University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR SCREENING HISTORY REVIEW (AUDIT) OF NEW CASES OF INVASIVE CERVICAL CANCER AND DISCLOSURE OF RESULTS

Reference Number	**Version:**		**Status**	**Author:** Alison Cropper
CL-CP/2009/010	V6		Final	**Job Title:** Cervical Screening Provider Lead (CSPL) for the UHDB Cervical Screening Programme
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	1	2004	Alison Cropper	Original version
	6	Jan 2024	Alison Cropper	Review - No changes
Intended Recipients: Cervical Screening Provider Lead, Gynaecology Clinicians, Clinical Nurse Specialists and all other staff involved in cervical screening, especially the process for audit and disclosure of invasive cervical cancer				
Training and Dissemination: The CSPL has received training in this process. Dissemination will be via the UHDB Cervical Screening Management Meeting, Gynaecology operational meetings, MDTs and the UHDB Intranet.				
To be read in conjunction with: the NHS Cancer Screening Programme guidance documents: • Cervical screening: disclosure of audit results toolkit, May 2021 https://www.gov.uk/government/publications/cervical-screening-disclosure-of-audit- results-toolkit • Cervical screening: auditing procedures, Sept 2021 https://www.gov.uk/government/publications/cervical-screening-auditing-procedures				
In consultation with and date: Consultant Gynaecologists, Gynae Clinical Nurse Specialists, Colposcopists, MDTs & Legal Services; December 2023				

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Contact for Review	Alison Cropper Cervical Screening Provider Lead
Executive Lead Signature	 Dr Gisela Robinson Interim Executive Medical Director

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1. Background, Purpose and Scope

The aim of the NHS Cervical Screening Programme (NHSCSP) is to reduce the incidence of and mortality from, invasive cervical cancer. This is achieved by offering regular cervical screening to eligible women so that conditions which otherwise might develop into cancer can be detected and treated before cancer develops.

All women who develop cervical cancer must have their screening history reviewed in accordance with national guidelines, which includes a review of any interactions with the NHSCSP in the ten years prior to her diagnosis, such as cervical screening tests, attendances at Colposcopy and any histological samples taken. The audit is run on a national level by Cancer Research UK on behalf of the NHSCSP.

The main purpose of the audit review is to:

- Monitor the effectiveness of the screening programme by comparing the screening histories of women who develop cervical cancer with those who do not
- Understand reasons why cervical cancers occur despite the existence of an excellent cervical screening programme in the UK
- Identify areas of good practice and indicate where improvements might be made to support evidence-based policy and practice
- Support the continuous learning and development of the healthcare professionals involved in the programme.

All organisations which provide cervical screening services take responsibility for undertaking nationally required audits of screening histories in a timely way, and for offering participants of the screening programme disclosure of their audit results in line with national guidance and screening service specifications.

NHSCSP publication No 28 ('Audit of Invasive Cancers', 2006, revised 2012) formalised details of how the audits should be performed, and an update in 2021 sets out the nationally agreed procedure for auditing all new cases of invasive cervical cancer:

https://www.gov.uk/government/publications/cervical-screening-auditing-procedures

A disclosure toolkit, also published in 2021, provides guidance for staff involved in invasive cancer reviews for the NHSCSP, covering disclosure of audit results and duty of candour:

https://www.gov.uk/government/publications/cervical-screening-disclosure-of-audit- results-toolkit/cervical-screening-review-and-classification-of-previous-screening-results

The Trust Medical Director has overall responsibility for ensuring this guidance is followed and the Cervical Screening Provider Lead (CSPL) has operational responsibility for overseeing the audit activities and reporting the findings.

The purpose of this local Trust policy is to provide a clear and consistent process by which all newly diagnosed cases of invasive cervical cancer in UHDB are audited, and the results disclosed to the individual women concerned, in line with current national programme guidelines.

1.2 Scope

All health services should regularly review their performance and the quality of care that they provide, and clinical audit is one component of this.

Within the NHSCSP this includes an audit:

- To ensure that all women diagnosed with cervical cancer are correctly identified as needing a screening history review, whether they have been previously screened or not
- To ensure that all women diagnosed with cervical cancer are informed of the process of the screening history review and provided with an information leaflet 'Reviewing your cervical screening history – information for patients'
- To ensure that all women diagnosed with cervical cancer are offered the results of their screening history review, unless they have no previous screening history or their most recent history is more than 10 years prior to diagnosis, in which case old samples will have been discarded
- To ensure that all processes outlined in the NHSCSP audit and disclosure guidance documents are adhered to.

A summary report of the audit results for each case is produced by the CSPL and discussed at the Gynaecology MDT. Information contained in this summary report can then be used to inform the disclosure process for those patients wishing to know the results.

All clinicians undertaking disclosure must have completed appropriate disclosure training, in line with national requirements – an e-learning module on the disclosure of audit results and duty of candour in cervical screening.

