NHS public health functions agreement 2018-19

Service specification no.25
Cervical Screening
NHS public health functions agreement 2018-19

Service specification no. 25 Cervical Screening

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Classification: OFFICIAL
Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it (as required under the Equality Act 2010); and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities (in accordance with the duties under sections 13G and 13N of the NHS Act 2006, as amended).
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Service specification No.25

This is a service specification to accompany the 'NHS public health functions agreement 2018-19 (the ‘2018-19 agreement’).

This service specification is to be applied by NHS England in accordance with the 2018-19 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2018-19 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2018-19 agreement in accordance with the procedures described in Chapter 3 of the 2018-19 agreement.

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2018-19 agreement is available at www.gov.uk (search for ‘commissioning public health’).

All current service specifications are available at www.england.nhs.uk (search for ‘commissioning public health’).
1. Background and introduction

Purpose of the cervical screening specification

1.1. The purpose of this specification is to ensure that there is a consistent and equitable approach to the provision and monitoring of cervical screening across England.

1.2. This document is designed to outline the service and quality indicators expected by NHS England to ensure that a high standard of service is provided to NHS England’s responsible population. It therefore sets out the specific policies, recommendations, and standards that NHS England expects services to meet.

1.3. The specification outlines the arrangements for commissioning the cervical screening programme, to include:
   - Call/recall
   - Cervical cytology services (including Human Papillomavirus (HPV) testing)
   - Cervical histology services
   - Colposcopy services.

1.4. This service specification applies to all organisations providing the above services as part of the delivery of the Young Person and Adult (YPA) Cervical Screening Programme. The service provided by such organisations must be consistent with national guidance (including cervical screening programme best practice guidance and ad hoc communications). Detailed documentation is available at https://www.gov.uk/topic/population-screening-programmes/cervical

1.5. The specification operates up to and including the point of diagnosis of cervical cancer. Subsequent staging, investigations, management and treatment are outside of the scope of this document.

1.6. The service specification is not designed to replicate, duplicate, or supersede any relevant legislative provisions which may apply, e.g. the Health and Social Care Act 2008, or the work undertaken by the Care Quality Commission. In the event of new guidance emerging, the specification will be reviewed and amended with as much rapidity as possible, but where necessary, both NHS England and service providers should work proactively to agree speedy variations of contract ahead of the production of a revised specification.

1.7. This service specification needs to be read in conjunction with the current screening programme guidance and recommendations. These can be found on the Gov.uk website: Population screening programmes https://www.gov.uk/topic/population-screening-programmes
Aims, objectives and health outcomes

Aims

1.8. The aim of the NHS Cervical Screening Programme is to reduce the incidence of and mortality from, cervical cancer by delivering a systematic, quality assured population-based screening programme for eligible women.

1.9. This will be achieved across the whole programme by delivering evidence-based, interventions that:

- identify the eligible population and ensure efficient delivery with maximum coverage
- are safe, effective, of a high quality, equitable, externally and independently monitored, and quality assured
- lead to earlier detection of cervical abnormalities, appropriate subsequent treatment of cervical intraepithelial neoplasia (CIN), cervical glandular intraepithelial neoplasia (CGIN) and improved outcomes
- are delivered in suitably equipped accommodation, and supported by suitably trained, competent, and qualified, clinical and non-clinical staff who, where relevant, participate in recognized ongoing Continuing Medical Education (CME), Continuing Professional Development (CPD), and External Quality Assessment (EQA) schemes
- meet all published national standards (refer to Appendix 3)
- have audit embedded in the service.

1.10. All elements of the programme must operate strictly within existing published national guidance, including any updated or new documentation. Colposcopy clinics and sampling both need to be provided close to the individual, but cytology and HPV testing can both be centralised.

Objectives

Activities prior to screening

1.11. In accordance with good management practice and experience, in order to ensure appropriate and efficient use of NHS resources, the programme as a whole should:

- identify and invite eligible women for screening at appropriate intervals
- provide the invited population with the information required, in the form in which it is required, so that women are able to make an informed choice about whether or not to participate
- ensure that GPs are informed of the final outcomes of screening invitations for each of their patients
- optimise attendance among informed/willing individuals
• maximise accessibility of the service for all groups in the community.

Initial Screening

1.12. The programme as a whole should:
• provide women who attend for cervical screening with a high quality, effective, and woman-centered service
• carry out cervical screening in a way that minimises the possible adverse aspects (e.g. discomfort, anxiety) and that maximises the benefits (i.e. detecting abnormalities at an early stage)
• optimise attendance rates and maximise accessibility of the service for all groups in the community
• use only equipment and technology that meets programme standards (refer to Appendix 3)
• allow women to opt out of the service, on a single occasion or permanently
• provide adequate numbers of appropriately trained, qualified, and competent staff to carry out high-quality screening and laboratory work
• ensure that at least 98% of women receive results within two weeks of attendance for screening.

Assessment, diagnosis, referral, follow-up

1.13. The programme as a whole should:
• undertake assessment and diagnosis of individuals with abnormal initial screening results in appropriately staffed and equipped settings, at levels expected within the cervical screening programme, and to the standards expected within the cervical screening programme
• provide those attending follow-up appointments with clear information about the assessment process
• ensure that assessment results are communicated clearly, accurately, and promptly
• notify GPs of the outcome of further examinations
• diagnose and, where appropriate, treat cervical intraepithelial neoplasia (CIN) or cervical glandular intraepithelial neoplasia (CGIN)
• refer women with cervical cancer for treatment by appropriately trained and qualified specialists
• maintain surveillance of women according to programme protocols.
Standards
1.14. The programme as a whole should:

- minimise the incidence of invasive cancer of the cervix
- maintain minimum standards of screening, whilst aiming for achievable standards (see Appendix 1 & 2)
- participate in both approved national routine audits and *ad hoc* audits to evaluate overall programme performance.

Administration, failsafe
1.15. The programme as a whole should:

- make the best use of screening resources for the benefit of the whole population.
- minimise non-attendance at screening/clinics
- ensure effective and timely communication with individuals being invited, screened, assessed, or treated, and with clinical multi-disciplinary teams, primary care support services, NHS England, Screening Quality Assurance Service (SQAS) teams within Public Health England (PHE), the national office team within Public Health England, and NHS Digital
- work to develop a seamless, integrated care pathway
- build robust failsafe measures into all key stages of that pathway
- deal with complaints in accordance with relevant protocols
- use the programme’s IT systems to capture key screening data/outcomes promptly and accurately, supporting local and national SQAS and cancer registration processes and programme evaluation
- Comply fully with YPA Screening Programmes / NHS information governance requirements relating to the confidentiality and disclosure of person identifiable information and system/information security. NHS CSP Information Security Policy version 3 July 2009, and the NHS CSP Confidentiality and Disclosure Policy version 4 November 2011, (refer to Appendix 3). PHE Office of Data Release (ODR) application for data processes should be followed.

