boards.**

2(a)8. A standard call-recall IT system is in place across all NHS Board areas (national criterion - this is not a local issue).

**This criterion is a national issue and, as such, was assessed as not applicable in all 15 NHS Boards at the time of the review visits.**

Uptake of cervical screening exceeds the essential standard of 80% in every area in Scotland and it was clear that effective call-recall arrangements are in place, although this is achieved in various ways. Smear-taking is generally carried out in GP practices and family planning clinics and the way in which they operate call-recall and failsafe falls into one of three categories:

- use of one of the two 'national' CHI-based computerised systems through a regional call-recall office (ie a service provided on behalf of the Board);
- use of GP practice-based call-recall systems; or
- a mix of GP-based systems and one of the two 'national' CHI-based computerised systems.

Where Boards are using one of the national systems, it is relatively straightforward to monitor call-recall activity and to maintain standardised procedures. Where there is a lot of GP call-recall activity, this is less easy to monitor as the information is not flowing through one system on a Board-wide basis. This can compromise failsafe arrangements in particular, as it is not possible to make sure women are followed up unless their status is known.

A new national system, Scottish Cervical Call-Recall System (SCCRS), is currently under development and will be rolled out across Scotland. It will also be accessible to all stakeholders in cervical cytology.

## Standard Statement 2(b)

***A follow-up protocol is in place, appropriate to the outcome of the screening episode.***

### Essential Criterion

2(b)1. There is a protocol for failsafe procedures for follow-up of women with non-negative smears.

**This criterion was met in all 15 NHS Boards.**

Protocols are in place in every Board for the follow-up of women with non-negative smears. These are mainly managed by laboratories, although due to variations in practice across Scotland, it is not always possible to ensure that women moving from area to area are followed up.

## Standard Statement 2(c)

***The prompt for screening includes the core information as identified in the NHSCSP, Improving the Quality of the Written Information Sent to Women About Cervical Screening.***

### Essential Criterion

2(c)1. The format of invitation letters is regularly reviewed by the local co-ordinating group.

**This criterion was met in 5/15 NHS Boards.**

Less than half of Boards regularly review invitation letters, and this was highlighted as a particular issue in areas where GPs are issuing their own letters.

## Standard Statement 2(d)

***Arrangements are in place to ensure that action is taken for all women with an abnormal smear, irrespective of age.***

### Essential Criterion

2(d)1. There is a protocol in place for the follow-up of women who have an abnormal smear and an 'unknown outcome' at 12 months.

**This criterion was met in all 15 NHS Boards.**

### Desirable Criterion

2(d)2. Not more than 5% of women on early recall have an 'unknown outcome' after 12 months.

**Where evidence was available this criterion was met in 4/15 NHS Boards.**

Every Board has a protocol in place for the follow-up of women who have an abnormal smear and an 'unknown outcome' at 12 months. However, having a protocol in place does not guarantee that prompt action is taken. Although this can be for a variety of reasons, including non-attendance, it is essential that this is closely monitored so that action can be taken where necessary. Most Boards were unable to provide audit data to demonstrate that they could monitor the number of women with an 'unknown outcome' after 12 months.

## Standard Statement 2(e)

***Women who opt out of the cervical screening programme remain on the call-recall system and have the opportunity to be reinstated at a later date.***

### Essential Criterion

2(e)1. A protocol is in place to communicate with women who have opted out of screening during a previous round.

**This criterion was met in 12/15 NHS Boards.**

Some women state explicitly that they do not wish to be called for cervical screening. This is described as 'opting out'. As personal circumstances can and do change over time, it is important that women who have opted out are asked to review this decision, and to assure them that they can be reinstated at any time, on request. Protocols are in place across Scotland to address this, although it was acknowledged that it is difficult to monitor whether or not these are strictly followed.

### Strengths

- High uptake rates for cervical screening across Scotland.
- A strong commitment in laboratories and call-recall offices to applying robust failsafe arrangements.
- Arrangements for the follow-up of non-negative smears.

### Challenges

- Monitoring of call-recall arrangements in GP practices that do not participate in either of the 'national' systems.
- Monitoring and reviewing the content of invitation letters, particularly those sent out directly by GPs.
- Monitoring the outcome for women on early recall following a non-negative smear.

### Recommendations

- The development of the new national system, Scottish Cervical Call-Recall System (SCCRS), should be completed as soon as possible and rolled out across Scotland.
- Interim arrangements must be in place and monitored. Essential modifications and fault-fixing, to ensure that women are screened appropriately, must be carried out on existing systems as required.

## Examples of local initiatives

### NHS Dumfries & Galloway

Women who default from a smear test are sent a final reminder letter from their GP practice, which is signed by someone from the practice. The Steering Group believes that women are more likely to respond to a letter from the GP practice as it is more personal, and that this approach has helped to contribute to the Board's high uptake rates.

### NHS Forth Valley

The Board has used a number of initiatives to address areas where there is low uptake in the cervical screening programme. In an area of low cervical screening uptake monies from the Primary Care Development Fund were used to provide an extra Saturday morning clinic. Funding was also provided for health promotion and to support outreach work in the area. A significant increase in the uptake of the cervical screening programme in that area has occurred as a result of the initiative.

### NHS Lanarkshire

The Board has set up a Homeless Planning Team, which aims to get homeless people registered with a GP, and facilitate access to sexual health services. This initiative has helped to increase the uptake of cervical screening within NHS Lanarkshire.

### NHS Lothian

In order to better monitor and support activities within primary care the Board has introduced the role of GP screening facilitator. At the time of the visit, two facilitators were in post and were in the process of visiting each GP practice to audit call-recall procedures and practices. This has allowed the screening co-ordinator to monitor call-recall in those GP practices.

## 2.3 Standard 3: Smear-taking

### Standard Statement 3(a)

***All women are given an explanation of how and why the smear will be taken before and when they attend.***

### Essential Criterion

3(a)1. Up-to-date information is available to staff, women having smears and the public in a form approved by the local committee with reference to the current National Standards.

**This criterion was met in all 15 NHS Boards.**

Much work has gone into making sure that information on cervical screening is available for staff, women having smears and the public generally. Co-ordinating groups approve the information used, which is then tailored to meet the needs of different groups of people. In particular, information has been adapted for those with learning disabilities, and translation telephone services are also in use to allow practice staff instant access to these services. Information on cervical screening is also available on websites, and a variety of campaigns have been introduced to appeal to students.

Staff have access to a range of information resources including videos, booklets and teaching packs.

### Standard Statement 3(b)

***Smear-taking is carried out in an environment in accordance with NHSCSP/SCSP guidelines.***

### Essential Criteria

3(b)1. Smear-taking is carried out in an environment of privacy, in which the women and smear-taker feel comfortable.

**Where evidence was available this criterion was met in 2/15 NHS Boards.**

3(b)2. The smear is taken using equipment and techniques in accordance with current BSCCP guidelines.

**This criterion was met in 12/15 NHS Boards.**

Most smears are taken in GP practices and, as there are over 1,000 in Scotland, review teams were not able to visit these as part of the review process. However, the screening environment is covered in the GP Practice Accreditation Scheme which is run by the Royal College of General Practitioners (RCGP). This scheme reviews the facilities with particular reference to privacy and comfort. While the Scottish Executive Health Department (SEHD) expects all practices to achieve accreditation, the target date for this is January 2005.

Boards throughout Scotland were clearly very committed to this scheme, although in general, most had no other routine monitoring of the smear-taking environment in place. As a result, it was difficult to determine whether they met the required standards. Two Boards demonstrated that they had teams that visited all premises routinely, and review teams reported that ad hoc arrangements were in place through primary care in some other Boards. Based on the information gathered during visits, review team members found a number of initiatives are in place, including chaperon schemes and surveys highlighting privacy and confidentiality.

Most Boards were able to confirm that the equipment and techniques used conformed fully with current guidelines. Unsatisfactory smear rates are a good indirect indicator of performance levels and these are monitored and followed up across most Boards.

NHSScotland is currently introducing a new smear-taking technique known as liquid based cytology (LBC). Smear-taking is simplified, as preparation of the slide that is sent to the laboratory is no longer required, and in turn, laboratory processing has been semi-automated to improve consistency. This has involved training of smear-takers in the new technique, and training of laboratory staff so that they can interpret the slides produced. Early results show that this can reduce unsatisfactory smear rates, and feedback from women and staff is positive.

## Standard Statement 3(c)

***All healthcare professionals taking smears are competent through experience or trained (or under supervision) using an approved training programme covering all aspects of cervical screening.***

### Essential Criteria

3(c)1. Training approved by the local multidisciplinary co-ordinating group, with reference to the current National Standards, is available eg Marie Curie courses.

**This criterion was met in all 15 NHS Boards.**

3(c)2. Training for smear-takers includes communication skills.

**This criterion was met in 14/15 NHS Boards.**

3(c)3. All new staff must have full training in smear-taking before working unsupervised, and all staff must receive training in new techniques.

**This criterion was met in 11/15 NHS Boards.**

3(c)4. All smear-takers keep up to date with current practice.