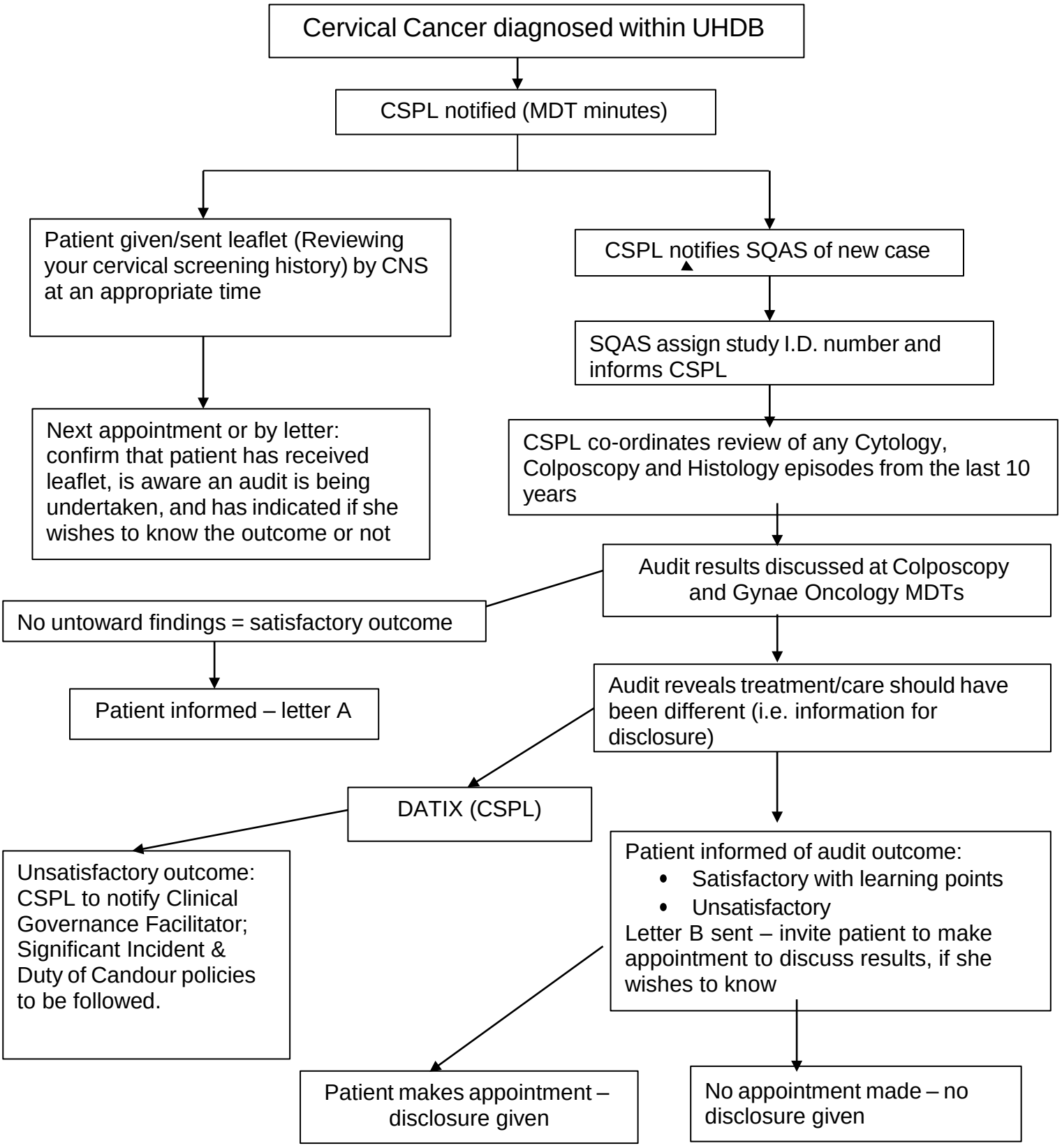
It should be noted that the summary audit report constitutes an NHSCSP audit, and although it can form the basis of information for disclosure, it is NOT a legal case review.

2. Definitions Used

Invasive Cervical Cancer	A histologically proven invasive tumor of the uterine cervix.
NHS Cervical Screening Programme (NHSCSP)	Aims to reduce the incidence of and mortality from, cervical cancer. This is achieved by regular screening of all women at risk, to detect early changes in the cervix, which if left untreated may develop into invasive disease. The primary screening test currently used is a HPV test followed by cytology triage for HPV positive samples.
HPV **LBC Sample**	Human Papilloma Virus Liquid Based Cytology sample - cells collected from the cervix into liquid medium, for processing onto a glass slide in the cytology laboratory, ready for examination
Open Exeter System	The national database and software used by screening offices to operate the call/recall system for inviting women for cervical screening when due, and generating result letters to women screened.

CSPL	The Cervical Screening Provider Lead is the individual responsible for coordinating all aspects of the cervical screening programme carried out within the Trust.
MDT	Multi-Disciplinary Team meeting – for case discussions in Gynecological Oncology and Colposcopy
SQAS	Screening Quality Assurance Service
DATIX	Incident reporting system used by UHDB
SIAF	Screening Incident Assessment Form
CNS	Clinical Nurse Specialist

3. Summary: UHDB Invasive Cervical Cancer Audit & Disclosure Process



N.B:- All the above steps must be documented in both the patient notes and on the audit/disclosure record sheet, which is sent to the CSPL when complete, as evidence that disclosure has been offered.

4. Key Responsibilities / Duties

The Cervical Screening Provider Lead (CSPL)

Is responsible for ensuring that all newly diagnosed cases of invasive cervical cancer in UHDB have a screening history review in line with NHSCSP guidance.

Cases diagnosed at the Royal Derby, Queens Hospital Burton, Sir Robert Peel and Buxton Colposcopy units are notified to the CSPL via the UHDB Colposcopy and /or Gynae Oncology MDT minutes.

(The audit of cases diagnosed at Ilkeston is currently the responsibility of the Nottingham University Hospitals' (NUH) CSPL and these audit outcomes are discussed at the NUH MDT).

