



Public Health
England

NHS Cervical Screening Programme

NHS cervical screening call and recall: guide to administrative good practice

Version 10 April 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England (PHE) exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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Published May 2017

PHE publications

gateway number: 2017005

PHE supports the UN

Sustainable Development Goals



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Glossary

Term	Abbreviation	Description
Cease/ceasing		Permanently stopped from call or recall by the programme
Cervical intraepithelial neoplasia	CIN	Abnormality within the cervix that can lead to cancer. Current cervical screening policy is to test for CIN using liquid-based cytology (LBC)
Community and Sexual Health (clinic)	CASH	Local clinic offering easy access to a range of health services relating to community and sexual health, including to people not registered with a GP
Confidentiality Advisory Group	CAG	Body within HRA that advises the Secretary of State for Health on patient confidentiality issues, particularly those relating to Section 251 of the NHS Act 2006
Department of Health	DH	Central government department for health
Defence Medical Services	DMS	Organisation within the Ministry of Defence responsible for health services for the armed forces and their dependents
Failsafe		Process or procedure designed to ensure that known risks in the screening pathway are mitigated
Female Genital Mutilation	FGM	Serious criminal offence involving the mutilation of a woman's sex organs
Human Papilloma Virus	HPV	Virus understood to be the primary cause of cervical intraepithelial neoplasia (CIN)
Health Research Authority	HRA	DH arms-length body to coordinate health research
Information Governance	IG	A range of laws, rules and processes relating to the correct management of data by public authorities
NHS Cervical Screening Programme	NHSCSP	Collective name for all agencies, processes and systems involved in providing the NHS cervical screening programme in England
National Health Application Infrastructure Service	NHAIS	Legacy IT system that underpins GP registration and other primary care coordinating functions
Next Test Due Date	NTDD	Date when the next scheduled screening test

		should take place
NHS England		Legally, the NHS Commissioning Board
Liquid-based Cytology	LBC	Current standard test regime used in cervical screening in England
Non-responder		Woman who does not take up her invitation to be screened, and does not request postponement or ceasing from recall
Primary Care Support	PCS	Range of 'back office' services for primary care commissioned by NHS England, including cervical screening call and recall, and GP registration
Public Health England	PHE	Government agency delegated some of the Secretary of State for Health's powers
Postpone/postponement		Temporarily stopped from call or recall for a defined time period and for a specific reason
Prior notification list	PNL	List of women on a GP practice list who will be invited to be screened within the next 12 weeks
Screening and Immunisation Lead	SIL	Public health professional employed by PHE and embedded with NHS England to oversee local screening and immunisation services and lead a SIT
Screening and Immunisation Team	SIT	Team responsible for overseeing local screening and immunisation services – headed by a SIL
Secretary of State for Health	SoS(H)	Cabinet-level minister with responsibility for health services including public health
Section 251	S251	Section of the NHS Act 2006 (and later Acts) allowing the Secretary of State for Health to grant access to personal data without explicit consent where there is a public interest justification
Suspended		Temporarily stopped from call or recall whilst on referral to colposcopy or further treatment
Screening Quality Assurance Service	SQAS	Public Health England department charged with the quality assurance of screening programmes

Related documents

All documents relating to the management of cervical screening in England are at:

<https://www.gov.uk/government/collections/cervical-screening-professional-guidance>

1 Introduction

1.1 Background

This document is a comprehensive revision of NHSCSP Good Practice Guide No.18, 'Cervical Screening Call and Recall: a guide to administrative good practice'¹ and replaces the version dated 2004. It must be read in conjunction with the 'NHS cervical screening programme call/recall service specification'².

In mid-2015 NHS England outsourced Primary Care Support (PCS) who run cervical call and recall services³. This included responsibility for the replacement of the National Health Application Infrastructure Service (NHAIS) or 'Exeter' IT system which is used for cervical call and recall. NHAIS will be de-commissioned in 2018 to 2019. NHS England's designated contractor will replace NHAIS with modern IT systems.