**This criterion was met in 10/15 NHS Boards.**

Training is available for all staff taking smears and is provided either through a course run by Marie Curie Cancer Care or Napier University, Edinburgh, or locally developed courses. While nurses taking smears are generally required to participate in these courses, which include a period of supervised smear-taking, it was less clear whether doctors received training and updates. However, the review teams reported that audit of smear-taking generally has not raised any concerns regarding general competency. Doctors usually sit the Diploma for the Faculty of Family Planning if they take smears regularly, and many practices require this for GPs who take responsibility for the provision of this service in a practice.

Smear-taking courses all include a module on communication skills, and many Boards reported that they have a range of communication skills based courses in place that are available to all staff. Personal development plans and appraisal are also used to identify specific needs.

Not all smear-takers have had full training before working unsupervised as places on courses are not always available when they start work. There was good evidence that staff taking smears are well supervised and, as LBC is rolled out, all staff are receiving training in this new technique.

There was good evidence that smear-takers are kept up to date with current practice in a variety of ways including news letters, local workshops, audits and practice surveys. It was also acknowledged that there is a personal responsibility to maintain skills and knowledge.

## Standard Statement 3(d)

***Women younger than 20 years should not be included in the NHS Scottish Cervical Screening Programme.***

### Essential Criterion

3(d)1. Smears are not taken from women younger than 20 years as part of the cervical screening programme. If a smear is taken, the reasons for this are clearly documented on the request form.

**This criterion was met in 9/15 NHS Boards.**

Based on the natural history of cervical cancer, there is no evidence of benefit from taking routine smears from women under the age of 20. For this reason, the age range specified in the national programme is 20-60. In several areas, smears are taken from women under 20, although not as part of the cervical screening programme. In most cases, the reasons for this are well documented. Where this was not the case, Boards had plans in place through their co-ordinating groups to address this.

## Standard Statement 3(e)

***All women receive their smear result timeously, in a format that takes account of their cultural, educational and physical needs.***

### Essential Criterion

3(e)1. 80% of women are sent the result within 4 weeks (20 working days) of the smear test being taken.

**Where evidence was available this criterion was met in 3/15 NHS Boards.**

### Desirable Criterion

3(e)2. 100% of women are sent the result within 6 weeks (30 working days) of the smear test being taken.

**Where evidence was available this criterion was met in 1/15 NHS Boards.**

Most Boards were unable to provide evidence that these criteria are met. There are three main reasons for this:

- difficulty in monitoring the time between the date the smear was taken and the date the result was sent, particularly when this is under the sole control of the GP;
- the format of the result, if this is not in writing the result is not 'sent'; and
- delays in reporting times due to staff turnover and recruitment in laboratories.

Boards that had centralised arrangements in place for sending out results were able to monitor this, and identify any delays at an early stage.

## Strengths

- Cervical screening is widely and readily available across Scotland.
- Up-to-date information that has been pre-tested on how and why the smear will be taken is widely available, and is provided in a variety of ways.
- Availability of approved training for healthcare professionals taking smears. These courses include communication skills.

## Challenges

- Making sure women receive their results, in writing, within 4 weeks, and monitoring this to ensure there are no delays.
- Being able to demonstrate that smear-taking is carried out in a suitable, private environment.

## Recommendations

- NHS Boards should use the training opportunities for smear-taking presented by the introduction of the new screening technique, liquid based cytology (LBC).
- Monitoring systems should be set up to monitor the time between taking the smear and sending out the results. Further, all women should receive their results in writing.
- Closer co-operation should be developed between primary care and the RCGP to limit the number of assessment visits.

## Examples of local initiatives

### NHS Borders

The Steering Group has proposed undertaking a substantial audit of all GP practices offering a cervical screening service. The audit will collect data on the service offered by the GPs, including information leaflets produced by the practice, letters sent to women, and training given by the practices to smear-takers. The proposed audit has the support of the Board's GP Subcommittee.

### NHS Grampian

It was reported that students are among the least likely groups of women to attend for a smear test. The Monitoring Group has produced an information leaflet and poster aimed specifically at encouraging students to attend for a smear test. This has helped increase the uptake rates at those practices with large numbers of students over 20 years of age.

### NHS Highland

The review team noted that primary care services in NHS Highland demonstrate innovative use of transport and premises to ensure access to cervical screening services by women in remote and rural areas.

### NHS Orkney

The Skerryvore practice has implemented an ongoing audit of the adequacy of cervical smears. The audit links in with issues such as annual self-evaluation and training needs, and results from the first year of the audit are cited in the practice's annual report.

### NHS Western Isles

The Board has used Cancer Monies to fund a rolling programme of communication skills courses, which includes a course on giving bad news to patients. This course is available to all staff involved in the cervical screening programme, and it was reported that uptake has been good. The Board is also planning to develop further communication skills courses, which will be available to smear-takers.

## Standard 4: Laboratory Reporting

### Standard Statement 4(a)

***Laboratories providing cervical screening services (cytology and histology) meet recognised professional standards.***

### Essential Criterion

4(a)1. Evidence of current Clinical Pathology Accreditation (CPA) (or equivalent).

**This criterion was met in all 15 NHS Boards.**

All NHSScotland laboratories reporting cervical smears are fully accredited.

### Standard Statement 4(b)

***Laboratories monitor cervical cytology reporting profiles.***

### Essential Criteria

4(b)1. The laboratory reporting profiles conform to the ranges given in current guidelines.

**This criterion was met in 12/15 NHS Boards.**

4(b)2. Sensitivity of primary screening conforms to standards recommended in the Achievable Standards, Benchmarks for Reporting, and Criteria for Evaluating Cervical Cytopathology document.

**This criterion was met in all 15 NHS Boards.**

4(b)3. Positive Predictive Value conforms to standards recommended in the Achievable Standards, Benchmarks for Reporting, and Criteria for Evaluating Cervical Cytopathology document.

**This criterion was met in 14/15 NHS Boards.**

Current guidelines specify a number of indicators that are used to build a profile for each laboratory. These include the way in which smears are reported and they aim to pick up any significant variations. For example, if one Board was reporting many more severe results than others, it would be important to make sure that this was because there were more severe abnormalities, and not because of a different way of interpreting

smears. The profiles include unsatisfactory smear rates, and while these involve smear-takers, it is also important that laboratories observe clear thresholds regarding the smears they will report on.

While not all laboratory profiles conform to current guidelines, there was good evidence that Boards are aware of differences and are actively addressing these.

All cervical smear reports are reviewed by two people. Sensitivity of primary screening is a term used to describe the probability that a disease (such as cervical cancer) will be identified using a specific test. All laboratories were able to provide evidence that they meet this criterion.

The positive predictive value (PPV) is a measure of the reliability of cytological diagnosis of 'significant abnormality' based on comparing the degree of abnormality with the grade of cervical intraepithelial neoplasia (CIN). All but one of the laboratories meet this criterion.

## Standard Statement 4(c)

***All staff screening and/or reporting smears are either in a recognised training programme or have successfully completed this.***

### Essential Criteria

4(c)1. Trainee screening staff do not sign off reports.

**This criterion was met in all 15 NHS Boards.**

4(c)2. All biomedical scientists appointed since 2000 and all cytoscreeners hold the Certificate in Cervical Cytology (Certificate of Competence in Cervical Cytology pre-1997).

**This criterion was met in all 15 NHS Boards.**

4(c)3. All biomedical scientists with an extended role in cervical cytology hold the Certificate in Advanced Practice in Cervical Cytology.

**At present, no biomedical scientists in NHSScotland have an extended role in cervical cytology. This criterion was not applicable in all 15 NHS Boards.**

4(c)4. All medical staff reporting cervical cytology are or have access to, a qualified cytopathologist, ie a consultant with membership of the Royal College of Pathologists, or hold its Diploma in Cytology.

**This criterion was met in all 15 NHS Boards.**

## Desirable Criterion

4(c)5. All medical staff reporting cervical cytology are consultants with membership of the Royal College of Pathologists, or hold its Diploma in Cytology.

**This criterion was met in 6/15 NHS Boards.**

Smear reports should only be signed off by staff who have completed a recognised training course and this is the case in every laboratory in Scotland. Those who are still in training are well supervised and their work is checked.

NHSScotland is fully committed to making sure that all those reporting smears and managing screening services in laboratories are fully trained. Review visits confirmed that this was the case in all laboratories.
At present, no biomedical scientists in NHSScotland have an extended role in cervical cytology. This criterion was not applicable in all 15 NHS Boards.

Medical staff involved in cervical screening in NHSScotland meet regularly and there is a strong professional ethos. All Boards providing these services submitted evidence that this criterion was met.

Due to difficulties in recruiting consultant pathologists, not all medical staff reporting smears are consultants with membership of the Royal College of Pathologists, or who hold the College Diploma in Cytology. However, most of the non-consultant staff have long service records and extensive experience in cervical cytology. In addition, all medical staff reporting smears and providing this service have access to, and are supervised by, consultants with these qualifications, and all laboratory departments are regularly audited.

## Standard Statement 4(d)

***Standards and skills in cervical screening are maintained and improved.***

### Essential Criteria

4(d)1. The laboratory processes a minimum of 15,000 screening programme smears annually.

**This criterion was met in all 15 NHS Boards.**

4(d)2. All individuals solely involved in primary screening view at least 3,000, but not more than 7,500, screening programme slides annually.

**This criterion was met in 5/15 NHS Boards.**

4(d)3. All checkers examine at least 750 cervical screening programme slides annually.