When a new case of invasive cancer is identified, the CSPL is responsible for triggering the audit process and notifying SQAS, who allocate a Study ID number to each case.

The CSPL is then responsible for managing the audit process of any Cytology, Histology and Colposcopy reviews to be undertaken, and ensuring that the completed audit result templates are uploaded onto the SQAS database.

The CSPL is responsible for obtaining reviews of any slides from other Trusts that may be needed for the audit. Results of these reviews must be included in the audit report, as must any reviews done externally to the Trust.

A summary report of each case audit is produced by the CSPL and must be discussed at the appropriate Colposcopy and /or Gynecology Oncology MDTs prior to any disclosure being undertaken.

The CSPL must undertake an annual audit to check that all women have been made aware of the audit and offered the results where this has been requested by the patient.

For any audit outcomes classified as 'satisfactory with learning points' or 'unsatisfactory' the CSPL must record the findings on Datix.

For those audit outcomes classified as 'unsatisfactory', the CSPL must trigger the Trusts' Duty of Candour process via the relevant divisional clinical governance team, and also complete a SIAF for submission to SQAS.

The Lead Colposcopist

Is responsible for ensuring that a review of colposcopy assessments and management is undertaken by a Colposcopist who was not involved in the patients care, and that the outcome of the review is sent to the requesting CSPL.

Maybe required to undertake disclosure for any patients who are followed up in Colposcopy rather than Gynecology, with arrangements for this having been previously agreed at the Gynae Oncology MDT.

The diagnosing clinician - Consultant Gynecologist / Colposcopist

Is responsible for ensuring that all patients are informed that a screening history review will be undertaken and for the subsequent disclosure of the outcome information if the patient has requested it.

The responsibility for giving information and ascertaining whether each patient wishes to be given the audit results can be discharged to a Clinical Nurse Specialist, but disclosure must only be undertaken by a Consultant who has undergone appropriate disclosure training.

The lead Consultant in cervical histology

Is responsible for ensuring that a Consultant who has not previously authorised the relevant histology reports undertakes any required reviews, and that the outcome of the review is sent to the requesting CSPL

The Screening Quality Assurance Service (SQAS)

Is responsible for linking together audit data to ensure a complete case history for each patient, for liaising between regional SQAS teams to obtain missing data, and for collating all regional cases on their database and submitting annually to the Cancer Research UK national database.

5. The Screening History Review process

Notification of Cases

All cases of invasive cervical cancer are discussed at the Colposcopy and/or Gynaecology Oncology MDT meeting. The minutes of the MDTs act as notification of new cases to the CSPL, who then commences the audit process in accordance with national guidance

https://www.gov.uk/government/publications/cervical-screening-auditing-procedures/national-invasive-cervical-cancer-audit

See Appendix A - MDT Notification Form

Allocation of Study ID numbers

The CSPL notifies SQAS of the new case.

SQAS assign a national study ID number to each case and send an audit dataset template* back to the CSPL for completion and return to SQAS when all relevant sections have been completed.

* Audit forms are found at:

https://www.gov.uk/government/publications/cervical-screening-auditing-procedures

Cytology Slide Review

The screening history for each case is obtained from the Open Exeter system and any cytology slides from the previous 10 years requiring review will be retrieved from the archives.

A consultant cytologist will review the slides. If the review opinion agrees with the original

report(s) then the audit outcome for cytology is 'satisfactory'.

If the review opinion does not agree with the original report and an abnormality is found on review that that was not originally reported then a second opinion from another Consultant must be sought and a consensus opinion should be agreed regarding the grade of abnormality found on review.

If the abnormality found on review is considered to have been found with hindsight and in the knowledge that it is from a cancer case then the audit outcome is '*satisfactory with learning points'*. Examples of such a classification are:

- Low abnormal cell numbers (<50 in an LBC sample)
- Hyperchromatic crowded groups
- Small cell / pale / bland dyskaryosis.

If the abnormality found on review is considered to be an 'obvious miss' then the audit outcome is '*unsatisfactory*' and duty of candour applies.

In cases where slides were reported elsewhere, the CSPL will ask SQAS to request the originating (or appropriate) laboratory to review the slides and send the results back to the CSPL.

The cytology review opinion is recorded on section E of the national audit dataset.

Histology Slide Review

A record of histology results from the 10 years preceding diagnosis is collated. The diagnostic sample does not need to be reviewed but any relevant cervical samples prior to the cancer diagnosis must be reviewed by a Consultant Pathologist, different to the Pathologist who originally reported the sample.

If the review opinion agrees with the original pathology report then the histology audit outcome is 'satisfactory'.

If review shows minor differences that would not have materially affected the report and management at the time of reporting, but are of educational value the audit outcome is '*satisfactory with learning points'*, examples being:

- Under / over / inappropriate use of stains or ancillary techniques
- A low-grade lesion called high grade
- The specimen is suboptimal for diagnostic purposes.

If the review shows significant differences which would have affected patient management the audit outcome is '*unsatisfactory*' and duty of candour applies. Examples are:

- High grade lesion called low grade or normal
- Missed invasive cancer.

The histology review opinion is recorded on section F of the national audit dataset.

Review of Colposcopy and Gynecological Management

This is undertaken by the lead Consultant Colposcopist, or another accredited Colposcopist if the lead participated in the original colposcopy, treatment, and management of the woman.