Audit and QA
1.16. The provider, subcontractor providers, and the screening quality assurance service team within Public Health England should work collaboratively to:

- regularly audit and evaluate the service to ensure that it is delivered in a safe, effective, timely, equitable, and ethical way, in accordance with national policy, standards and guidelines, internal and external SQAS arrangements, and risk assessments
• monitor, collect, and report statistical data and other relevant information to relevant bodies, use it to promote continuous improvement in service performance and outcomes, give formal feedback to the appropriate NHS England Director of Commissioning Operations (DCO) team and the population served by the programme, and provide key information and models of good practice/innovation/achievement to those working in the area of cervical screening

• participate willingly in multidisciplinary SQAS visits organised by the SQAS team within PHE.

1.17. The provider will maintain a high quality service at all times, to include:

• collection and circulation of routine activity data, outcome data, and statistics, and use of these to monitor the service against the published standards of the programme, thereby assisting NHS England, public health screening staff, and SQAS team within PHE

• The above cervical screening data will contribute towards the local public health screening annual report

• attendance of lead staff from each discipline (and provision of relevant data) at quarterly multi-agency cervical screening coordinating groups/programme boards.

• documentation and implementation of comprehensive internal QA processes

• full participation in external SQAS activities, including audits, investigation of incidents in the programme, external quality assessment schemes and SQAS visits by the SQAS team within Public Health England; this includes responsibility for taking action on recommendations made at SQAS visits.

Information Technology

1.18. The call and recall service must:

• maintain electronic links with GP surgeries and laboratories and colposcopy clinics

• check that staff in GP practices and community clinics record all necessary data promptly and accurately via the NHAIS/Open Exeter system/PCSE Cervical Screening System and PSCE Online system

• check that laboratories and colposcopy services capture key screening data/outcomes promptly and accurately in clinical systems, supporting local and national SQAS, cancer registration processes, and programme evaluation

• comply fully with local cervical screening programme and NHS information governance requirements relating to the confidentiality and disclosure of person identifiable information and system/information security. NHS CSP Information Security Policy version 3 July 2009, and the NHS CSP Confidentiality and Disclosure Policy version 4 November 2011, (refer to Appendix 3). PHE Office of Data Release (ODR) application for data processes
should be followed.

**Accreditation, training, guidance, research**

1.19. GP practices and community clinics should:
   - ensure that all staff who undertake sample taking have appropriate initial training and achieve and maintain the necessary competencies. This must include regular updates on policy and technology.

1.20. The provider should:
   - Maintain electronic links with call/recall services
   - ensure that staff in provider Trusts are appropriately trained and supported by national continuing professional development and competency skills frameworks, enabling them to develop their skills, competencies, and potential. Only approved/accredited training courses should be used
   - contribute to nationally-approved research into the screening and diagnosis of cervical cancer, to inform screening practice and policy
   - ensure that all pathology laboratories dealing with screening programmes are formally accredited by United Kingdom Accreditation Service (UKAS) or equivalent
   - ensure pathologists reporting material comply with Royal College of Pathologists (RCPPath)/cervical screening programme reporting guidelines (refer to Appendix 3)
   - ensure that all staff who sign out cervical samples as either negative or abnormal report sufficient numbers of samples (defined in programme guidance) and participate routinely in the appropriate EQA schemes. (refer to Appendix 3)

**Safety and Safeguarding**

1.21. The provider should refer to and comply with the safety and safeguarding requirements as set out in the NHS Standard Contract.

**Common Health Outcomes**

1.22. The programme as a whole aims to:
   - reduce the incidence of and mortality from cervical cancer
   - refer women promptly to treatment services
   - ensure equity of access to cervical screening across all groups in society
   - minimise the adverse, physical/psychological/clinical aspects of screening e.g. anxiety, unnecessary investigation.

**Common Programme Aims**

1.23. The programme as a whole aims to:
   - detect cervical abnormalities which, left untreated, could develop into cancer
treat cervical intraepithelial neoplasia (CIN) and cervical glandular intraepithelial neoplasia (CGIN) where appropriate

- meet all published national standards
- deliver a safe, effective, equitable, high quality, externally monitored and assured service
- make effective and efficient use of resources for the benefit of the whole population
- deliver a service supported by a suitably competent and trained clinical/non-clinical workforce, within suitably equipped accommodation
- refer women promptly to treatment services
- ensure equity of access across all groups in society
- minimise adverse physical/psychological/clinical aspects of screening (e.g. anxiety, unnecessary investigations)
- encourage early presentation to primary care of symptoms which may develop between screening episodes
- underpin services by a solid audit and research base
- meet local population needs


**Equality Section**

Delivery of the screening programme contributes to reducing health inequalities and should include the following deliverables:

- screening should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary
- a Health Equity Audit should be undertaken as part of both the commissioning and review of this screening programme, including equality characteristics, socio-economic factors and local vulnerable populations
- the service should be delivered in a culturally sensitive way to meet the needs of local diverse populations
- user involvement should include representation from service users with equality characteristics reflecting the local community including those with protected characteristics
- providers should exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow equality, health inequality and screening guidance when making such decisions

The provider will demonstrate they have systems in place to address health inequalities and make sure there is equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to make sure that there are no obstacles to access on the grounds of the nine protected characteristics as

The provider will have procedures in place to identify and support those persons who are considered vulnerable/hard-to-reach, including but not exclusive to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers, gypsy traveller groups and sex workers; those in prison; those with mental health problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties. The provider will comply with safeguarding policies and good practice recommendations for such persons.

Providers are expected to meet the public sector Equality Duty which means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees

https://www.gov.uk/equality-act-2010-guidance

It also requires that public bodies:
• have due regard to the need to eliminate discrimination
• advance equality of opportunity
• foster good relations between different people when carrying out their activities

All screening programme providers should ensure they have included members of the armed forces who are registered with Defence Medical Centres within their responsible population boundaries
2. Scope of the screening programme

Description of the screening programme

2.1. Individual clinical areas discussed in this section can be included or excluded according to the local situation. For example, the information on laboratory services can be ignored if only colposcopy services are required.

2.2. This service specification is for the provision of cervical screening services to include:
   - Call/recall services
   - Cervical cytology services, including HPV testing
   - Cervical histology services
   - Colposcopy services.

2.3. Participation in screening and cervical sample taking is an additional service within the General Medical Services (GMS) contract.