**This criterion was met in all 15 NHS Boards.**

4(d)4. All biochemical scientists with an extended role in cervical cytology, and medical staff, report at least 750 cervical screening programme smears annually.

**This criterion was met in 11/15 NHS Boards.**

4(d)5. Non medical staff attend an update course every 3 years.

**This criterion was met in 14/15 NHS Boards.**

4(d)6. Medical staff are enrolled in the RCPath CPD scheme.

**This criterion was met in 14/15 NHS Boards.**

It is important that laboratories report enough smears each year to maintain skills, expertise and experience. All laboratories in NHSScotland meet this criterion.

Staff in some areas are not reviewing at least 3,000 smears every year, and in other areas they are reviewing more than the recommended maximum. All Boards recognise this and are actively working to address it.

Every abnormal smear result is checked by medical staff, and all Boards meet this criterion.

At present, no biomedical scientists in NHSScotland have an extended role in cervical cytology. However, medical staff in most Boards are reporting at least 750 cervical screening programme smears annually.

Update courses are available for non-medical staff but, due to work constraints, it is not always possible to attend these every 3 years. Further, this is not routinely monitored.

Most medical staff take part in the Royal College of Pathologists (RCPath) Continuing Professional Development (CPD) scheme. Where this is not the case, alternatives are in place.

## Standard Statement 4(e)

***There is evidence of internal quality control and external quality assurance.***

### Essential Criteria

4(e)1. Rapid review carried out for all normal and inadequate smears prior to issuing the final report.

**This criterion was met in all 15 NHS Boards.**

4(e)2. All staff reporting cervical cytology participate in the national proficiency-testing scheme.

**This criterion was met in all 15 NHS Boards.**

4(e)3. All staff participate in the slide circulation scheme.

**This criterion was met in all 15 NHS Boards.**

### Desirable Criterion

4(e)4. Laboratories participate in the technical External Quality Assurance (EQA) scheme.

**This criterion was met in all 15 NHS Boards.**

All normal and inadequate smears are reviewed before the final report is issued.

The national proficiency-testing scheme is a quality assurance programme that has been set up to support the development of skills. All NHSScotland laboratory staff participate in this scheme.

The slide circulation scheme is supported by all laboratories, and they provide a range of smears under certain categories to develop experience and learning. All NHSScotland cervical screening laboratories take part in this.

The technical EQA scheme was set up to make sure that smears are prepared to consistently high standards. All NHSScotland laboratories take part in this.

## Standard Statement 4(f)

*There is timely issue of laboratory results to smear-takers.*

### Essential Criteria

4(f)1. A minimum of 80% of smears are reported to smear-takers within 3 weeks (15 working days).

**This criterion was met in 9/15 NHS Boards.**

4(f)2. 100% of smears are reported to smear-takers within 5 weeks (25 working days).

**This criterion was met in 8/15 NHS Boards.**

Where Boards are not achieving these targets, there was evidence that action is being taken to address this. Staffing cover has been a particular issue as it takes some time before trainees reach the stage where they can sign off smear reports, but a range of innovative solutions have been explored, including a review of working practices and additional overtime payments. All are working towards meeting these targets and are confident that this will be the case in future.

## Standard Statement 4(g)

*There is evidence of comprehensive correlation of colposcopic biopsies and subsequent histological specimens with cervical smears.*

### Essential Criteria

4(g)1. Cytology laboratories have a system in place for pursuing the outcome of all patients with abnormal smears referred to colposcopy.

**This criterion was met in 13/15 NHS Boards.**

4(g)2. In all cases where there is a significant discrepancy between the referral smear and colposcopic biopsy (more than one grade difference), a review of the smears taken within the 12 months prior to biopsy is undertaken.

**This criterion was met in all 15 NHS Boards.**

## Desirable Criterion

4(g)3. The colposcopic biopsy is reported to the same laboratory as the referral smear.

**This criterion was met in 8/15 NHS Boards.**

Robust arrangements to follow up patients with abnormal smears who have been referred to colposcopy are in place in most Boards. Where this was not the case, the Board is actively following this up.

While not all colposcopic biopsies are reported in the same laboratory as the referral smear, every Board has arrangements in place to report the biopsies, and cases are reviewed as and when necessary if there are significant differences.

## Strengths

- Standardisation of reporting practices.
- CPA accreditation of all laboratories and robust quality assurance arrangements, particularly relating to participation in internal and external schemes.
- All normal smear reports are double-checked and any non-negative smear reports are medically reviewed. Where there is a big difference between the smear result and the result of any biopsy (tissue) taken at colposcopy, there is a review of the recent smear history.

## Challenges

- Making sure that staff report enough smears to maintain their skills and expertise, and not so many that they may be overburdened.
- Ensuring that reporting time targets are met in all areas.

## Recommendations

- Workload should be reviewed where the current balance does not meet the set standard. Collaboration with other laboratories should be explored in order to address this.
- Co-operation with other laboratories should also be considered in areas where reporting time standards cannot be met.

## Standard 5: Colposcopy

### Standard Statement 5(a)

***All women referred for colposcopy receive written information on colposcopy relevant to local practice prior to their first visit. The information will take account of their cultural, educational and physical needs.***

### Essential Criterion

5(a)1. Information leaflets are available for all women referred for colposcopy.

**This criterion was met in 14/15 NHS Boards.**

### Desirable Criteria

5(a)2. Relevant information leaflets are issued with the woman's appointment letter.

**This criterion was met in 14/15 NHS Boards.**

5(a)3. Flexible multi-media information is available if requested.

**This criterion was met in 14/15 NHS Boards.**

A lot of work has gone into developing information about colposcopy, and this has involved consultation with the public. Many areas carry out regular surveys, and there was evidence that any changes required to the information, or the way in which it is given, are made. The one Board that does not currently provide information before the appointment is currently updating arrangements, and will have this in place shortly.

A range of different ways of giving information is in place across Scotland. These include pictorial booklets, support for those with hearing or sight disabilities, and translation services. Staff in the colposcopy clinics are trained to work with people with special needs and, in particular, on checking consent to treatment.

## Standard Statement 5(b)

***There is early colposcopy assessment for all women referred for investigation of an abnormal smear.***

### Essential Criteria

5(b)1. A minimum of 90% of all referrals for dyskaryotic smears are given an appointment, the date of which falls within 8 weeks (40 working days) of the referral being received.

**This criterion was met in 5/15 NHS Boards.**

5(b)2. A minimum of 90% of women with moderately/severely dyskaryotic smears referred for colposcopic assessment are given an appointment, the date of which falls within 4 weeks (20 working days).

**This criterion was met in 3/15 NHS Boards.**

### Desirable Criteria

5(b)3. No woman waits more than 8 weeks (40 working days) for a colposcopy appointment.

**This criterion was met in 4/15 NHS Boards.**

5(b)4. Colposcopy clinics have arrangements in place to optimise the use of clinic appointments.

**This criterion was met in 13/15 NHS Boards.**

5(b)5. Colposcopy clinics have a protocol in place to deal with patients who default.

**This criterion was met in all 15 NHS Boards.**

Referrals are prioritised in all areas and urgent referrals are seen within 8 weeks. However only five Boards meet this target for all referrals, and the main reasons for this appeared to be a shortage of colposcopists, and the increase of referrals to colposcopy clinics, not all of which are appropriate.

Most Boards have good arrangements in place to reduce the number of 'lost' appointments. In particular, there are arrangements in place to fill appointments at short notice, and regular review of the reasons why women do not attend. Many have carried out extensive audits into the reasons for non-attendance, and work closely with primary care teams on following up women in this category.

## Standard Statement 5(c)

***The colposcopy service is of a recognised professional standard.***

### Essential Criteria

5(c)1. Colposcopists providing a clinical service are accredited with the BSCCP.

**This criterion was met in 12/15 NHS Boards.**

5(c)2. There should be two nurses for each clinic. The primary nurse should be a registered nurse trained in counselling.

**This criterion was met in 1/15 NHS Boards.**

5(c)3. The clinic must provide private changing and toilet facilities and there must be separate waiting and recovery areas.

**This criterion was met in 13/15 NHS Boards.**

5(c)4. In clinics offering treatment, there must be one effective form of outpatient treatment with which the staff involved are familiar.

**This criterion was met in 14/15 NHS Boards.**

5(c)5. There is no dyskaryosis on cytology in a minimum of 90% of women treated for CIN2 or CIN3 at 6-12 months follow-up.

**This criterion was met in 4/15 NHS Boards.**

5(c)6. A minimum of 90% of women treated at first visit have evidence of CIN on histology.

**This criterion was not met by any of the NHS Boards.**

Most colposcopists are accredited. Where this is not the case, accreditation has been applied for.

Most Boards do not have the necessary nursing staff for clinics, and are frequently dependent on auxilliary support. Not all primary nurses have attended training in counselling.

Most Boards have the necessary facilities in place, and improvement plans were being developed where this was not the case. Staff working in the colposcopy clinics are all familiar with the equipment and the techniques used, and induction training is provided. However in one Board, more frequent clinic sessions are required to maintain skill levels. All Boards reported problems with collecting data to monitor performance against this target.

It is important to avoid unnecessary treatment although many Boards in Scotland run a 'see and treat' system, particularly if women have to travel long distances. Again, Boards reported difficulties in collecting data to monitor this.