Notes from all Colposcopy examinations that pre-date the index cytology sample by up to 10 years must be reviewed and the results recorded on section C of the national audit dataset forms.

If review shows minor differences that would not have materially affected the patients management at that time but are of educational value the audit outcome is '*satisfactory with learning points'*, examples being:

- Incomplete documentation
- Not undertaking treatment in a poor attender with a high grade referral
- Surveillance chosen over treatment.

If review indicates significant differences that would have affected management or treatment at the time then the case should be reviewed by another Colposcopist; the audit outcome is '*unsatisfactory*' and duty of candour applies. Examples are:

- High grade referral but no biopsy taken
- Ablative treatment without a biopsy being taken

- Incompletely excised CGIN not offered repeat excision
- Failure to follow national guidance without MDT discussion.

Note - Any Colposcopy examination(s) associated with the index referral sample and made within 18 months of a subsequent cancer diagnosis do not require review.

6. Reporting the Audit Findings

Internal

A summary sheet of the screening history review is completed by the CSPL and the case put on both the Colposcopy and Gynae-Oncology MDTs.

See Appendix B – Cervical Cancer Screening History Review – Summary

All elements of the screening history review - cytology, colposcopy and histology - should be assigned a classification depending on the findings of each review as described in the previous section:

- Satisfactory outcome – nothing untoward found
- Satisfactory with learning points – something found that was not obvious on original assessment and considered to be a limitation of screening
- Unsatisfactory – something found that should obviously not have happened; Duty of Candour applies.

At the Gynae MDT the overall audit outcome must be agreed, and where any element has an 'unsatisfactory' outcome the overall outcome must be 'unsatisfactory' and Duty of Candour applies.

The MDT must agree and document which clinician is to be responsible for undertaking disclosure in cases where the audit outcome is 'satisfactory with learning points' or 'unsatisfactory'.

A final copy of the screening history review summary sheet is sent by the CSPL to the relevant

Gynecologist, confirming the MDT decision about the screening history review classification and disclosure.

Any cases where the review outcome is classified as 'satisfactory with learning points' or 'unsatisfactory' are registered onto the Datix incident reporting system by the CSPL and notified to the UHDB legal services department in case of potential litigation.

Any cases where the review outcome is classified as 'unsatisfactory' are escalated to the appropriate divisional clinical governance facilitator by the CSPL. The Trusts' Duty of Candour and Serious Incident Management policies will then be followed accordingly.

External

The CSPL uploads a completed national audit dataset on each case audit to SQAS, who will then complete the national data return to Cancer Research UK for further analysis.

Any cases with an 'unsatisfactory' outcome are reported onto the Strategic Executive Information System (STEIS) system by the clinical governance team.

7. Audit & Disclosure: the patient pathway

See Appendix C – Patient Process – Invasive Cervical Cancer Audit

Informing patients about the screening history review

When a new case of cervical cancer is diagnosed the CNS will discuss the screening history review process with women who have previously been screened, and initiate a 'cervical cancer audit / disclosure record sheet' for every patient.

Appendix D – Cervical Cancer Audit/Disclosure Record Sheet

The patient is given the Trust leaflet 'Reviewing your cervical screening history' and a response form. The leaflet explains that a screening history review will be undertaken for all women diagnosed with cervical cancer and that the results of the review will be made available should she wish to have them. The patient needs to indicate on the response form whether she wishes to be informed of the review outcome or not.

See Appendix E – Patient Leaflet - Reviewing your Cervical Screening History See

Appendix F – Review results response form

It must be recorded on the patients' audit & disclosure record sheet that the leaflet/response form has been given.

In some cases the patient will be written to about the screening history review and the leaflet/response form must be sent with this letter.

See Appendix G – Patient audit notification letter

MDT discussion

Once the screening history review has been completed by the CSPL, the findings are discussed at the MDT and the final audit outcome and classification agreed. Depending on the outcome the patient is sent one of 2 letters:

- **Letter A** – the screening history review outcome is '**satisfactory'.**
  The patient will be written to or told this at her next appointment with her Consultant. Confirmation of this letter / discussion must be documented in the patient's notes and on the audit and disclosure tracking sheet.

  See Appendix H – Patient letter A

- **Letter B** - the screening history review outcome is '**satisfactory with learning points'** or '**unsatisfactory.**
  The letter says that the results of the audit are now available and an appointment has been made to discuss the results with her Consultant.

  See Appendix I – Patient letter B.

Note - If the patient has not completed the response form at the time of the MDT then she is first written to advising that the results are available and asking if she wants to be informed.

See Appendix J – Patient letter C

If the patient responds that she does not wish to know then her decision must be respected. If she says she wishes to know then letter A or B is sent as appropriate.

The sending of letters A and B must be recorded on the audit disclosure record sheet.

8. Disclosure of the audit results

The disclosure appointment

The results of the screening history review must only be given by a clinician who has completed the appropriate training, and given carefully to ensure good understanding by the patient.

If the outcome is 'satisfactory with learning points' or 'unsatisfactory' (i.e. there was an under-reported cervical cytology or histology result, or that her Colposcopy treatment /care should have been different) then the conversation giving the patient that information should be treated as a 'bad news interview' in accordance with Trust protocols. The interview should follow the process below:

- Check the patient's understanding of why she has asked for the results of her review
- Ascertain how much information she wishes to know
- Discuss the relevant reports and implications
- Invite her to voice any concerns or ask any questions.