Invitations for Screening and Results

2.4. The call and recall service should:
   - Invite eligible women for screening six months before their 25th birthday, then at three-yearly intervals between the ages of 25 and 49 years. Thereafter, between the ages of 50 and 64, women should be invited at five-yearly intervals
   - Invite to screening any women aged 65 or over who remain eligible as part of the screening pathways.
   - Keep supporting documentary evidence for an indefinite time period for any woman who is ceased from the programme
   - Follow national guidance on the routine ceasing of women (refer to Appendix 3)
   - Cooperate with and/or carry out annual audits of ceased women.
   - Send results in writing to the woman within two weeks of her sample being taken (refer to Appendix 1)

Initial Screening

2.5. NHS England must ensure that arrangements are in place to:
   - Verify the appropriateness for the screening of women on call/recall lists
   - Make sure that women who are not on NHS lists have access to screening, and that local arrangements are made to cover residential institutions, including prisons.
   - Ensure that all equipment used complies with national equipment standards (refer to Appendix 3)
• ensure that staff working in the programme are trained to meet the required standards of competence and are actively involved in continuing personal and professional development. (refer to Appendix 3)

2.6. The cytopathology laboratory will, as a minimum:

• accept appropriate samples with the minimum data requirements from eligible women according to programme protocols and guidance
• communicate any issues with samples received to the appropriate parties as indicated in the relevant guidance/advice (refer to Appendix 3)
• receive book in process and examine/report appropriate cervical cytology samples and provide clinical reports of these tests in line with programme guidance (refer to Appendix 3)
  • send results securely to the sample taker and the relevant GP (if different)
  • send results securely to the appropriate PCSE and ensure that suitable systems are in place to verify that all tests are reported and safely transmitted according to programme standards (refer to Appendix 3)
  • deal promptly with telephone and email queries in relation to cervical screening activities
  • make sample results available at colposcopy
  • make cytology slide(s) and/or result available to the histopathologist
  • manage a safe and robust direct referral system for women where cytology results indicate that referral for colposcopy is required, according to programme guidance (refer to Appendix 3)
  • contribute to multi-disciplinary (MDTM) case discussions and to mismatch meetings designed to audit cytology/histology/colposcopy findings to agreed local protocols. These meetings must meet the requirements outlined in relevant cervical screening programme publications (refer to Appendix 3)
  • produce quarterly activity reports, as determined locally, for both SQAS teams within PHE and NHS England, who will discuss these at local multi-agency cervical screening coordinating groups and programme boards.
  • produce a validated mandatory annual return (KC61) for each laboratory and provide this to the SQAS teams within PHE and NHS England, by the specified deadline
  • work with NHS England to maintain a sample taker register, as determined locally, and provide comprehensive feedback both by individual sample taker and by general practice/clinic on reporting profiles, workload, and sample error issues (for example missing patient identifier), as agreed with NHS England
• provide feedback to trainee sample takers where required locally
• ensure that the performance of all staff involved in reporting cervical cytology tests is monitored according to cervical screening programme and relevant professional society guidance (refer to Appendix 3)
• Take appropriate action where performance is outside national standards/guidelines
• provide a comprehensive failsafe system as defined by programme guidance (refer to Appendix 3)
• comply with cervical screening programme guidance and with local SQAS processes and audit requests from the SQAS team within Public Health England
• undertake regular audits on cervical screening activities, including the review of cytology tests on samples taken from women subsequently diagnosed with cervical cancer, in line with programme guidance (refer to Appendix 3)
• maintain comprehensive quality management and quality control systems, including internal and external QA and processes (which includes participation in mandatory cervical screening programme EQA schemes). All such activities should be documented in protocols and procedures that comply with programme guidance. (refer to Appendix 3)
• undertake HPV triage and test of cure on appropriate samples, as defined by the programme, in accordance with the cervical screening programme HR-HPV triage and test of cure protocol (refer to Appendix 3)
• In the event that HPV testing is undertaken outside the cervical cytology service, identify a senior individual (i.e. clinical or scientific lead in the laboratory) as the lead for the HPV testing service. This individual is expected to participate fully in provider-based multi-disciplinary management meetings and, as determined locally, multi-agency cervical screening meetings.

Assessment, diagnosis, referral, follow-up

2.7. In accordance with programme standards and protocols, (refer to Appendices 1, 2 and 3) the organisations within the cervical screening programme should undertake to meet the following criteria.

2.8. The GP practice will:
• counsel women before the screening test, and also after, where the result is abnormal and this is requested by the woman
• ensure that follow-up/ treatment/ referral is recommended and initiated, and verify direct referral.

2.9. The colposcopy service will, as a minimum:
• provide services in line with all programme standards and guidance (refer to Appendix 3) and British Society of Colposcopy and Cervical Pathology...
(BSCCP) standards and guidance, including accreditation of colposcopists www.bsccp.org.uk

- appropriately and efficiently manage women referred via direct referral, GP referrals, and tertiary referral within, or between, providers
- make sure women are fully informed and counselled before an appointment
- manage/ treat precursor lesions and early stage 1A cancers according to protocol and retrieve excised tissue for histological evaluation (refer to Appendix 3)
- ensure that all clinical, operational, and administrative activities are documented in up-to-date service guidelines, and that usual practice avoids unnecessary attendance (refer to Appendix 3)
- make sure that women are provided with the necessary information and advice in advance of their colposcopy appointment, including information relating to see-and-treat (when appropriate). All information given to individuals should conform with programme standards (refer to Appendix 3)
- Make sure that the colposcopist to whom the woman is referred takes responsibility for her management, including arranging further follow-up (either in the colposcopy or gynaecology clinic), and informs the GP (or responsible clinician) of the outcome of the examination, including any investigation performed, and the due date of subsequent colposcopic examination.
- When the woman is discharged from colposcopy or back to primary care the colposcopist is responsible for informing PCSE of the next test due date and completing the discharge template. Any failsafe process can then be closed (refer to Appendix 3)
- have a failsafe system in place, consistent with guidance from the Cervical Screening Programmes within Public Health England (refer to Appendix 3)
- where a hysterectomy is undertaken, take responsibility for ensuring that the GP is informed of the type of operation, whether it included total removal of the cervix, and the results of any histology conducted and provide advice in relation to future screening for women who undergo such procedures
- meet the cervical screening programme standards for attendance by colposcopists at multi-disciplinary case discussions/ mismatch meetings to audit cytology, histology, and colposcopy findings to the agreed local protocol. These meetings should meet the requirements outlined in relevant publications from the Cancer Screening Programmes within Public Health England (refer to Appendix 3)
- carry out an agreed annual colposcopy audit programme and take the necessary action where performance is outside national standards
- produce validated quarterly KC65 reports for each clinic to the SQAS team
within Public Health England and NHS England, within a maximum of six weeks after the end of each quarter. An overall annual KC65 return for each clinic should be supplied within 6 weeks of the end of the financial year

- carry out patient satisfaction surveys at least annually. The findings of such surveys should be used to improve the service
- undertake colposcopy and associated activities within accommodation that meets programme standards, using equipment that meets programme standards (refer to Appendix 3)
- maintain a suitable IT system to enable an accurate electronic record to be made of all activity carried out within the colposcopy service, including colposcopy carried out under general anaesthetic. The IT system should support the audit and quality assurance processes.
- ensure that staff working in the programme are trained to meet the required standards of competence and are actively involved in continuing personal and professional development. (refer to Appendix 3)