## Standard Statement 5(d)

***Quality standards will be demonstrated by ongoing audit. This is an integral part of the screening programme.***

### Essential Criterion

5(d)1. Multidisciplinary Team meetings are held locally for case review.

**This criterion was met in 14/15 NHS Boards.**

### Desirable Criterion

5(d)2. Annual data returns are completed to ISD standard to facilitate audit.

**This criterion was met in 4/15 NHS Boards.**

Most Boards hold regular, multidisciplinary meetings to discuss cases.

Many Boards were experiencing difficulties in collecting data on colposcopy and, where arrangements were in place, the data were often reported as unreliable.

## Standard Statement 5(e)

***A professional and efficient colposcopy service requires good communication.***

### Essential Criteria

5(e)1. A copy of the referral smear is available to the colposcopist at the first colposcopy visit.

**This criterion was met in 12/15 NHS Boards.**

5(e)2. All women and referring agencies are sent results timeously.

**This criterion was met in 8/15 NHS Boards.**

## Desirable Criterion

5(e)3. All women and referring agents are sent results/management plan within 4 weeks (20 working days) of their clinic visit.

**Where evidence was available this criterion was met in 2/15 NHS Boards.**

While not every Board was able to ensure that on every occasion a copy of the referral smear was available, all reported that a copy of the referral smear is available in the majority of cases.

All Board areas are making every effort to make sure that women and referring agencies receive results as quickly as possible. However, due to staffing shortages, this is not always possible.

## Strengths

- Information is provided to women before their colposcopy appointment.
- Work on determining the reasons for non-attendance and on maximising clinic appointments is ongoing.
- UK standards (the British Society for Colposcopy and Cervical Pathology) have been widely adopted.
- Multidisciplinary team meetings take place to review cases.

## Challenges

- Making sure women receive an appointment within 8 weeks of referral.
- Ensuring that women receive their results and management plans within 4 weeks and monitoring this to identify any delays.
- Monitoring performance in colposcopy clinics to provide evidence of robust quality assurance processes.
- Making sure that two nurses cover each clinic, and that the primary nurse in each clinic has been trained in counselling skills.
- Ensuring that ‘see and treat’ policies do not result in over-treatment.

### Recommendations

- Referral pathways should be reviewed to make sure that these are appropriate. Where necessary, education programmes should be introduced.
- Data collection and monitoring systems should be established in all areas.
- Training in counselling should be provided for nurses running colposcopy clinics.

## Examples of local initiatives

### NHS Argyll & Clyde

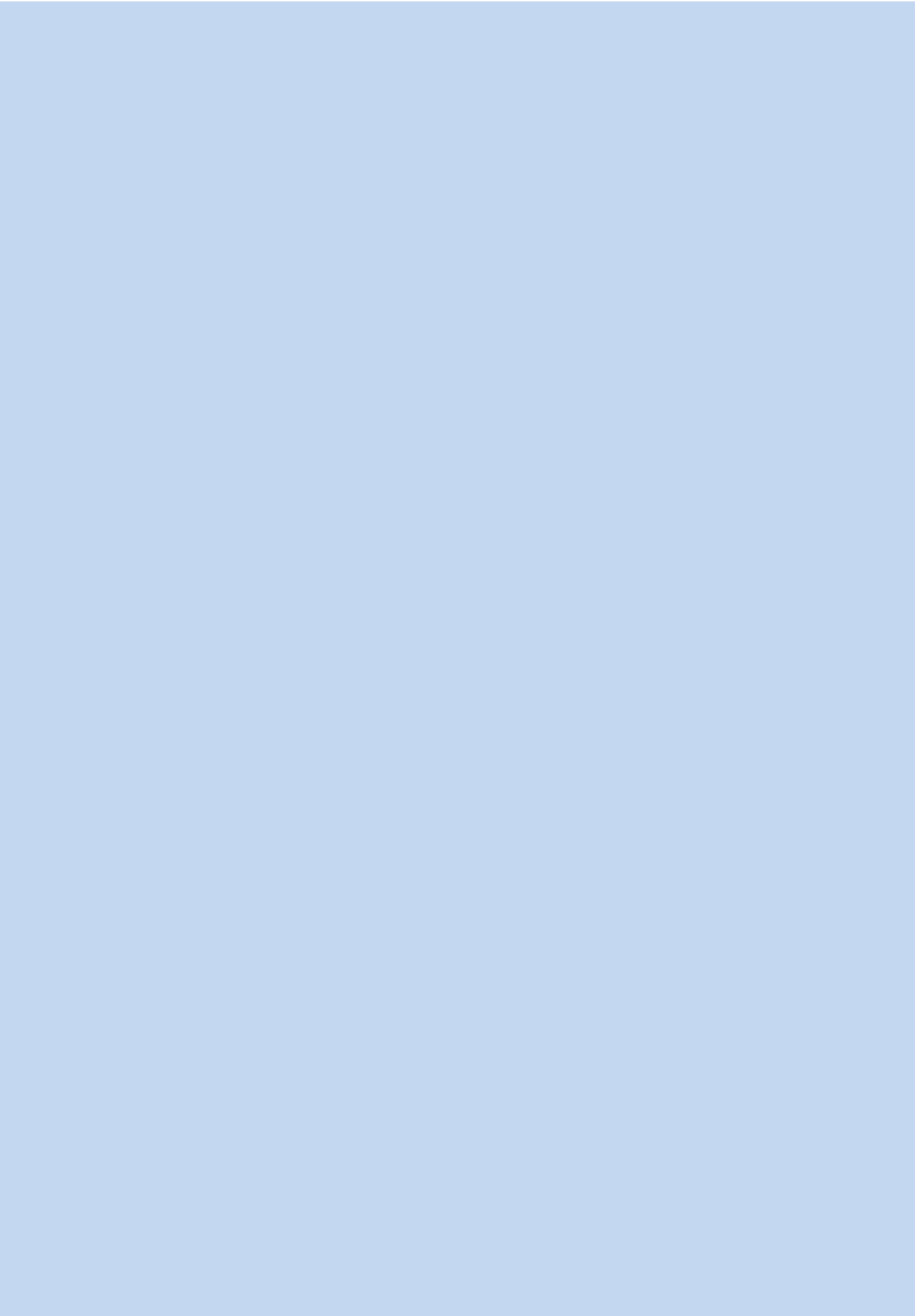
The colposcopy service carried out an audit of first-time defaulters, which has improved attendance rates for women referred for colposcopy. Clinic staff phone patients after they have defaulted, to ascertain reasons why they defaulted, and encourage them to attend again.

### NHS Fife

The colposcopy service has developed counselling guidelines, which all staff working at the clinic are familiar with. The guidelines ensure that all women who attend the clinic are given consistent information. Counsellling given to women includes: what women should expect during their appointment; support with regards to having an abnormal smear; and the opportunity to ask questions.