The patient must be helped to understand the limitations of the screening programme and reasons for any missed abnormality or incorrect treatment. It must be emphasised that any reporting discrepancies found on review do not imply that the same findings should have been made under routine conditions and, importantly, why this is so. The quality of this explanation is vital.

Lack of empathy in discussing results, especially if a false negative result has been identified in the audit, often gives rise to complaints and claims. If the patient perceives that the process leading up to being given the results has been open and transparent, and that they receive an apology or expression of sympathy for their present position, they are less likely to make a complaint or claim.

Following the disclosure appointment

The meeting must be documented in the patient notes and recorded on the audit and disclosure record sheet. A copy of the completed record sheet must be sent to the CSPL.

The patient should be written to, outlining what has been discussed, and a copy sent to the GP and CSPL.

Patients often consult their GP after a bad news interview and it is therefore important that the GP understands what has been said. The CSPL is required to ensure that all women have been offered disclosure and that it has been given where appropriate.

An annual audit of the offer of disclosure must be undertaken by the CSPL.

9. Monitoring Compliance and Effectiveness

The audit findings constitute an NHS screening history review, not a legal review, and as such must be carefully discussed in this light.

Data collected as part of the case audit can also be used for disclosure, but it does not constitute disclosure in itself.

Monitoring Requirement:	Audit data from every case reviewed is submitted to the regional SQAS for submission to the national database held by Cancer Research UK. Audit and disclosure record sheet (appendix C) to be completed for every cervical cancer patient.
Monitoring Method:	A summary of each audit undertaken will be discussed at the Gynecology MDT and a final summary sent by the CSPL to the woman's Consultant Gynecologist prior to disclosure, if applicable. Any untoward outcomes of the audit ('unsatisfactory' outcome classifications) must be escalated via the appropriate Divisional Quality meetings. Completed audit / disclosure record sheets will be subject to an annual audit by the CSPL in order to monitor policy compliance by offering of results to all women.
Report Prepared by:	Cervical Screening Provider Lead.
Monitoring Report presented to:	Data on all screening history reviews is reported in the CSPL's Annual Report on the UHDB CSP, which is presented to the UHDB Screening Group, chaired by the Medical Director for Quality & Safety. Any issues from the annual audit report are escalated to the UHDB Quality Review Group.
Frequency of Report	Annually.

10. References

Source of data	Date of publication/issue
NHSCSP Publication No. 28 'Audit of Cervical Cancers'	December 2006 Revised May 2012
'Audit of invasive cervical cancers: colposcopy review', addendum 1 to NHSCSP no.28	September 2012
'Protocol changes to the audit of invasive cervical cancers: to be implemented April 2013', addendum 2 to NHSCSP No.28	March 2013
'Coding guide for the audit of invasive cancers (April 2013 protocol)', addendum 3 to NHSCSP No.28	March 2013
Cancer Screening Programme Series No. 3 'Disclosure of audit results in cancer screening'	April 2006
'Guidance for the Disclosure of Audit Results in Cancer Screening'	September 2014
Cervical Screening : auditing procedures	May 2021, revised September 2021
Cervical Screening :disclosure of audit results toolkit	October 2021

APPENDIX A

MDT Notification Form

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST

GYNAE ONCOLOGY MULTI DISCIPLINARY TEAM MEETING

MDT DATE:

Name:	**Referral Route:**
Hosp No:	**First Discussion**:
DoB: **Age:**	**First Treatment:**
Cons:	**Recurrence:**
NHS Number:	**First Def. Treatment by:**
	Target Date:

PRESENTING SYMPTOMS AND HISTORY:
Performance Status:

INVESTIGATIONS AND RESULTS:
Histology Snomed at Diagnosis: **Grade of Differentiation at Diagnosis:**

DATE OF DIAGNOSIS:
CANCER SITE: **Tumour Laterality:**
Pre Treatment Staging:
Post Treatment Staging:
TRIALS CONSIDERED:

MDT OUTCOME/PLAN OF ACTION:	
Has a HNA been considered?: No **Date Completed?:**	
NEXT OPA & CONS:	
SIGNED:……	**DATE:**

KEYWORKER: **CONTACT No:**
KEYWORKER(2): **CONTACT No:**
KEYWORKER(3): **CONTACT No:**

Name: **Hospital No**:
DOB: **Cons:** **NHS No**:

APPENDIX B

CERVICAL CANCER SCREENING HISTORY REVIEW - SUMMARY

PATIENTS NAME:…….. **DOB:** …… **NHS NUMBER:** ……..

HISTOLOGY: Squamous Carcinoma ☐ ***PRESENTATION:*** Screening ☐

Endocervical Adenoca ☐ Symptomatic ☐

Other type* ☐ *Please specify: ……

Stage:……...

Treatment:……..