2.10. The histology laboratory will, as a minimum:

- be accredited by UKAS, or equivalent, and provide a comprehensive histology service to support the cytology and colposcopy services (refer to Appendix 3)
- process and report diagnostic and treatment specimens taken by the colposcopy service (including those taken under general anaesthetic) in a timely manner to allow colposcopy to meet reporting time standards for biopsy results (refer to Appendix 1 and 2) and relevant professional guidance
- send results securely to the originating clinician and to the cytology laboratory, where these are located in a different healthcare organisation
- provide histology results to cytology
- participate fully in the cancer registration process for CIN3, cervical glandular intraepithelial neoplasia (CGIN) and cervical cancer results
- contribute fully to multi-disciplinary case discussions/mismatch meetings to audit cytology, histology, and colposcopy findings to the agreed local protocol. These meetings must meet the requirements of the relevant cervical screening programme publications (refer to Appendix 3)
- undertake internal and external quality control measures and regular audits, in accordance with published standards. Take appropriate action where performance is outside national standards/guidelines (refer to Appendices 1, 2 and 3)
- participate in relevant EQA schemes, where available
- audit all cases where invasive cervical cancer is found in women within the programme run by the laboratory, in line with cervical screening programme guidance (refer to Appendix 3)
• comply with cervical screening programme /Royal College of Pathologists histopathology reporting guidelines. (refer to Appendix 3)

2.11. Where colposcopy is provided on more than one site, there must be consistency of procedures and protocols, accommodation, equipment, and IT, including robust policies for onward referral. In this situation, the lead colposcopist and lead colposcopy nurse will be responsible, as appropriate to their roles, for colposcopy activities occurring on all sites.

Standards

2.12. In accordance with best practice and national guidance shown in Appendix 3 PHE Screening should:

• Provide all staff working in the cervical screening programme with relevant clinical, programme and SQAS guidelines
• Provide all staff with minimum standards, to adhere to programme guidance and recommendations, and conduct internal audit and external SQAS monitoring take prompt action where standards are lower than expected to identify the causes and improve the service
• agree early warning systems and triggers with the local SQAS team within Public Health England
• manage failures to provide services to the level specified in the cervical screening programme SQAS guidelines according to programme protocols (see Appendix 3Managing Safety Incidents in NHS Screening Programmes August 2017) screening-programmes
• ensure that all programmes have a multi-disciplinary SQAS visit in line with the programme specific operating model
• use nationally developed and agreed letters and leaflets.

Administration, audit, QA, failsafe, IT

2.13. The various elements of the service have the following responsibilities:

Call/recall

2.14. The call/recall database used by the programme is the National Health Application Infrastructure Services (NHAIS) system, often referred to as the Exeter system. The Exeter system is a population database, with details of all eligible women registered with GPs in England. The system is used to:

• invite eligible women at the appropriate intervals
• manage and acknowledge receipt, and accurate recording of test results
• ensure that women and GPs are promptly notified of test results
• handle the results/screening histories of women moving in or out of the area
and those screened outside of the cervical screening programme

- set the next test due date
- Manage and acknowledge receipt of next test due date following discharge from colposcopy
- facilitate failsafe, e.g. by running regular searches to ensure that no individual is missed
- ensure that women who transfer between databases have their screening histories available and screening intervals maintained
- Report coverage on KC53 and provide management information linked to standards for the programme.
- Provide mandatory returns as specified by the programme
- record the HPV vaccination status for girls

A new I.T. system (PCSE Cervical Screening System) will be developed for PCSE and is planned to go live in 2018 this system is expected to provide the same functions as NHAIS.

The GP should:

- ensure that they and their staff are adequately trained for the clinical practice they undertake
- be able to demonstrate training and competence for all staff taking samples, including understanding of up to date programme policies (refer to Appendix 3)
- make sure there is adequate clinical capacity to meet the needs to their eligible population
- record all cervical tests and ensure sample taker access to all previous test results
- ensure that all women are appropriately informed of their test result in writing
- comply fully and promptly with non-responder and failsafe procedures
- provide specified data for national and local audits and other agreed purposes
- audit the data of all individuals taking cervical samples individually and for the practice as a whole on a quarterly basis

2.15. The cytology laboratory should:

- contribute effectively to MDT/audit meetings
- produce periodic and suitably detailed activity reports and returns as required for cervical screening programme SQAS processes and national/regional audit.

2.16. The histopathology laboratory should:
• send results to the clinician and cytology laboratory as appropriate
• record and report on rejected and inadequate samples.

2.17. Each colposcopy service should:
• identify a lead colposcopist to oversee continuity of management/follow-up, and notification of outcome/ discharge/ next text due date
• manage external relationships
• organise failsafe arrangements to cover key stages of the process, including non attendance. (refer to Appendix 3)

**Accreditation, training, guidance, research**

2.18. The programme as a whole should:
• ensure that all screening service staff regularly participate in SQAS activities (including SQAS visits, the EQA scheme (pathologists and technical staff), and that all professionals meet CPD/CME requirements
• invite eligible women to participate in appropriate studies related to cervical screening.

**Failsafe arrangements**

• QA within the screening pathway is managed by the inclusion of failsafe processes. Failsafes are a back-up mechanism, designed to ensure that, where something goes wrong, processes are in place to identify what is going wrong and what actions are necessary to ensure a safe outcome. (refer to Appendix 3)

2.19. The provider is expected to:
• include appropriate failsafe mechanisms across the whole screening pathway for women who participate. Details of appropriate procedures are embedded in the guidance and recommendations on the cervical screening programme website and may need development in some areas (refer to Appendix 3)
• review and risk assess local screening pathways in the light of guidance offered by SQAS processes or the cervical screening programme
• work with NHS England and SQAS teams to develop, implement, and maintain appropriate risk reduction measures
• ensure that mechanisms are in place to audit implementation of risk reduction measures regularly and report incidents should these occur (refer to Appendix 3)
• ensure that appropriate links are made with internal provider governance arrangements, such as risk registers
- ensure routine staff training and ongoing development takes place
- maintain a record of tests taken
- check that results are received from the laboratory for every sample
- ensure women whose samples they report will be notified of results (either via the practice, colposcopy or call & recall)
- ensure women whose samples are taken in genitourinary medicine clinics or colposcopy clinics obtain their results in writing
- act on non-responder notifications (screening, and colposcopy appointments)
- ensure required colposcopy referrals are made
- respond to failsafe enquiries from laboratories/report incidents in line with screening incident guidance (Appendix 3).