The previous version of this guidance was largely concerned with good practice in the use of NHAIS in administering cervical screening call and recall services. This revised version takes a different approach, laying out the basic principles and requirements for the call and recall service, but avoiding the detail of how IT systems should support the process.

1.2 Target audience

This document intended for all of those involved in the commissioning, management, governance, delivery and quality assurance of cervical screening call and recall services. This includes:

- NHS primary care commissioners
- NHS public health commissioners
- local Screening and Immunisation Teams (SIT) including Screening & Immunisation Leads (SILs)

¹ Last version is dated February 2004

² <https://www.gov.uk/government/publications/cervical-screening-call-and-recall-service-specification>

³ <http://pcse.england.nhs.uk/cervical-screening/>

- call and recall service providers including managers and staff
- PHE Screening Quality Assurance Service (SQAS) teams
- software teams developing new call and recall IT systems

1.3 Programme governance

The ‘Immunisation and Screening National Delivery Framework and Local Operating Model’⁴ defines the governance structures for screening programmes in England. This includes the roles and responsibilities of the various national and local bodies involved in the commissioning, delivery and oversight of local programmes. A diagram capturing the main organisational relationships at the highest level is in Appendix A. Under these arrangements, PHE holds the responsibility for the national coordination and oversight of the screening programmes, and NHS England commissions and performance manages operational services.

2 Records management and retention

2.1 Physical records

Records management must comply with the latest version of ‘Records management code of practice for health and social care’ published by NHS Digital⁵. This sets out responsibilities and high-level document retention schedules. Where NHSCSP has requirements to retain specific types of document, these are set out in Appendix B including the business reasons for the period of retention.

2.2 Electronic records

The electronic records in the call and recall IT systems constitute the primary or master electronic record for NHSCSP. They are fundamental to the efficient operation of the service, to the assurance of quality and safety, and the longer-term evaluation and

⁴ <https://www.england.nhs.uk/wp-content/uploads/2013/05/del-frame-local-op-model-130524.pdf>

⁵ See <https://digital.nhs.uk/article/494/NHS-Codes-of-Practice-and-Legal-Obligations>

development of the programme. NHSCSP policy is that these records are retained intact in perpetuity.

This does not rule out a separation of data for operational use from that retained for audit, quality assurance and evaluation purposes.

3 Legal basis for cervical screening

3.1 Population screening in England

The Secretary Of State for Health (SoS-H) has a responsibility to protect the health of the public by providing population screening programmes. This responsibility is defined under Section 2 of the National Health Service Act 2006⁶ as amended by Part 1 Section 11 of the Health and Social Care Act 2012⁷. The SoS-H delegates the responsibility for the coordination and oversight of the programmes to PHE through the annual remit letter. The SoS-H also delegates the responsibility to commission the population screening services to NHS England through Section 7 of the NHS Act 2006⁸ using a set of standard service specifications. Service Specification 25⁹ covers cervical screening.

3.2 Processing GP registration data for call and recall (S251)

The NHSCSP processes demographic data from GP registration IT systems. This data underpins the operational work of the programme including:

- initial invitations to participate
- recall invitations at set periods
- sending results
- invitations for follow up investigations where necessary
- quality assuring the safety and effectiveness of the programme
- long-term evaluation of the safety and effectiveness of the programme

⁶ <http://www.legislation.gov.uk/ukpga/2006/41/section/2>

⁷ <http://www.legislation.gov.uk/ukpga/2012/7/section/11/enacted>

⁸ <http://www.legislation.gov.uk/ukpga/2006/41/section/7>

⁹ Public Health Functions to be Exercised by NHS England: Service Specification No.25 Cervical Screening. See online for the latest version.

Special permission is required from the SoS-H to process the data for screening without breaking the Data Protection Act 1998¹⁰ because the data were not collected for this purpose.

Section 251 (S251) of the National Health Service Act 2006¹¹ allows the SoS-H to permit the processing of personal data without consent where there is an overriding public interest to do so, and where gaining explicit consent is not practical.