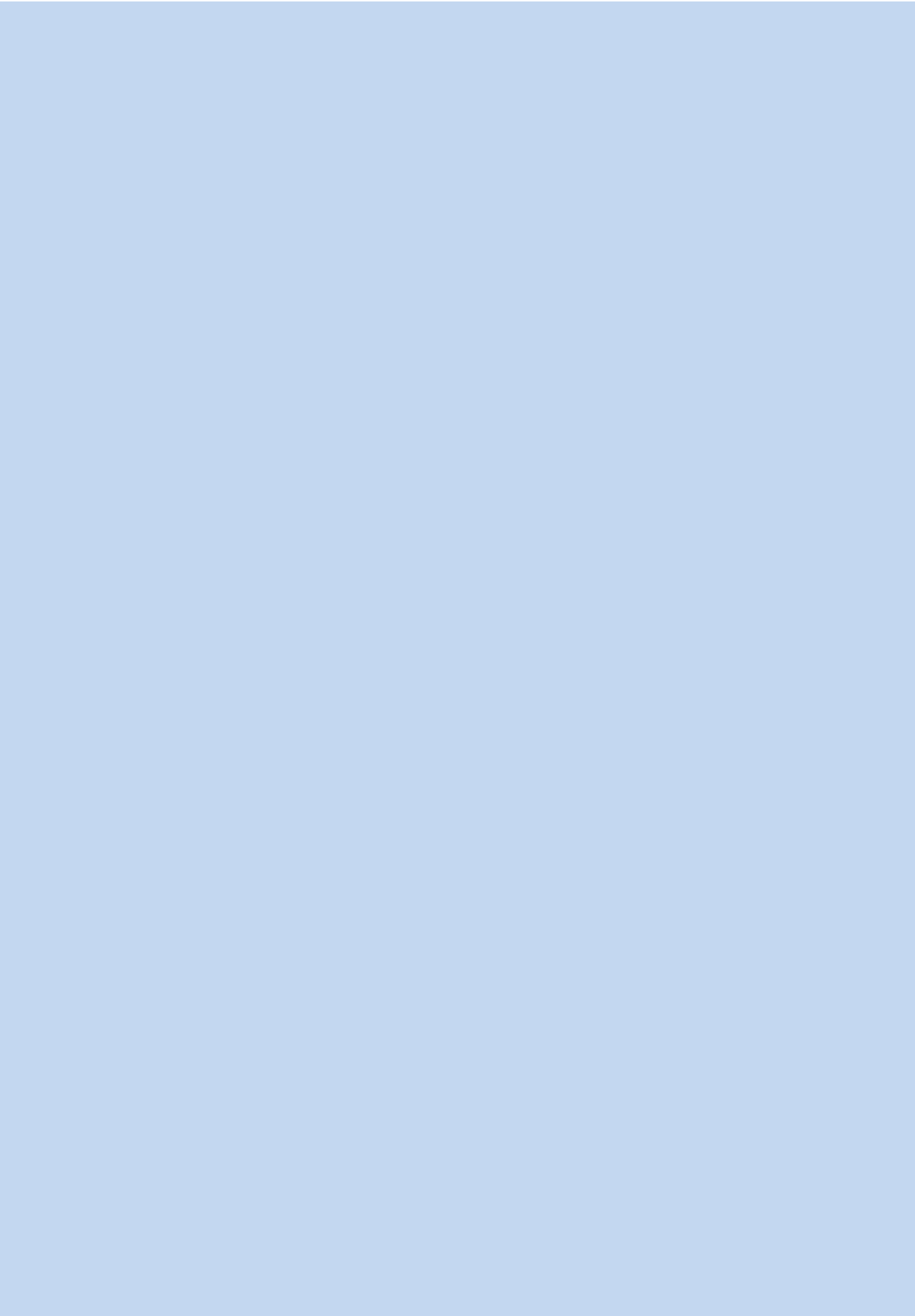
### NHS Tayside

At the beginning of 2003 an audit of the overall effectiveness of the information leaflets for the colposcopy service was undertaken. The leaflets contain information on why women are referred to the clinic, what to expect during the appointment, and answers to frequently asked questions. Of the 42 women who responded, 75% reported that receiving information prior to their colposcopy appointment reduced overall anxiety.



Chapter 3

# Conclusions



# 3. Conclusions

This national overview, and the accompanying local reports, set out the performance of NHSScotland as a whole and of each NHS Board area against the cervical screening standards published in September 2002. A number of general themes have emerged which apply across the country.

Firstly, without exception, the review teams were struck by the commitment, dedication, and hard work of the staff involved in providing cervical screening services, frequently under difficult circumstances. Wherever possible, these services were clearly responsive to the needs of the women and to the staff, and a number of innovative service developments were seen during visits. However, all too often services were stretched, and the review teams found evidence that this affected three key areas across the screening programme:

- The issuing and monitoring of smear results in writing - only three NHS Boards could demonstrate that they were meeting the standard set for issuing results within 20 days of taking the smear.
- Appointments for further investigation and treatment - only five NHS Boards were able to offer women an appointment for further investigations within 8 weeks.
- Results following colposcopy - only two NHS Boards could demonstrate that colposcopy results were sent out within 4 weeks.

Secondly, there were many examples of public and patient involvement at every stage of the cervical screening programme. In particular, women had been involved in the development of information materials, and a wide range of leaflets and resource packs are in use, both for staff and for those using the services. A number of targeted initiatives have also been set up with public involvement, including campaigns to attract students to attend for screening, and the introduction of colposcopy clinic waiting lists of those willing to attend at short notice in the event of a cancellation.

Thirdly, it is clear that many policies and procedures have been developed, and that compliance with these is monitored. The review teams suggested that they be reviewed locally in the wake of the visits, to make sure they reflect the standards, and that all staff are aware of them.

Finally, the cervical screening programme is entering a period of change, as is NHSScotland generally. For screening, the next 3 years holds many challenges as a new call-recall system is rolled out, a new smear-taking technique is introduced, and different smear preparation methods are implemented in laboratories. These changes will impact on all aspects of

the programme and will affect call-recall staff, smear-takers, laboratory staff, and women using the service. However, the evidence base that has brought about these changes shows that, implemented effectively, these developments will improve the quality of patient care and support the service in delivering this.

This report, and the local reports on each cervical screening service, together with the examples of good practice they contain, are designed to support and encourage the process of continual improvement in the Scottish Cervical Screening Programme (SCSP). NHS Quality Improvement Scotland looks to each of the host NHS Boards, guided by NSD, to ensure that, where relevant, practice is reviewed in the light of this report's findings and recommendations. Any action must be taken in close collaboration with the staff responsible for providing the service. A considerable momentum for quality assurance in the SCSP has been built up since its inception, and it is important to use this enthusiasm to take forward work on strengthening and improving cervical screening services.

Each NHS Board is responsible for the performance of its local NHS services, and is accountable to the Scottish Executive Health Department, who will use the reports and local responses to them to monitor local and national performance. The public, both locally and nationally, also has an important role to play in ensuring changes are made.

NHS Quality Improvement Scotland reserves the right to revisit a service where it considers there are serious issues that need further external monitoring and reporting. NHS Quality Improvement Scotland intends periodically to review and raise the cervical screening standards in light of the latest evidence about 'best practice' and the performance of the SCSP, and to conduct further local and national reviews, to encourage continuing quality improvement.

# Appendices

# Appendix 1

## Cervical Screening Project Group Members

### Chair

**Dr Jocelyn Imrie OBE**
Medical Advisor for Quality Assurance in the Scottish Cervical Screening Programme

### Project Group Members

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General Practitioner, Fife

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**Mrs Linda McCredie**
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**Mrs Anne Simpson**
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**Ms Jill Telfer**
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**Dr Eric Walker**
Consultant Cytopathologist, NHS Ayrshire & Arran

The NHS Quality Improvement Scotland Board member specifically working with the Cervical Screening Project Group was **Ms Margaret Williamson** (until June 2003) and **Ms Cheynee Whipps** (from June 2003).

Support from NHS Quality Improvement Scotland for the peer review programme was provided by:

**Ms Hilary Davison**
Review Team Manager

**Ms Jacqueline Ellis**
Project Administrator

**Mr Richard Meade**
Project Officer

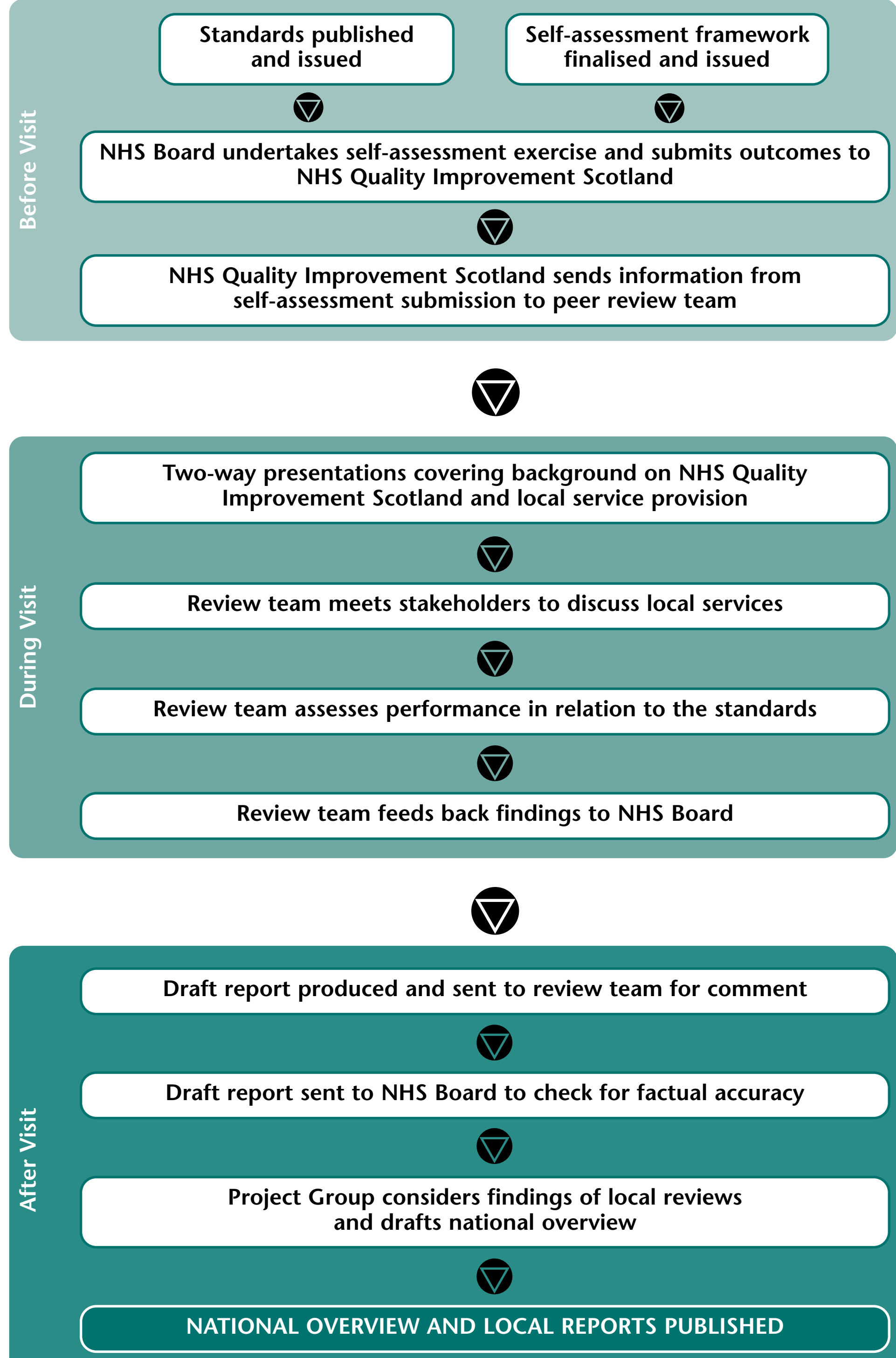
**Mrs Fiona Russell**
Senior Project Officer

**Ms Morag Swankie**
Senior Project Officer

**Ms Jan Warner**
Interim Director,
Standards & Reviews

# Appendix 2

## The Quality Assurance Process: Approach Used in this Review



## Standards

All standards set by NHS Quality Improvement Scotland comprise a standard statement and related criteria.