CYTOLOGY SLIDE REVIEW:

SLIDE NUMBER	ORIGINAL REPORT	REVIEW FINDINGS	AUDIT CLASSIFICATION

HISTOLOGY REVIEW COMMENTS / AUDIT CLASSIFICATION:

COLPOSCOPY REVIEW COMMENTS / AUDIT CLASSIFICATION:

SUMMARY / ADDITIONAL COMMENTS:

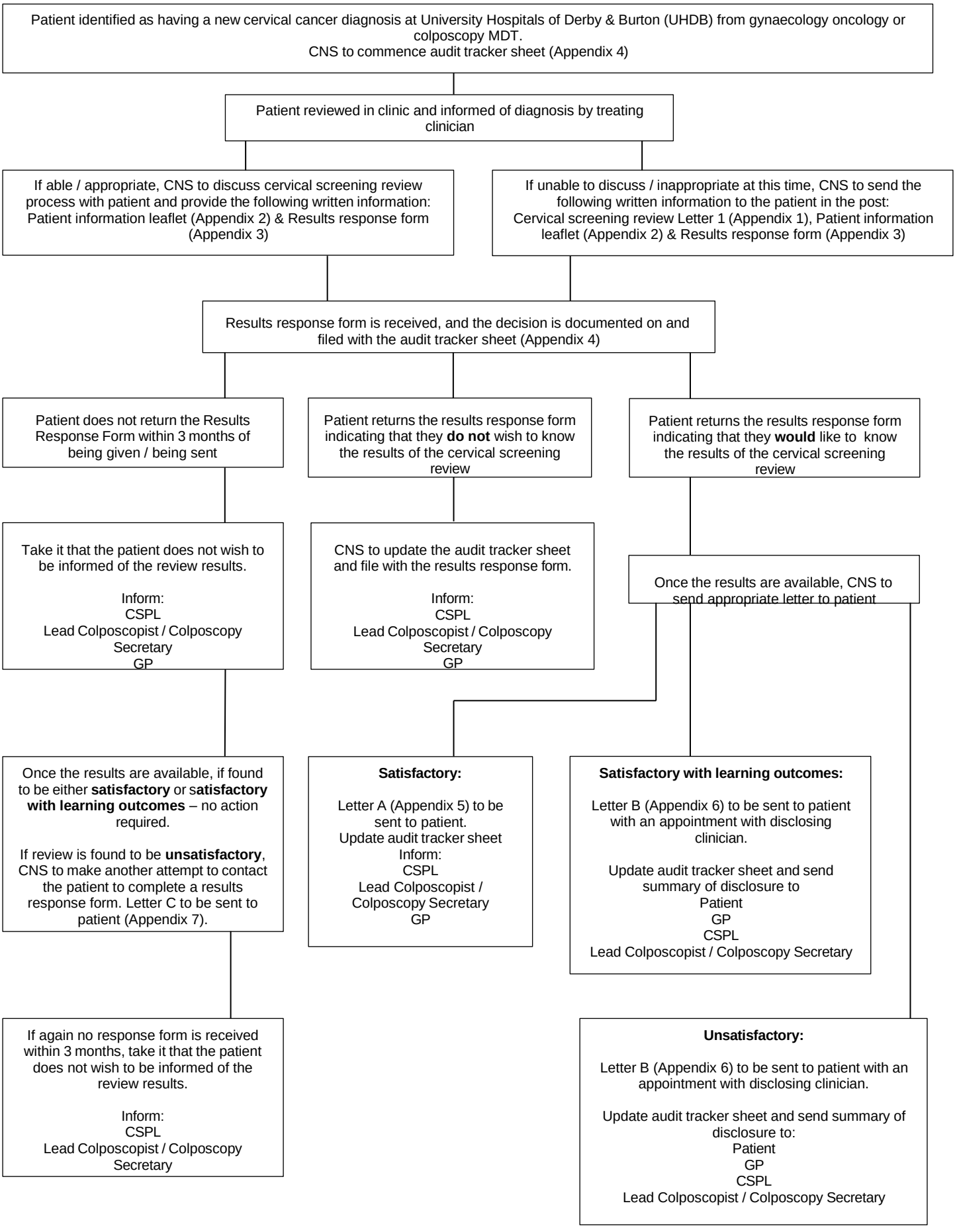
MDT OUTCOME / AUDIT CLASSIFICATION:

CSPL SIGNATURE: …… ***REVIEW DATE:*** ……

N.B. Please note that this review is not a medico-legal review and is carried out by NHS staff for educational purposes. This report constitutes an NHSCSP audit review, not a legal review, and as such must be carefully discussed in this light.

APPENDIX C Patient Process – Invasive Cervical Cancer Audit

PATIENT PROCESS – INVASIVE CERVICAL CANCER AUDIT



APPENDIX D

Cervical Cancer Audit/Disclosure Record Sheet

CERVICAL CANCER AUDIT / DISCLOSURE RECORD SHEET

(To be uploaded to Cito and a copy sent to CSPL when complete – along with Response form if received).

PATIENTS NAME: _____ **DOB:** _____ **HOSPITAL NUMBER:** _____
NHS NUMBER: _____

HISTOLOGY:

- Squamous Carcinoma
- Endocervical Adenocarcinoma
- Other type *Please Specify: _____

PRESENTATION:

- Screening
- Symptomatic

STAGE: _____ **TREATMENT:** _____

1. Patient aware of cervical cancer diagnosis

The following information should be been given/sent to the patient once their diagnosis has been discussed with them

- Letter 1 **(if sending in post)**
- 'Review Results Response' form
- 'Reviewing your cervical screening history' leaflet

Name: _____ Signature: _____ Date: _____

2. Results response form:

Has the 'Review Results Response Form' been returned within 3 months? YES / NO
If yes, would the patient like to be informed of the outcome? YES / NO

3. MDT action agreed:

- Satisfactory – **Letter A** to be sent to patient.
- Satisfactory with learning outcomes – **Letter B** to be sent to patient and appointment made to discuss findings.
- Unsatisfactory – **Letter B** to be sent to the patient and appointment made re: D.O.C.
- Patient does not wish to be informed of the results.