**Roles and accountabilities**

2.20. The provider must create clear lines of accountability and responsibility for all cervical screening services carried out under this agreement. This includes identification of individuals to undertake the following roles, as defined by programme guidance, (refer to Appendix 3) supplemented as appropriate by best practice guidance from SQAS teams within Public Health England:

- a hospital-based cervical screening programme co-ordinator (HBPC) with delegated responsibility from the chief executive for the quality of all cervical screening activities carried out by the provider. This role may be combined with that of pathway manager or Cervical Screening Provider Lead.
- a lead cytopathologist
- a lead histopathologist
- a named laboratory lead (usually a senior biomedical scientist)
- a lead colposcopist
- a lead colposcopy nurse
- a pathway manager.

2.21. Key staff should be formally appointed, should have sufficient designated sessions, and should be able to access sufficient administrative support in order to fulfil their roles. Where possible, deputies for key roles should be identified to provide cover in the event of absence.

2.22. The HBPC should maintain a close working relationship between all parts of the provider’s cervical screening activities, and with NHS England and stakeholders. Where the provider undertakes cytology which results in colposcopy referrals to another Trust, the HBPC at the provider should ensure close working relationships with neighbouring HBPCs are maintained.

2.23. Regular multi-disciplinary cervical screening management meetings should take place within the provider, convened on a quarterly basis, to discuss performance...
and any issues arising with cervical screening services. Where appropriate, these should include representatives from subcontracted Trusts. Appropriate Trust systems should be in place to enable an annual report with six-monthly update from the HBPC to be discussed at a formal clinical governance committee within the provider’s institution, thereby enabling escalation of key issues to the chief executive as required.

2.24. The provider will convene regular multi-disciplinary clinical case discussion meetings as outlined in programme guidance, (refer to Appendix 3) and/or will ensure that provider staff attend and support (i.e. through sample review) meetings convened by other providers e.g. where colposcopy is carried out by other Trusts, to which the provider directs referrals. The provider will ensure that all staff involved in cervical screening activities are kept informed of programme performance and issues.

2.25. The cervical screening programme is dependent on systematic, specified relationships between stakeholders, including relationships with treatment services, the laboratory, external diagnostic services, Primary Care representatives, etc. The lead provider will be expected to identify a pathway manager to take the lead and ensure that inter-organisational systems are in place to maintain the quality of the whole screening pathway. This will include, but is not limited to:

- providing coordinated screening across organisations, so that all parties are clear about their roles and responsibilities at every stage of the screening pathway, and particularly where responsibility is transferred from one party to another
- developing joint audit and monitoring processes
- agreeing joint failsafe mechanisms, where required, to ensure safe and timely processes across the whole screening pathway
- contributing to any initiatives led by NHS England or public health screening teams to develop the screening pathway in line with the programme expectations
- maintaining robust electronic links with IT systems and relevant organisations across the screening pathway
- agreeing links with primary care, and with secondary and/or tertiary care.

The role of pathway manager may be combined with that of the hospital-based programme co-ordinator or Cervical Screening Provider Lead.

**Commissioning arrangements**

2.26. Cervical screening services will be commissioned by NHS England alongside specialised commissioning of cancer services where appropriate. Minimum data requirements for NHS England are shown in Appendix 1.
Links with the National Programme and ‘Do once and share’

2.27. Certain functions of English national screening programmes are managed from PHE by the national team of the Young Person and Adult Screening Programmes. National guidance documents can be accessed via the .GOV.UK website https://www.gov.uk/topic/population-screening-programmes

PHE, through the national screening programmes, is responsible for leading high-quality, uniform screening, providing accessible information to both the public and health care professionals, and developing and monitoring standards. It is also responsible for the delivery of national quality assurance, based at regional level, and for ensuring training and education for all those providing screening is developed, commissioned and delivered through appropriate partner organisations.

Education and training:

Providers must facilitate training in line with cervical screening programme requirements/standards (appendix 3). Providers should ensure training has been completed satisfactorily and recorded and that they have a system in place to assess on-going competency.

Providers must allow appropriate annual CPD in line with programme and professional requirements, for example a screening study day or completion of e-learning.

Public information:

- Providers must always use the patient information leaflets from PHE Screening at all relevant stages of the screening pathway to ensure accurate messages about the risks and benefits of screening and any subsequent surveillance or treatment are provided. PHE Screening should be consulted and involved before developing any other supporting materials.
- Providers must involve PHE Screening and PHE Communications in the development of local publicity campaigns to ensure accurate and consistent messaging, particularly around informed choice, and to access nationally-developed resources. For local awareness campaigns, local contact details must be used.
- Providers must not develop their own information about screening for local NHS websites but should always link through to the national information on NHS Choices (http://www.nhs.uk/Livewell/Screening/Pages/screening.aspx or the relevant programme page) and GOV.UK (https://www.gov.uk/topic/population-screening-programmes or the relevant programme page).
- To support PHE Screening to carry out regular reviews of the national screening public information leaflets and online content, providers are encouraged to send PHE Screening the results of any local patient surveys which contain feedback on these national resources.
Increasing Uptake

It is recommended that:

- Commissioners and providers work with local authorities and third sector organisations to understand and develop plans to address uptake and inequalities. QA visits include an assessment of the process to develop such plans and their implementation at a local level.

- Commissioners work with providers to ensure that letters and invitations have been endorsed by GPs (where the GP agrees), timed first and second appointments are offered and appointment reminders are used.

Providers, commissioners and local authorities are encouraged to pilot, evaluate and publish (preferably in peer reviewed journals) local solutions to address inequalities of access. Before piloting, these local proposals must be agreed with the PHE screening team to ensure consistency of message with nationally agreed letters.

PHE screening team will share new and emerging knowledge via the screening inequalities network and blogs.
3. Delivery of the screening programme

Service model summary

3.1. Providers should provide cervical screening services to the standard outlined in national standards, to all eligible women within the population defined by NHS England. This specification operates up to the point of diagnosis of cervical cancer; subsequent management and treatment is outside its scope.

3.2. If the optimal deliverable benefits from a screening programme are to be achieved, there must be seamless links between ‘screening responsibility’ and ‘treatment responsibility’, so that women at the end of the screening process are referred to treatment services if necessary.

3.3. All elements of the screening pathway must be delivered by appropriate staff, to national standards and guidelines.

Population coverage

3.4. NHS England and the service provider will work together to:
   - ensure that up-to-date population registers and lists of GP registered populations are maintained and cleaned to guarantee accuracy and completeness
   - optimise coverage and uptake across their catchment area
   - co-operate with regular analysis of coverage to identify groups of women who either access screening at lower levels, or do not access services at all

Programme Coordination

The provider or subcontracted provider will be responsible for ensuring that the part of the programme that they deliver is coordinated. Where collaboration is necessary, one part of the programme should interface seamlessly with others, particularly in the areas of timeliness and data sharing. This will ensure that the aims and objectives of the cervical screening programme are met and an integrated service offered to women.