### Standard Statement

Describes the agreed performance for the specific area, determined by those who are involved in the delivery/receipt of the service.

### Criteria

State exactly what must be done for the standard to be reached.

Some criteria are **essential** as it is expected that they will be met wherever a service is provided. Others are **desirable/aspirational** in that they will promote continuous quality improvement as they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve.

### Self-Assessment

Each set of standards has an accompanying self-assessment framework. This framework gives guidance about the type of evidence required to demonstrate performance against the standards. It is completed and submitted to NHS Quality Improvement Scotland prior to a peer review visit, together with extensive additional documentation. The evidence obtained from this self-assessment exercise comprises the main source of written evidence considered by each peer review team.

### Peer Review

Peer review is the process by which a multidisciplinary review team, including members of the public, carries out a service visit to validate the quantitative data submitted through the self-assessment. This is done by means of gathering qualitative information through discussions with staff.

During each review, the review team is guided by a team leader to ensure a multidisciplinary consensual assessment is reached. At the conclusion of the review, the review team provides feedback to the service, giving a broad overview of its assessment, which is based on the written self-assessment and on evidence obtained during the review visit.

To enhance the consistency of the process, an NHS Quality Improvement Scotland manager and project officer accompany each visit.
The schedule for a cervical screening external peer review visit includes:

- initial meeting with representatives for the service under review;
- dialogue with clinicians, managers and administrators based on the written evidence;
- scrutiny of documentation;
- interviews with staff members;
- regular team briefings throughout the day to assess progress and to compile the local report; and
- feedback to the service representatives on conclusion of the visit.

The composition of each review team varies, and all review team members come from outwith the geographical areas they are reviewing. Although this presents challenges in achieving consistency of process, it promotes sharing of good practice and ensures that each review team assesses the performance of a service against the standards, not by comparing one service with another.

In order to determine whether a particular criterion is 'met' or 'not met', each review team requires to assess evidence on a variety of levels. For example, to demonstrate that a particular issue is addressed in a local protocol, evidence is sought during the peer review process as follows:

- description of the issue and how it should be managed in a local written protocol (submitted as part of the self-assessment);
- confirmation of awareness of the location and content of the protocol through staff interviews;
- evidence of a process in place for the protocol to be regularly updated; and
- collection of data through an integrated care pathway/audit sheet, leading to provision of collated audit data confirming compliance with the local protocol.

Until a legal interpretation of the Data Protection Act is made as to whether patient records can be accessed for purposes other than managing patient care, NHS Quality Improvement Scotland review teams are not scrutinising individual patient records. Therefore, in cases where it is stated that information is recorded in individual patient case notes, and the claim is corroborated in staff interviews during the visit, an assessment of 'met' will be made.

The responsibility of NHS Quality Improvement Scotland is to report whether the services provided by NHSScotland, both nationally and locally, meet agreed standards, but not to review individual cases or the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered. Where such variation exists between parts of a service, this will be stated, but will not identify service users or healthcare professionals.

### Reports

A local written report is drafted at the time of each visit by NHS Quality Improvement Scotland. The draft report is then circulated to the review team for comment, and to the service concerned to allow a check for factual accuracy.

On conclusion of the peer review programme, the Project Group is reconvened to study the findings and examine trends in order to draw conclusions and make recommendations to NHS Quality Improvement Scotland.

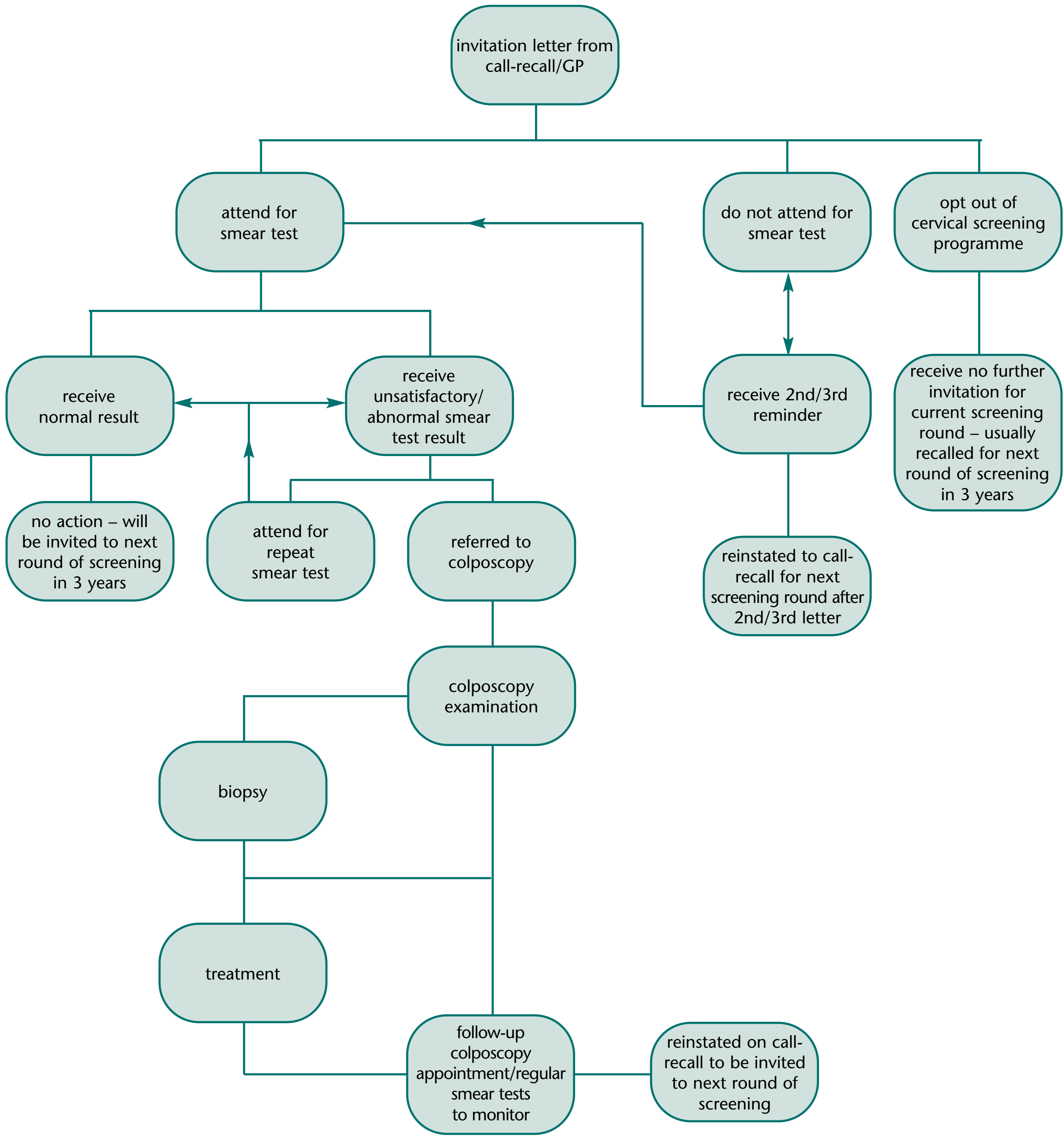
# Appendix 3

## Co-ordinating Cervical Screening Services

### Pathway of Care for Women Invited for a Cervical Screening Test in Scotland

| Stage | What might happen | Where | Who might be involved |
|---|---|---|---|
| **Initial Contact** | • Invitation to attend for cervical screening (women aged 20-60)<br>• Self–referral to cervical screening programme<br>• Discussion with relevant healthcare professional | • Home (letter of invitation)<br>• GP surgery, family planning clinic, well woman clinic | • Cervical screening call-recall administrators<br>• GP practice<br>• GP, practice nurse, family planning doctor, gynaecologist, other relevant healthcare professionals |
| **Screening** | • Smear test taken<br>• Smear test sent to laboratory for analysis<br>• Results:<br>**normal** - return to routine recall<br>**unsatisfactory** - repeat smear test<br>**abnormal** - repeat test or referred to colposcopy for further investigation | • GP surgery, well woman clinic, family planning clinic, hospital clinic | • GP, practice nurse, family planning doctor, gynaecologist<br>• Laboratory staff: biomedical scientist, cytoscreener, cytopathologist<br>• Cervical screening call-recall administrators<br>• Colposcopist, nurse colposcopist |
| **Assessment/ Treatment** | • Information and advice<br>• Colposcopic examination<br>• Biopsy<br>• Discussion of assessment results and agreement on course of action<br>• Treatment:<br>- cold coagulation<br>- laser treatment<br>- surgery | • Sent to home with referral letter, GP surgery, colposcopy clinic<br>• Colposcopy clinic<br>• Colposcopy clinic, hospital | • GP, practice nurse, colposcopist, nurse colposcopist<br>• Colposcopist, nurse colposcopist<br>• Colposcopist, nurse colposcopist, surgeon |
| **Monitoring and Follow-up** | • Monitoring/check up at colposcopy clinic<br>• Repeat smear tests | • Colposcopy clinic<br>• Colposcopy clinic, GP surgery | • Colposcopist, nurse colposcopist<br>• Colposcopist, nurse colposcopist, GP, practice nurse |