The S251 agreement is overseen by the Health Research Authority's (HRA) Confidentiality Advisory Group (CAG), who carry out an annual review of the agreement to ensure they are being applied fairly and lawfully. '15/CAG/0207 - NHS Cancer Screening Programmes: National Coordination and Quality Assurance'¹².

3.3 Maintenance of Section 251 agreement

To maintain the S251 approval, PHE must be able to demonstrate to CAG that appropriate information governance safeguards are in place for all organisations that provide cancer screening services. Many of these safeguards are standard controls mandated by the NHS and enforced through the commissioning process and standard contracts for providers.

PHE demonstrates conformance with CAG's recommended controls through its own Confidentiality and Disclosure Policy¹³ and Security Policy¹⁴. Organisations providing elements of screening programmes must ensure that all staff that have access to screening data formally sign up to the policy. They must also maintain a register to demonstrate this so that PHE's Screening Quality Assurance Service (SQAS) can audit this and provided evidence to CAG where necessary.

¹⁰ <http://www.legislation.gov.uk/ukpga/1998/29/contents>

¹¹ <http://www.legislation.gov.uk/ukpga/2006/41/section/251>

¹² This was formerly PIAG 1-08(a)/2003 Contacting National Health Application Infrastructure Services Data Subjects for Cancer Screening

¹³ <http://webarchive.nationalarchives.gov.uk/20150505143305/http://www.cancerscreening.nhs.uk/confidentiality-disclosure-policy-november2011.pdf>

¹⁴ <http://webarchive.nationalarchives.gov.uk/20150505143305/http://www.cancerscreening.nhs.uk/information-security-policy.pdf>

4 Informed choice and consent

4.1 Approach to consent

The cervical screening programme aims to maximise coverage and uptake amongst the eligible population in line with NHSCSP Publication No.4 'Consent to Cancer Screening'¹⁵. Women should make an informed choice whether to participate. Comprehensive explanatory material is provided with every screening invitation and for any follow up procedure to achieve this¹⁶. This information provides a clear description of the benefits and risks of screening, including the risks of both false positive and false negative results. It explains that a well-managed and audited service carried out by trained staff will maximise the benefits and minimise the risks.

Women who choose to attend for screening are deemed to have provided consent to be screened and to have consented to the data processing necessary to provide a safe and effective service. Consent to receive further screening invitations is assumed unless a woman makes an informed choice not to participate in the screening programme and tells the programme through her GP practice. The call and recall service must include the standard leaflet for the programme with all invitations to participate. The leaflet in current use is 'NHS Cervical Screening: helping you decide'¹⁷.

4.2 At the point of sample taking

The sample taker has a responsibility to explain the procedure, answer any questions and provide support if the women changes her mind. They must as far as possible ensure that women understand:

- the purpose of cervical screening
- their rights to stop the procedure at any time if they do not wish to continue
- the likelihood of a normal result and its meaning (low risk, not no risk)

¹⁵ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/436770/cs4.pdf

¹⁶ See Section 7 Agreement Specification 25; Section 1.12, page 8

¹⁷ <https://www.gov.uk/government/publications/cervical-screening-description-in-brief>

- the likelihood of an abnormal result and its meaning (not a diagnosis but requiring recall for further investigation)
- how and when results will be made available
- the importance of always reporting abnormal bleeding or discharge

More detailed information is available in the 'cervical sample taker training resource pack'¹⁸.

4.3 On referral to colposcopy

Colposcopy units must gain additional consent before they perform any procedure. This process is covered in the latest version of NHSCSP Publication 20: 'Colposcopy and programme management guidelines'¹⁹.

4.4 Opting out of screening

Many women who choose not to participate in the programme will do so by not making an appointment to have a sample taken rather than by making a request to be ceased. Where women do not respond to a screening invitation, they are designated as 'non-responders' after 32 weeks. Women may receive additional reminder letters from their GP practice. Women who remain eligible for screening will be recalled periodically according to current protocols.

Women can make an informed choice to be permanently ceased from call and recall by contacting their GP practice. NHSCSP Good Practice Guide No.1 'Ceasing women from the NHS cervical screening programme'²⁰ covers this in more detail.