Name: _____ Signature: _____ Date: _____

If no response form received within 3 months:

- If satisfactory or satisfactory with learning outcomes – No action required.
- If unsatisfactory – **Letter C** to be sent to patient.

Name: _____ Signature: _____ Date: _____

4. Summary of Disclosure given – to be completed by Consultant Gynaecologist:

Patient and GP written to, confirming what was discussed in disclosure interview.

Name: _____ Signature: _____ Date: _____

APPENDIX E

Patient Leaflet - Reviewing your Cervical Screening History

University Hospitals of Derby and Burton NHS Foundation Trust

Reviewing your Cervical Screening History

We know that this is a difficult time for you and naturally you will be concerned about your treatment and future health. However, you may also be wondering why you have developed cervical cancer, especially if you have had screening tests (often known as smear tests) in the past.

Cervical screening reduces the risk of developing cervical cancer. Regular screening is by far the best way to detect changes to the cervix early on, but like other screening tests, it is not perfect.

The cervical screening process involves many different steps which aim to identify and treat abnormal cells on the cervix to prevent cervical cancer. It may be that all steps have been followed efficiently and that a cervical cancer has developed despite the screening programme working properly. Or, it could be that at one or more of these steps, something may not have worked as well as it should. Reviewing your case history and previous tests will help identify what has happened in your case and if anything should have been done differently.

Reviews are an essential part of every high-quality screening programme and are a routine part of the cervical screening process. Information we gather from individual cases helps to improve the programme and also helps us to learn more about how cancers develop and how they are diagnosed.

Once we have completed the review we will contact you and invite you to arrange a convenient time for you to come and discuss the results with your doctor if you wish to do so.

What does the review involve?

We review all records connected to the letters inviting you to come for screening, your cervical screening tests, result letters and any previous medical investigations you have had related to cervical screening. A group of professionals will look again at your previous tests, your medical notes related to cervical screening, and also examine whether your screening history meets national guidance.

What will the review show?

In most cases, the review will show that the correct procedures have been followed and that you received appropriate care. Occasionally, the review may find that one or more steps in the process have not worked as well as they should and may highlight where we could make improvements.

Could my cancer have been found earlier?"

In most cases the cancer will have been detected at the earliest possible stage. **Although cervical screening prevents about 75% of cervical cancers, it cannot prevent all of them**. The review process aims to highlight any possible areas of weakness so we can make improvements for everyone. Some examples are given below:

- Screening cannot always identify abnormal cells on a cervical sample slide because:
  - sometimes the cells do not look much different from normal cells
  - there may be very few abnormal cells on the slide
  - consequently, the person reading the slide may miss the abnormality (this happens occasionally, no matter how experienced the reader is).

- ❖ Colposcopy (a visual examination of the cervix) cannot always identify abnormal areas of the cervix because:
  - The abnormal area might not be visible during the examination
  - The abnormal area might not be taken as a sample in a biopsy as it did not appear to be abnormal on Colposcopy.
  - The abnormal cells might be hidden higher up inside the cervix
  - some types of abnormality are simply not easy to identify on colposcopy.

How will I find out the results of the review?

Your doctor will let you know when the outcome is available, and invite you to make an appointment to come in and discuss the results, if you wish to do so.

What if I don't want to know the results of the review?

It is completely up to you to decide whether or not you want to know the results of the review. It will not make any difference to your care.

What if I don't want to know the results of the review now, but change my mind later?

We understand this is a difficult time and you may not want to receive the results of the review now. If you decide that you do want to know the results in the future, please contact your hospital doctor who will discuss the review with you.

Can my family ask for the results if I don't want to know?

No, unless you give permission; we cannot give your relatives access to any details of your medical records.

What happens to the information collected for my review?

We collect screening information as part of an ongoing process. Your information (without your name) goes towards improving the systems of the programme, and to help discover more about how cancers develop and how they are diagnosed and treated. This is done whether or not you want to know the results of the review.

Your notes or questions

Please write down any questions you have and bring them with you to your next appointment.

More information

If you have any more questions about your referral, treatment or the review process,

please phone the Gynaecology Clinical Nurse Specialists on **01332 785925**

(OR INSERT RELEVANT SITE SPECIFIC NUMBER)

If you have any questions about the review process, pleasecontact

PALS (Patient Advice and Liaison service)
Royal Derby Hospital and London Rd Community on **01332 785156**
or TEXT 07799 337500
Queens Hospital Burton, Samuel Johnson and Sir Robert Peel Hospitals on
01283 593110 or **01283 598182**

APPENDIX F

Review results response form

Review results response form
(Please read together with the 'Reviewing your cervical screening history' leaflet)

NHS Cervical Screening Programme Reviewing your cervical screening history

We review the screening history of everyone diagnosed with cervical cancer to make sure that cervical screening tests and investigations meet national standards.

We will be reviewing your cervical screening history including any tests you have had in the last 10 years. The review is likely to take at least 6 months to complete. Once this review is finished, we will offer you the results and an opportunity to discuss the findings if you wish.

Cervical screening is not a test for cancer. It aims to detect abnormal cells in the cervix which can develop into cancer if left untreated. Even in the best performing screening programmes, where all quality standards are met, not every cancer can be prevented. Some people can go on to develop cervical cancer despite previous screening tests being reported as negative, or despite having been previously treated for abnormal cells.

Reviewing the screening histories of all people diagnosed with a cervical cancer may help identify ways to improve screening in the future.

The review of your previous screening tests may occasionally involve sending samples to be looked at by a team at a different hospital. This is done in a confidential manner so that your personal details cannot be identified.