## Pathway of Care for Women Invited for a Cervical Screening Test in Scotland



# Appendix 4

## Cervical Screening Review Team Members

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Staff Grade (Obstetrics & Gynaecology), Argyll & Clyde Acute Hospitals NHS Trust

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**Ms Jennifer Blair**
Lay Representative, Greater Glasgow

**Mrs Liz Bow**
Lay Representative, Highland

**Mr Allan Brown**
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**Ms Mairi Brown**
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**Mrs Maureen Buist**
Lay Representative, Lothian

**Mr Rodney Chapman**
Lay Representative, Greater Glasgow

**Dr Robert Cole**
Obstetrics & Gynaecology Consultant, Forth Valley Acute Hospitals NHS Trust

**Mrs Anne Cooper**
Chair, Scottish Practice Nurses Association

**Dr James Cordiner**
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**Dr Maggie Cruickshank**
Consultant Gynaecologist, Grampian University Hospitals NHS Trust

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**Ms Citty Finlayson**
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**Ms Moira Grant**
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**Dr Val Harper**
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**Mrs Denise Hogarth**
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**Ms Mareth Irvine**
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**Ms Kim Kingan**
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**Mrs Helen Macguire**
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**Ms Irene MacKenzie**
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**Mrs Margaret Rule**
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**Mrs Anne Simpson**
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**Ms Angela Trueman**
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**Mrs Sheila Tunstall-James**
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**Mrs Elizabeth Walker**
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**Mrs Patricia Weir**
Lay Representative, Argyll & Clyde

**Mr Allan Wilson**
Senior Chief Biomedical Scientist, Lanarkshire Acute Hospitals NHS Trust

# Appendix 5

## Glossary of Terms

| | |
|---|---|
| abnormal smear | Smear test indicating a need for further investigation or treatment. |
| abnormality | A finding requiring further investigation/treatment. |
| accreditation | A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation. |
| acute sector | Hospital-based health services which are provided on an in-patient or out-patient basis. |
| anonymised data | Data from which there is no theoretical or practical risk that a patient could be identified by the recipient of the information. |
| assessment | The process of measuring the quality of an activity, service or organisation. |
| audit (clinical) | Systematic review of the procedures used for: diagnosis, care, treatment, and rehabilitation, examining how associated resources are used, and investigating the effect care has on the outcome and quality of life for the patient, and making changes if necessary. |
| biopsy | See colposcopic biopsy. |
| BMS | Biomedical scientist. |
| BSCCP | British Society of Colposcopy and Cervical Pathology. Website address: www.bsccp.org.uk/ |
| call-recall | The process used to invite people for a screening test. |
| case review | Re-examination of the diagnosis and management of a person's condition at a defined point in time. |
| CCS system | Cervical Cytology Screening (CCS) system. |
| cervical cancer (invasive) | Cancer of the neck (cervix) of the uterus. The tumour has spread to involve surrounding tissue and adjacent organs (invasion). It may be detected in a pre-cancer stage of development (CIN) by a cervical smear test. |
| cervical carcinoma | The same as cervical cancer. See cervical cancer. |
| cervical intraepithelial neoplasia (CIN) | Cellular changes in the cervix (neck of the womb) preceding the invasive stages of cervical cancer. The CIN grading system distinguishes three stages. |

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| cervical smear | A sample of cells scraped from the cervix of the uterus that is stained and examined under a microscope. Routine cervical smears are taken to detect precancerous and early cancerous changes. |
| cervix | Neck of uterus (womb). |
| CHI number | The Community Health Index (CHI) is a unique patient identifier that is allocated to every patient registered with a GP in Scotland. It is entered onto a database that underpins a wide range of patient care processes in Scotland. There are strict controls on access to patient identifiable details. |
| CIN | See cervical intraepithelial neoplasia. |
| clinical effectiveness | Clinical effectiveness is the extent to which specific clinical interventions, when deployed, do what they are intended to do, ie maintain and improve health, securing the greatest possible health gain from the available resources. |
| clinical governance | A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish. Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk. |
| clinical history | Record of medical events and treatments. |
| Clinical Pathology Accreditation (CPA) | UK-based company created to set standards for laboratories. It enables an external audit of the ability to provide a service by declaring a defined standard of practice, which is confirmed by peer review. Website address: www.cpa-uk.co.uk/ |

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| Clinical Standards Board for Scotland (CSBS) | The Clinical Standards Board for Scotland was a statutory body, established as a Special Health Board in April 1999. Its role was to develop and run a system of quality control of clinical services designed to promote public confidence that the services provided by the NHS met nationally agreed standards, and to demonstrate that, within the resources available, the NHS was delivering the highest possible standards of care. On 1 January 2003, CSBS was merged, along with four other clinical effectiveness bodies, to form NHS Quality Improvement Scotland (NHS QIS). See NHS Quality Improvement Scotland. |
| clinician | A healthcare practitioner who specialises in seeing, diagnosing and/or treating patients. |
| college | In the UK, the term college, when used relating to healthcare, as for example in "The Royal College of...", refers to organisations which usually combine an education role with promotion of professional standards. |
| colposcope | An instrument used for colposcopy examination (see colposcopy) which gives low magnification and a bright light. |
| colposcopic biopsy | The process of taking a small piece of tissue from the cervix during colposcopy for the purpose of diagnosis. |
| colposcopy | A visual examination of the cervix and upper vagina using a colposcope. Low magnification and a bright light allow pre-cancer changes to be identified. These can be biopsied to make a diagnosis. |
| Community Health Index (CHI) | See CHI number. |
| consultant in public health medicine (CPHM) | A senior doctor who specialises in the health of populations. |
| continuing professional development (CPD) | An ongoing commitment to learning in various forms, which maintains and enhances professional standards of work, and develops the ability to recognise good practice. |

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| core data set (CDS) | The essential information related to a specific medical condition - may include demographic, clinical management and outcome data used for audit and research. |
| CPA | See Clinical Pathology Accreditation. |
| CPD | See continuing professional development. |
| CPHM | See consultant in public health medicine. |
| criterion(s)/ criteria(pl) | Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors. |
| CSBS | See Clinical Standards Board for Scotland. |
| cytology/ cytopathology | The study of cells under the microscope. |
| cytopathologist | A pathologist who studies disease processes by examining cells and groups of cells. |
| cytoscreener | A healthcare professional holding the Certificate of Competence in Cervical Cytology. |
| data source | The source of evidence to demonstrate whether a standard or criterion is being met. |
| desirable (criterion/criteria) | Good practice that is being achieved in some parts of the service and demonstrates levels of quality to which other providers of a similar service should strive. |
| diagnosis | Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and casual factors for the symptoms. |
| dyskaryotic smear | A cervical smear which identifies dyskaryotic cells from a patient's cervix, ie abnormal cells whose nuclei show the features characteristic of the earliest stage of malignancy. |
| eligible women | Women age 20-60 are eligible to be invited for cervical screening. |
| EQA | External quality assurance. |
| essential (criterion/criteria) | A criterion that should be met wherever a service is provided. |
| evaluation | The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity. |

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| evidence-based medicine | Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best. |
| failsafe | Reliable back-up. |
| generic standards | Standards that apply to most, if not all, clinical services. |
| GP | General Practitioner. |
| GPASS | General Practice Administration System for Scotland. Website address: www.show.scot.nhs.uk/gpass/ |
| guidelines | Systematically developed statements which help in deciding how to treat particular conditions. |
| HDL | See Health Department Letter. |
| Health Board | See NHS Boards. |
| Health Council | Each NHS Board has a Health Council, an organisation whose aim is to promote public consultation and participation in health-related matters. Sometimes referred to as a Local Health Council. |
| Health Department Letter (HDL) | Health Department Letter (formerly known as Management Executive Letter – MEL), formal communications from the Scottish Executive Health Department to NHSScotland. |
| healthcare professional | A person qualified in a health discipline. |
| histological specimen | A sample of tissue prepared for examination under a microscope. |
| histology/ histopathology | The study of the structure, composition and function of tissues under the microscope, and of their abnormalities (histopathology). |
| inadequate smear | A cervical smear which cannot be properly assessed microscopically due to poor quality or too few cells/materials. |
| incidence | The number of new cases of a disease within a defined group of people over a period of time. |