4.5 Objecting to data processing

If a woman objects to the programme processing her data, those operating the programme must take all reasonable steps to stop her data being processed. To do this, the woman must put her objection in writing to her GP practice who will forward this to the call and recall service. It is programme policy to respect the wishes of

¹⁸ <https://cpdscreeing.phe.org.uk/csp/samplemaker>

¹⁹ <https://www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management>

²⁰ <https://www.gov.uk/government/publications/cervical-screening-removing-women-from-routine-invitations>

women objecting to their data being processed. There is no legal obligation to do so in the part of the Data Protection Act 1998 that deals with objecting to data processing²¹.

5 Eligibility and inclusion criteria

5.1 Age

NHSCSP send the first invitation for cervical screening when a woman reaches 24½. Women are then recalled every 3 years until they turn 50, when the recall interval changes to every 5 years. Automatic recall stops when the woman's next test due date (NTDD) is on or after when she turns 65.

These are the standard age criteria and recall intervals. Assuming a woman attends regularly and each test is normal (she does not need any further investigation) a woman will have up to 12 samples taken whilst of screening age (not including recalls for inadequate tests).

5.2 Eligibility for NHS care

Women must be eligible for NHS care to participate in NHSCSP. Sample takers are responsible for checking this. GP practices are expected to check this through their registration processes.

5.3 Registration with a GP

Women are invited by the call and recall service to participate in the programme using demographic data on GP practice registration. The call and recall service use this data to manage their progress through the screening pathway.

GP practices take the majority of cervical samples in England. Registration with a GP is not an eligibility criterion in itself, although non-registration presents the programmes

²¹ <https://ico.org.uk/for-organisations/guide-to-data-protection/principle-6-rights/>

with practical difficulties in identifying and contacting individuals for call and recall and any further follow-up.

5.4 Samples taken in other NHS settings

Where samples are taken in other settings (e.g. Community and Sexual Health Clinics) the sample taker must ensure they:

- check the woman's eligibility for screening
- record accurate information about the woman's identity
- record accurate contact information

This will ensure that the woman can be followed-up if necessary.

Women screened through this route must be made aware by the sample taker that their contact details will be kept on record by the call and recall services and used to contact them for future screening invitations as well as to provide test results. The programme does not support anonymous screening.

5.5 Private samples

Women who have a sample taken privately remain eligible for screening under the NHS at the standard intervals. Samples taken by private providers should be recorded in a woman's screening history by the call and recall service when they are made available by the relevant cytology laboratory.

If the result is normal, private test results must not be used to calculate the woman's NTDD under the NHS funded programme. The programme must always act on abnormal results, including those from private tests.

5.6 Notification on changing GP practice

Where a woman who has had an abnormal result or is under care or surveillance changes GP practice, the call and recall service must ensure the receiving GP practice is aware of the woman's status and any requirement for early follow up.

5.7 Residency

To be eligible for screening under the English programme, women must have their primary residence in England. This is consistent with policy in Wales and Scotland which is to screen by resident population - determined by postcode - along the borders. For practical purposes, the address used for GP registration is treated as the primary address. However, for women not currently registered with a GP practice, the last available address must be used unless it is known that the woman has moved outside England.

5.8 Offenders

Women offenders in the English residential prison estate are eligible for screening by NHSCSP.

There are some practical difficulties with identifying and contacting offenders as there is no index of offenders and institutions available to the screening programmes at the present time. However, many prisons have well developed procedures for screening their eligible populations.

The majority of women offenders are on short sentences (6 months or less)²². Although many will not be deducted by their GP practice, and may have call/recall invitations forwarded on to them in prison, this cannot be relied upon. It is recommended that when women offenders are received into prison their screening history is checked, and where possible, they are offered screening in line with their NTDD. The relevant prison health service should be used as a correspondence address for results and follow-up for the screening episode.

5.9 Defence Medical Service (DMS)

Women registered under the Defence Medical Service (DMS) are eligible for screening by NHSCSP. The management of call and recall for this population will require additional security arrangements that must be agreed with DMS and NHS England.