Governance and Leadership

The provider will:

- cooperate with and have representation on local oversight arrangements as agreed with NHS England commissioners
- identify a Trust director who is responsible for the screening programme
• ensure internal clinical oversight and governance by an identified clinical lead and a programme manager

• provide documented evidence of clinical governance that includes:
  o compliance with the NHS Trust and NHS England information governance/records management
  o user involvement, experience and complaints
  o failsafe procedures
  o risks and mitigation plans
  o Compliance with the NHS cancer screening programme confidentiality and disclosure policy

• ensure that there is regular monitoring and audit of the screening programme, and as part of the organisation's clinical governance arrangements, the board is assured of the quality and integrity of the screening programme

• produce an annual report of screening services, which is signed off by the board

• ensure the programme is delivered by trained workforce that meet national requirements

**Definition, identification, and invitation of cohort/eligibility**

3.5. The target population to whom screening is to be offered comprises all women in the eligible age group who are registered on specified NHAIS systems with specified GPs, or who are resident in the specified area and not registered with the NHS but entitled to NHS care.

3.6. The target age group is currently:

- Age 25: first invitation (in practice, invitations to first screen are issued at 24.5 years)
- Ages 25 – 49: 3 yearly screening
- Ages 50 – 64: 5 yearly screening
- Ages 65+: screening of those who have not been screened since age 50, or those who have not yet met the criteria to be ceased from the programme.

3.7. The provider must cooperate with efforts to optimise screening participation amongst vulnerable and hard-to-reach groups within the eligible population.

**Location(s) of programme delivery**

3.8. The providers of both initial screening and subsequent colposcopy must ensure that these elements of the programme take place in suitable and appropriate locations, which should take account of the public transport links and car parking facilities.

3.9. The lead provider will ensure accessible service provision for all referred women, while ensuring that all locations fully comply with the standards and guidelines
referenced in this service specification. All services (cytology, histology, colposcopy) must be provided in locations that enable a full service to be delivered and that are compliant with the requirements of this service specification.

**Days/hours of operation**

3.10 The days and hours of operation of both screening appointments and colposcopy clinics will be locally determined and appropriate for the local populations. Easy access to initial screening appointments and timely further examination is essential, and this is a key criterion of quality for the entire screening pathway. The provider should therefore be able to demonstrate efficient and effective use of resources.

**Working across interfaces**

3.11 The screening programme is dependent on strong working relationships (both formal and informal) between the professionals and organisations involved in the screening pathway. Accurate and timely communication and handover across these interfaces are necessary to reduce the potential for errors and ensure a seamless pathway for service users. The provider will

- Ensure that there are clear, named lines of clinical responsibility at all times, and particularly where there is handover of care.

3.12 State these lines of clinical responsibility in an operational policy within the programme.

3.13 The provider will ensure that appropriate systems are in place to support an interagency approach to the quality of the interface between these services. This will include, but is not limited to:

   3.13.1 taking the lead role in oversight of the entire screening pathway
   3.13.2 agreeing and documenting roles and responsibilities relating to all elements of the screening pathway across organisations
   3.13.3 providing strong clinical leadership and clear lines of accountability.
   3.13.4 developing joint audit and monitoring processes
   3.13.5 working to agreed programme standards and policies
   3.13.6 agreeing jointly, between all agencies, the failsafe mechanisms that are required to ensure safe and timely processes across the whole screening pathway
   3.13.7 meeting the screening programme standards set by YPA Screening Programmes within Public Health England

3.14 The lead provider must ensure that procedures at interfaces follow these guidelines:

   3.14.1 letters should be sent to women, inviting them for screening at appropriate intervals
3.14.2 A failsafe system should ensure laboratory receipt of correctly identified samples.

3.14.3 The laboratory service should provide results to the screening MDT.

3.14.4 The laboratory service should provide results to the call/recall system.

3.14.5 MDT outcomes should be accurately recorded on local cervical screening IT systems.

3.14.6 GPs should be informed of screening outcomes.

3.14.7 Symptomatic services should inform screening about cervical cancers diagnosed outside of screening.

3.15 To ensure that the service delivered forms part of a high quality cervical screening programme for the local population, the provider will:

3.15.1 Work collaboratively with other services to deliver services to national standards,

3.15.2 Ensure appropriate failsafe systems are in place between the different organisations involved in the provision of cervical screening.

3.15.3 Where necessary, refer women on to appropriate services outside screening e.g. for cancer treatment.

**Information on test/screening programme**

3.16 The provider will ensure that:

- At relevant points throughout the screening pathway, women are provided with appropriate information on cervical screening.
- A trained interpreter is available during appointments for women whose functional language is not English, along with appropriate written information.
- Provide appropriate support for women with physical disabilities.
- Ensure that women with learning disabilities are provided with support to enable them to understand all processes and results.

**Testing (laboratory service, performance of tests by individuals)**

3.11 Laboratories are expected to follow the policy guidance and standards laid out in standard operating protocols. Laboratories must be accredited by UKAS, or equivalent, and must process at least 35,000 cervical cytology samples from GP and community clinics each year. The evidence for this is set out in the cervical screening programme advice to the NHS on achieving 14 day turnaround times to screening results.
3.12 Laboratories are also required to provide routine data to NHS England in a timely manner and using an agreed format. This includes but is not limited to:

- data on samples analysed both number and results
- notification of positive results
- notification of outcome data where possible.

Results reporting and recording

3.13 The laboratory will

- send results to relevant parties within the screening programme, including GPs and Call & Recall, ideally using electronic means. Data should be presented with the nationally approved format and codes and follow NHS reporting formats and rules.

Providing results

3.14 Laboratories must notify relevant parties of the result of the screening process in a time period which supports achievement of the overall pathway requirement to issue results to women within 2 weeks of the screening test being taken.

3.15 It is recognised that during the transition to HPV as a primary screening test many services are challenged in meeting the 14 day turnaround target. Commissioners and providers are responsible for implementing mitigation plans to ensure local service delivery achieves the DH Vital signs standards during the development of planning and introduction of HPV Primary screening. Commissioners will work with local laboratory providers to mitigate any capacity issues and commission HPV primary screening to address turnaround times for screening results.

Transfer of, and discharge from, care obligations

3.16 The screening programme covers the period from identification of the eligible population to diagnosis of cervical cancer. On diagnosis, women will be transferred efficiently to treatment services. Any post-treatment follow-up will be the responsibility of the treatment services.

3.17 Women who have had cervical abnormalities treated will be followed up in accordance with current cervical screening programme protocols.

3.18 This specification does not include the following activities, or any work or cost associated with them:

- Follow-up and management after a diagnosis of cancer

3.19 Women under the age of 24.5 are not eligible for cervical screening. They will be
automatically invited as they approach their 25\textsuperscript{th} birthday. In addition, women are normally excluded from the routine programme when they:

- will be aged 65 or over at the date of their next test, and meet the criteria for automatic ceasing
- have been ceased from the programme at their own request
- have no cervix, either because of a congenital absence, or because they have undergone a procedure to remove the cervix completely
- have had radiotherapy for cervical cancer, so that it is not possible to make an accurate cytological report.