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| Information and Statistics Division (ISD) | The Information and Statistics Division is part of the Common Services Agency, NHSScotland. Health service activity, manpower and finance data are collected, validated, interpreted and disseminated by the division. This data is received from NHS Boards, NHS Trusts and general practices. Website address: www.show.scot.nhs.uk/isd/index.htm |
| invasive cancer | Cancer that can or has spread from its site of origin. |
| ISD | See Information and Statistics Division. |
| Island NHS Board | There are three Island NHS Boards (Orkney, Shetland and the Western Isles). They have always had a combined strategic and operational role. See NHS Board. |
| IT | Information Technology. |
| lay representation | The inclusion of a member(s) of the general public in a professional group. |
| LBC | See liquid based cytology. |
| LHCC | See Local Health Care Co-operative. |
| liquid based cytology (LBC) | Techniques, which are established practice in other screening areas, and which offer a new way to prepare the smear sample for examination in the laboratory. The sample is collected using a special spatula device, which gently brushes cells from the neck of the cervix. The head of the spatula where the cells are lodged is then broken off into a small jar containing preservative fluid, or alternatively, the cells are rinsed directly into the preservative fluid. This sample is then transported to the laboratory, where it is mixed and treated to remove unwanted material. A thin layer of the resulting cell suspension is deposited onto a slide and stained. The slide is then examined in the usual way. |
| Local Health Care Co-operative (LHCC) | In Scotland, Local Health Care Co-operatives are voluntary groupings of GPs and other local healthcare professionals intended to strengthen and support the primary healthcare team in delivering local care. |
| malignancy | See invasive cancer. |

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| Managed Clinical Network (MCN) | A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions. |
| Management Executive Letter (MEL) | Formal communications from the Scottish Executive Health Department to NHSScotland, now known as Health Department Letters (HDLs). |
| medical records | Patients' notes; documentation of care. |
| MEL | See Management Executive Letter. |
| Membership of RCPath | A qualification achieved by practical and theoretical examination by a pathologist. |
| monitoring | The systematic process of collecting information on clinical and non-clinical performance. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas. |
| multidisciplinary co-ordinating group | A group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These may include the specific condition, the scale of the service being provided and geographical/socio-economic factors in the local area. |
| national guidelines | Guidelines defined at a national level. See guidelines. |
| national standards | Standards defined at a national level. |
| NHS | National Health Service. |
| NHS Board | NHS Boards are responsible for strategic planning, performance management and governance of each of Scotland's 15 local health systems. Most Board areas contain one Acute and one Primary Care Trust, with operational and employment responsibilities, but since 2001 they have operated within a strategic framework drawn up by the NHS Board. By 2004 Trusts will have been abolished and replaced by operating divisions of the NHS Board (see also NHS Trust). |

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| NHS QIS | See NHS Quality Improvement Scotland. |
| NHS Quality Improvement Scotland (NHS QIS) | NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It will have a particular emphasis on the quality of care and the patient journey for vulnerable groups. NHS Quality Improvement Scotland has been created by the merger of five organisations: Clinical Standards Board for Scotland (CSBS); Health Technology Board for Scotland (HTBS); Scottish Health Advisory Service (SHAS); Nursing and Midwifery Practice Development Unit (NMPDU), and the Clinical Resources and Audit Group (CRAG). Website address: www.nhshealthquality.org |
| NHS Trust | A Trust is an NHS organisation responsible for providing a group of healthcare services for the local population. An Acute hospital Trust provides hospital services. A Primary Care Trust provides primary care/community health services. Mental health services (both hospital and community based) are usually provided by Primary Care Trusts. Since 2001 Trusts have operated within an overall framework drawn up by their NHS Board. Subject to legislation, Trusts will be dissolved by April 2004, becoming operating divisions of the NHS Board. The NHS Board will be the single employer for the local system. In two areas - Borders and Dumfries & Galloway - since April 2003 there have been no Trusts or operating divisions with the NHS Board fulfilling a dual strategic and operational role (like the three Island Boards). The term 'Trust' is retained in NHS QIS publications during the period of Trust abolition. Where unification has occurred, the term 'Trust' should be taken to signify an operating division of the local NHS Board. See also NHS Board. |
| NHSCSP | National Health Service Cervical Screening Programme. |
| NHSScotland | The National Health Service in Scotland. |

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| non-attenders | Eligible people who do not attend following an invitation for screening. |
| OCCURS | Online Cervical Cytology Update and Recall System. |
| outcome | The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation. |
| pathogen | Any agent that can cause disease. |
| pathologist | Doctor who identifies diseases by studying cells and tissues under a microscope. |
| pathology | The study of disease processes with the aim of understanding their nature and causes. This is achieved by observing samples of blood, urine, faeces and diseased tissue obtained from the living patient or at autopsy, by the use of X-rays, and by many other techniques. |
| patient | A person who is receiving medical care or treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary. Sometimes referred to as user. |
| patient journey | The pathway through the health services taken by the patient (the person who is receiving treatment) and as viewed by the patient. |
| PCT | Primary Care Trust. See NHS Trust and primary care. |
| peer review | Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS Quality Improvement Scotland approach, all members of a review team are equal. |
| physician | A specialist in medicine. |
| population-based screening | An investigation available to all eligible, apparently healthy, people to identify a disease or abnormality which may be treated, cured or prevented (before symptoms appear). |
| positive predictive value | A measure of the reliability of a cytological diagnosis of 'significant abnormality', expressed as how often the cytological diagnosis is confirmed by histology. |

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| primary care | The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners. |
| protocol | A policy or strategy which defines appropriate action in specific circumstances. Protocols may be national, or agreed locally to take into account local requirements. |
| public consultation | The process of formal consultation and feedback on NHS Quality Improvement Scotland standards with healthcare professionals and members of the public. |
| QA | See quality assurance. |
| quality assurance (QA) | Improving performance and preventing problems through planned and systematic activities including documentation, training and review. |
| rationale | Scientific/objective reason for taking specific action. |
| RCGP | See Royal College of General Practitioners. |
| RCPath | See Royal College of Pathologists. |
| referral | The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment. |
| reporting profile | The outline of an individual's or laboratory's categories of results in an abbreviated form to allow comparison with others. |
| Royal College of General Practitioners (RCGP) | Royal College of General Practitioners. Website address: www.rcgp.org.uk/ |
| Royal College of Pathologists (RCPath) | The professional and advisory body overseeing education and qualifications of pathologists. Website address: www.rcpath.org/ |
| satisfactory smear | A smear that is of sufficient quality that the diagnosis given is likely to be correct. |

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| Scottish Executive Health Department (SEHD) | The Scottish Executive Health Department is responsible for health policy and the administration of NHSScotland. Website address: www.show.scot.nhs.uk/sehd/ |
| Scottish Intercollegiate Guidelines Network (SIGN) | SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland, to sponsor and support the development of evidence-based clinical guidelines for NHSScotland. Where a SIGN guideline exists for a specialty or service for which CSBS had set standards, or NHS QIS is taking forward standards, it will be referenced. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Executive, Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ. Website address: www.sign.ac.uk/ |
| screening | Examination of people with no symptoms, to detect unsuspected disease. |
| screening episode | A cycle of a person's screening events. |
| SCSP | Scottish Cervical Screening Programme. |
| secondary care | Care provided in an acute sector setting. See acute sector. |
| SEHD | See Scottish Executive Health Department. |
| self-assessment | Assessment of performance against standards by an individual/clinical team/Trust providing the service to which the standards are related. |
| sensitivity | The ability of a test to detect a disease. A test with a sensitivity of 90% will give a positive result in 9 out of 10 people who have the disease. |
| SIGN | See Scottish Intercollegiate Guidelines Network. |
| SIGN guideline | Scottish Intercollegiate Guidelines Network guideline. See also guideline. |
| smear | A specimen of tissue or other material taken from part of the body and spread ('smeared') onto a microscope slide for examination. |
| smear history | A record of the results of a woman's previous smears and biopsies. |
| smear reporting | The process of interpreting and recording the microscopic appearance of a cervical smear. |
| smear-taking | The process of taking a cervical smear. |

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| Special Health Board | The name is given to Health Boards with a national remit. These boards are focused on specific areas – eg, NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading. |
| specificity | The ability of a test to exclude people who do not have disease. A test with a specificity of 90% will give a negative result (ie a correct result) in 9 out of 10 people who do not have the disease. |
| specimen | A sample of tissue. |
| squamous (cell) epithelium | Epithelium is the tissue that covers the external surface of the body and lines hollow structures. Epithelial cells may be flat and scalelike (squamous), cuboidal or columnar. |
| standard statement | An overall statement of desired performance. |
| statutory | Enacted by statute; depending on statute for its authority as a statutory provision. Required by law. |
| transformation zone | The area in the cervix where abnormalities are more likely to arise. |
| unifed Board | See NHS Board. |
| unknown outcome | An unfinished clinical episode or one for which the end result is not known. |

## Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
  - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
  - ~ reaching our own conclusions and communicating what we find
- **partnership**
  - ~ involving patients, carers and the public in all parts of our work
  - ~ working with and supporting NHS staff in improving quality
  - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
  - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
  - ~ promoting understanding of our work
  - ~ explaining the rationale for our recommendations and conclusions
  - ~ communicating in language and formats that are easily accessible
- **quality assurance**
  - ~ aiming to focus our work on areas where significant improvements can be made
  - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
  - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
  - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

This document can be viewed on the NHS Quality Improvement Scotland website. It is also available, on request, from NHS Quality Improvement Scotland in the following formats:

- Electronic
- Audio cassette
- Large print


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