We will write to you when your review is available, and you can choose if you want to know the outcome. If you do not wish to have this information straight away, you can change your mind at any time. You just need to let your consultant or nurse specialist know so they can make the arrangements.

Please tick one of the boxes below and return this form to your doctor or nurse specialist as soon as possible to let them know whether you want to know the outcome of your review.

- ☐ I want to know the results of my cervical screening history review.

- ☐ I do not want to know the results of my cervical screening history review. I understand that I can change my mind at any time.

Name..... Signature.....

Date .....

APPENDIX G

Patient audit notification letter

University Hospitals of Derby and Burton
NHS Foundation Trust

Royal Derby Hospital
Uttoxeter Road
DERBY
DE22 3NE
01332 340131

Ref: /XXXXXX

<Date>

PRIVATE & CONFIDENTIAL
<Name>
<Address 1>
<Address 2>
<Address 3>
<Postcode>

Dear <Name>

For all ladies diagnosed with a cervical cancer, we review the cervical screening history from over the last 10 years, to ensure that cervical screening tests and investigations meet national standards. We have included the following written information for you to have a read of:

- Reviewing your cervical screening history' patient information leaflet
- Review results response form

We advise that you read the enclosed information and then please complete the review response form as soon as possible. This can either be handed in to your doctor or nurse specialist at your next hospital appointment, or sent in the post to:

Gynaecology Oncology Clinical Nurse Specialist Team
Gynaecology Outpatient Department
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3NE

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS

If we do not receive a response form within 3 months, we will take it that you do not wish to be informed of the results of your cervical screening history review. If you have any questions or wish to discuss this further, please contact your nurse specialist team.

Yours sincerely

Claire Hill, Sam Foster & Kirsty Berrington
Gynaecology Oncology Clinical Nurse Specialists

Tel: 01332 785925
Email: uhdb.gynaeoncologycns@nhs.net
Hours of work: Monday – Friday 08:00 – 16:00

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS

APPENDIX H

Patient letter A

University Hospitals of Derby and Burton
NHS Foundation Trust

Royal Derby Hospital
Uttoxeter Road
DERBY
DE22 3NE
01332 340131

Ref: /XXXXXX

<Date>

PRIVATE & CONFIDENTIAL
<Name>
<Address 1>
<Address 2>
<Address 3>
<Postcode>

Dear <Name>

Thank you for returning your form indicating that you would like to receive the results of your cervical screening history review. Your review did not identify any problems with your care and this requires no further action. If you would like to discuss this further, either by telephone or in person, please contact our nurse specialist team to arrange this.

Yours sincerely

Claire Hill, Sam Foster & Kirsty Berrington
Gynaecology Oncology Clinical Nurse Specialists

Tel: 01332 785925
Email: uhdb.gynaeoncologycns@nhs.net
Hours of work: Monday – Friday 08:00 – 16:00

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS

APPENDIX I
Patient letter B

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Royal Derby Hospital
Uttoxeter Road
DERBY
DE22 3NE
01332 340131

Ref: /XXXXXX

<Date>

PRIVATE & CONFIDENTIAL
<Name>
<Address 1>
<Address 2>
<Address 3>
<Postcode>

Dear <Name>

Thank you for returning your form indicating that you would like to receive the results of your cervical screening history review. We would like to invite you to a meeting to discuss the findings and have included an appointment within this letter.

Please feel free to bring a partner, a family member or friend with you to the appointment if you would like. If you have any questions or would like to discuss this further please do not hesitate to contact your nurse specialist team.

Yours sincerely

Claire Hill, Sam Foster & Kirsty Berrington
Gynaecology Oncology Clinical Nurse Specialists

Tel: 01332 785925
Email: uhdb.gynaeoncologycns@nhs.net
Hours of work: Monday – Friday 08:00 – 16:00

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS

APPENDIX J

Patient letter C

University Hospitals of Derby and Burton
NHS Foundation Trust

Royal Derby Hospital
Uttoxeter Road
DERBY
DE22 3NE
01332 340131

<Date>

PRIVATE & CONFIDENTIAL
<Name>
<Address 1>
<Address 2>
<Address 3>
<Postcode>

Dear <Name>

We have previously written to you explaining that for all ladies diagnosed with a cervical cancer, we review the cervical screening history from over the last 10 years, to ensure that cervical screening tests and investigations meet national standards. Included within our last letter were some written information and a review results response form for you to complete and send back to us. However, our records show that we have not yet received your response.

We would like to take this opportunity to provide you with the following information again for you to have a read of:

- Reviewing your cervical screening history' patient information leaflet
- Review results response form.

We advise that you read the enclosed information and kindly request that you please complete the review response form as soon as possible and hand it back to us. This can be given to your doctor or nurse specialist at your next hospital appointment, or sent in the post to:

Gynaecology Oncology Clinical Nurse Specialist Team
Gynaecology Outpatient Department
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3NE

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS

If we do not receive a response form within 3 months, we will take it that you do not wish to be informed of the results of your cervical screening history review. If you have any questions or wish to discuss this further, please contact your nurse specialist team.

Yours sincerely
Claire Hill, Sam Foster & Kirsty Berrington
Gynaecology Oncology Clinical Nurse Specialists

Tel: 01332 785925
Email: uhdb.gynaeoncologycns@nhs.net
Hours of work: Monday – Friday 08:00 – 16:00

INSERT RELEVANT SITE SPECIFIC CONTACT DETAILS