3.20 Women who are not registered on any NHAIS system do not receive automatic invitations, but may be registered if a sample is received (e.g. from a community outreach clinic). These samples should be reported if the woman is eligible for NHS care. If women aged 65 and over who have never attended for a test request screening, their samples should be reported.

3.21 Contractual requirements for equity of access, equality, and the avoidance of discrimination are detailed in the Standard NHS Contract.

**Staffing**

3.22 The provider will ensure that there are adequate numbers of trained, qualified, and competent staff in place to deliver a high-quality cervical screening programme, in line with best practice guidelines and cervical screening programme national policy.

3.23 Qualifications will be specific to the groups of staff delivering the service across the care pathway. However, all staff must demonstrate competence in their area (this is linked to training).

3.24 All professionals involved in the screening programme are required to keep up-to-date with nationally approved training programmes and CPD/CME etc. and should participate in educational schemes such as histopathology EQA as appropriate.
User involvement

The provider(s) will be expected to:
• demonstrate that they regularly seek out the views of service users, families and others in respect of planning, implementing and delivering services
• demonstrate how those views will influence service delivery for the purposes of raising standards
• make results of any user surveys/questionnaires available to NHS England on request

In accordance with good practice, to gain feedback on services provided, and to have public involvement on service provision, the provider will collect the views of service users, which may be via surveys or questionnaires. It is expected that such surveys will take place on a regular (rather than ad hoc) basis and that the results will be made available to NHS England. The provider will:
• demonstrate that they have collected (or have plans in place to collect) the views of service users, in respect of the services they provide
• demonstrate how those views will influence service delivery for the purposes of raising quality
• show that all women are given information about how to provide feedback about the services they receive, including the complaints procedure.

Premises and equipment

3.25 The provider will ensure that:
• suitable premises and equipment are provided for the screening programme
• appropriate policies are in place for equipment calibration, maintenance, and replacement
• IT systems are able to support the programme and supply accurate and complete data for the purpose of monitoring national standards and KPIs and for quality assurance activities. These systems must be backed up appropriately
• the IT systems are able to perform failsafe checks
• there are appropriate and secure premises on which screening can safely take place.
• only technologies and protocols that have been evaluated and recommended by the YPA cervical screening programme within PHE are used in the programme, and that the manner of their use accords with national guidelines. The provider must make all staff aware that unorthodox use of approved technologies or used of unapproved technologies is prohibited within the NHS Cervical Screening Programme, except as part of a formal national pilot, or a properly constituted and approved research project. The definition of ‘technology’ here is an inclusive one.

Key Performance Indicators

3.26 Each provider as applicable to their element of the programme will adhere to the requirements specified in Appendix 1.
Data collection and monitoring

3.27 The Screening Quality Assurance Service, in liaison with the providers, will provide validated data for the following purposes:

- contribute to national data collection exercises where required for national analysis.
- provide annual data, measuring performance against both standards and the Key Performance Indicators to monitor performance and measure trends.

Data reporting

3.28 Each provider will

- Ensure that data is reported to NHS England and SQAS teams within Public Health England on a quarterly and annual basis as applicable to their element of the service. Appendices 1 & 2 show routine data requirements. Further details of SQAS data requirements are contained within the published programme specific operating model (https://www.gov.uk/government/publications/cervical-screening-programme-specific-operating-model)

3.29 Consolidated annual reports activity and coverage are published at a national level and detail local activity.
Section 4: National standards, risks and quality assurance

The provider will:

- meet the acceptable national screening standards and work towards attaining and maintaining the achievable standards adhere to specific professional standards and guidance

- maintain a register of risks, working with NHS England and quality assurance teams within Public Health England to identify key areas of risk in the screening pathway, and make sure these points are reviewed in contracting and peer review processes

- participate fully in national quality assurance (QA) processes which includes:
  - submitting agreed minimum data sets and reports from external quality assurance schemes
  - undertaking ad-hoc audits and reviews as requested
  - completing self-assessment questionnaires / tools and associated evidence
  - responding to SQAS recommendations within agreed timescales providing specified evidence
  - producing with agreement of commissioners of the service an action plan to address areas for improvement that are identified in recommendations

- all screening laboratories must
  - be accredited by the UK Accreditation Service (UKAS) to ISO. 'Medical laboratories – Requirements for quality and competence (ISO 15189)' or be CPA accredited and actively transitioning towards ISO 15189
  - participate in EQA schemes accredited to ISO. 'Conformity assessment. General requirements for proficiency testing schemes (ISO 17043)'
  - meet the screening programme quality assurance requirements mapped to ISO 15189
  - and use ISO 15189 accredited reference laboratories

The UK Accreditation Service (UKAS) will look at both ISO 15189 and the screening requirements on behalf of PHE Screening Quality Assurance Services and the national screening programme

- operate and evidence
  - check points that track individuals through the screening pathway
  - identify, as early as possible, individuals that may have missed screening, where screening results are incomplete or where referral has not happened
  - have process in place to mitigate against weakness in the pathway

- have arrangements in place to refer individuals to appropriate treatment services in a timely manner and these should meet programme standards

- demonstrate that there are audited procedures, policies and protocols in place to ensure the screening programme consistently meets programme requirements

- ensure business continuity - business continuity plans must be in place where required

- ensure sub-contracts and/or service level agreements with other providers meet national standards and guidance

The provider will develop and agree with commissioners a CSIP (continual service improvement plan) in cases where national recommendations and/or screening standards are not fully met. The CSIP will include the following:
  - action plans specifying changes and improvements that will be made during the contracting period
  - defined timescales for actions
  - roles and responsibilities for actions
  - performance issues highlighted by the commissioners
  - concerns raised by service users

**New technologies:**

New technologies should not be used for screening unless approved by the UK National Screening Committee or NICE.
4 Teaching and research activities

4.11 Any research activities undertaken by the provider must have the appropriate approvals from the cervical programme Research Advisory Group
**National Health Service Cervical Screening Programme**

**Appendix 1: Key Performance Indicators**

Key Performance Indicators (KPIs) for cervical screening programme are produced and validated by the Screening Quality Assurance Service and are available for Regional Teams, Commissioners, Screening Programme Personnel and SQAS Professionals to assess the performance of their programmes. The reporting period is variable depending on the individual indicator and may be reported in arrears to ensure that the data is valid and reliable.

Some indicators are reported quarterly, although data is generated monthly to allow for monitoring of trends and more in depth analysis.

### Appendix 1: Key Performance Indicators

<table>
<thead>
<tr>
<th>Objective</th>
<th>Standard</th>
<th>Current acceptable value</th>
<th>Reporting period</th>
<th>Source of report (provided by SQAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To ensure efficiency of cytology reporting Laboratory workload should be within national standards</td>
<td>&gt;35,000 cytology samples p.a from GP and community clinics</td>
<td>n/a</td>
<td>Annually</td>
<td>KC61 Part A1 – submitted to SQAS by labs. Available from 8 weeks after end of year.</td>
</tr>
<tr>
<td>To maximise attendance in the eligible population within 3.5 years of previous screen</td>
<td>The proportion of women in the resident population eligible for cervical screening aged 25 to 49 years at end of period reported who were screened adequately within the previous 3.5 years.</td>
<td>Acceptable level: ≥ 80.0%</td>
<td>Quarterly and annually</td>
<td>KC53 – Open Exeter (data is cleaned by NHS DIGITAL)</td>
</tr>
<tr>
<td><strong>To maximise attendance in the eligible population within 5.5 years of previous screen</strong></td>
<td>The proportion of women in the resident population eligible for cervical screening aged 50 to 64 years at end of period reported who were screened adequately within the previous 5.5 years.</td>
<td>Acceptable level: ≥ 80.0%</td>
<td>Quarterly and annually</td>
<td>KC53 – Open Exeter (data is cleaned by NHS DIGITAL)</td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>3. To reduce test waiting times along the whole pathway and to reduce non-attendance</strong></td>
<td>Waiting times to 1st appointment-all referrals</td>
<td>99% within 6 weeks</td>
<td>Quarterly</td>
<td>Submitted to SQAS by Colposcopy units. Available from around 8 weeks after the quarter. (NB Not currently reported on KC65 so ad hoc reports required)</td>
</tr>
<tr>
<td></td>
<td>Proportion of women who are offered a colposcopy appointment within 2 weeks of referral due to cytological report of possible invasion</td>
<td>≥93%</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>Proportion of women who are offered a colposcopy appointment within 2 weeks of referral due to cytological report of high-grade dyskaryosis (severe) or worse</td>
<td>&gt;=93%</td>
<td>Quarterly</td>
<td>Adhoc reports until KC65Part A is revised.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>Proportion of women who are offered a colposcopy appointment within 2 weeks of referral due to cytological report of high-grade dyskaryosis (moderate)</td>
<td>&gt;=93%</td>
<td>Quarterly</td>
<td>Adhoc reports until KC65Part A is revised.</td>
<td></td>
</tr>
<tr>
<td>Proportion of women who are offered a colposcopy appointment within 6 weeks of referral due to a positive HPV test and cytological report of low-grade or borderline dyskaryosis</td>
<td>&gt;=99%</td>
<td>Quarterly</td>
<td>Adhoc reports until KC65Part A is revised.</td>
<td></td>
</tr>
<tr>
<td>Proportion of women having definitive treatment for high grade CIN within four weeks of the colposcopy clinic receiving a diagnostic biopsy report</td>
<td>&gt;=90%</td>
<td>Annually</td>
<td>Submitted to SQAS by Colposcopy units.</td>
<td></td>
</tr>
</tbody>
</table>

4. To ensure that women receive accurate results in a timely manner

| Proportion of women to receive cytology results within 2 weeks from date of screen | >=98% | Monthly | VSA15–run monthly on Exeter system. |
| Proportion of women to receive colposcopy/biopsy results within 4 weeks from date of test | >=90% (100% within 8 weeks) | Quarterly | KC65 Part D–run by clinics and submitted to SQAS. |
Appendix 2: Performance Indicators

These indicators are used for quality assurance purposes. Whilst achievement of at least the minimum standard is required, they are not generally considered KPIs for contract monitoring purposes.

The cancer screening programmes have published guidelines for all disciplines involved in the three services (bowel, breast and cervical). The Screening Quality Assurance service provides on-going monitoring of the numerous indicators associated with the guidance and these are formally reported at QA visits. Commissioners who require confirmation on the quality of any aspect of their screening services can access this information readily from the regional QA service.

### Appendix 2: Performance Indicators

<table>
<thead>
<tr>
<th>Objective/Measure</th>
<th>Standard</th>
<th>Current acceptable value</th>
<th>Reporting period</th>
<th>Source of report (provided by SQAS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. ABC3 measures of Referral Value, mean CIN score and PPV (ranges published each year by the NHS DIGITAL)</td>
<td>n/a</td>
<td>Within national standards (calculated normal range 5th to 95th percentile)</td>
<td>Annual</td>
<td>KC61 Part C. – submitted to SQAS by labs. Available from 8 weeks after end of year. To allow time for follow up of cases, data is available a year in arrears e.g. final histological outcome is reported in 2014 for women with cytology taken in 2012/13.</td>
</tr>
<tr>
<td>6. Laboratory sensitivity for all abnormalities</td>
<td>(&gt;90%)</td>
<td>n/a</td>
<td>Annually</td>
<td>Report run by laboratory and submitted to SQAS.</td>
</tr>
<tr>
<td>Laboratory sensitivity for high grade abnormalities</td>
<td>(&gt;95%)</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. To reduce test waiting times along the whole pathway and to reduce non-attendance</td>
<td>Proportion of women failing to attend for first or subsequent colposcopy appointment</td>
<td>&lt;15%</td>
<td>Quarterly</td>
<td>KC61 Part B. – submitted to SQAS by colposcopy units. Available from 8 weeks after end of quarter.</td>
</tr>
</tbody>
</table>
Appendix 3: Professional Best Practice Guidance

Achievable standards, benchmarks for reporting and criteria for evaluating cervical cytopathology. NHSCSP Publications No 1, January 2013


Cervical Screening Call and Recall: Guide to Administrative Good Practice. April 2017


Confidentiality and Disclosure Policy. NHS CSP version 4 November 2011

Programme Specific Operating Model for Quality Assurance of Cervical Screening Programmes. NHSCSP, July 2017

Guidelines on Failsafe Actions for the Follow-up of Cervical Cytology Reports. NHSCSP Publications No 21, December 2004

Histopathology Reporting in Cervical Screening. NHSCSP Publications No 10, September 2012

HPV Triage and Test of Cure Implementation Guide. NHSCSP Good Practice Guide No 3, January 2012

HPV Triage and Test of Cure Protocol Algorithm. NHSCSP July 2014


Interim Good practice guidance for cervical sample takers. NHSCSP Publications: Good Practice Guide No 2, July 2011

Interim Implementation of “No Further Review”(NFR) using the BD FocalPointTM Slide Profiler Guidance for the NHS Cervical Screening Programme. NHSCSP, Guide No.4-second edition April 2013


Managing Safety Incidents in the NHS Screening Programmes. Published August 2017

National external quality assessment (EQA) scheme for gynaecological cytopathology: scheme protocol, April 2017


Laboratory Quality Control and Assurance for Human papillomavirus Testing, NHSCSP, January 2017

Classification: official
Guidance for the training of cervical sample takers, NHS cervical screening programme, November 2016

Guidance for acceptance of cervical screening samples in laboratories and pathways, roles and responsibilities, NHS cervical screening programme April 2017