²² <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prisonthefacts.pdf>

The protocol agreed for the routing of call and recall information to the DMS population is for the DMS primary care practice to be used as the point of contact.

5.10 Gender reassignment

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

5.10.1 Female to male gender reassignment

Following the change of gender, the individual will be recorded as male on the GP registration system and will no longer receive invitations from the call and recall service. It is not necessarily the case that the individual will have undergone gender reassignment surgery. If the individual has not undergone a hysterectomy which included the removal of the cervix they are still eligible for screening and should be encouraged to attend.

Where the individual chooses to continue to be screened, the GP practice is responsible for managing invitations and sample taking at the appropriate intervals and for notifying results. The practice should notify the cervical screening laboratory that results should be sent back to the practice and not to the call and recall service. When the change of gender takes place, the call and recall service must send a copy of the individual's screening history to the GP practice in a sealed envelope marked 'Strictly Private and Confidential'.

5.10.2 Male to female gender reassignment

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

5.10.3 Hysterectomy

Women who have undergone a total hysterectomy (including removal of the cervix) will no longer require screening and should be ceased.

Women who have undergone a sub-total hysterectomy remain eligible for recall and should continue to be offered screening.

Detailed guidance on the management of women undergoing hysterectomy is provided in NHSCSP publication 20: 'Colposcopy and Programme Management Guidelines'²³. It is very important that there is absolute certainty over the type of hysterectomy before a woman is ceased from recall.

5.11 Congenital absence of cervix

Women born with this condition are not at risk of cervical cancer and therefore are not eligible for the programme. They should be ceased from recall (see 'Ceasing guidelines'²⁴).

5.12 Intersex

Intersex covers a range of conditions where a person's reproductive and or sexual anatomy does not fit the typical definitions of male or female. This means intersex people's gender as identified in national NHS IT systems may not reliably indicate whether they should be offered cervical screening. In this circumstance, it becomes the responsibility of the person's GP practice to provide cervical screening for those intersex people that need it, and for ceasing those that do not.

For intersex people who identify as male but who require cervical screening, a similar approach should be adopted to female to male transgender patients. The GP should

²³ NHSCSP Publication No 20:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/515817/NHSCSP_colposcopy_management.pdf

²⁴ <https://www.gov.uk/government/publications/cervical-screening-removing-women-from-routine-invitations>

take responsibility for the screening process, and notify the laboratory that results should be returned to the practice directly and not to the call and recall service.

5.13 Trauma and abuse

Women who have experienced sexual abuse or other sexual trauma such as rape may find it extremely difficult or distressing to participate in the programme. Sample takers are expected to provide as much support as possible to enable these women to be screened if they wish to do so. Each case must be considered individually and any decision to defer screening or be ceased from recall must be made with the full informed consent of the woman.

5.14 Female genital mutilation

Female genital mutilation (FGM)²⁵ is a serious crime under the Serious Crime Act 2015²⁶. It is a specific type of sexual trauma. As for other types of trauma and abuse, extreme sensitivity is required from sample takers in supporting women who wish to be screened.

Women who have been badly injured may find it difficult or impossible for a sample to be taken. Discussions on the practicality of sample taking need to be taken on a case by case basis in discussion with the woman. FGM is not a legitimate justification for ceasing without the full informed consent of the woman.

5.15 Terminal illness

Women with terminal illness remain eligible and should be invited for screening. It must be left to them to decide whether to postpone recall for a specified period, or request to be ceased from recall.

²⁵ Referred to as 'female circumcision' in previous versions of this document.

²⁶ <http://www.legislation.gov.uk/ukpga/2015/9/part/5/crossheading/female-genital-mutilation/enacted>

5.16 Radiotherapy affecting the cervix

It may not be possible to take a reliable sample for a woman who has undergone radiotherapy for cancer in the pelvic area. This includes cancer of the bladder and rectum as well as cervical cancer.

All cases should be considered individually and a decision made by the woman in consultation with her GP practice. In some cases women may choose to defer screening or to be ceased from recall.

Women undergoing radiotherapy to other parts of the body remain eligible for screening.

5.17 Physical disabilities

Physical disability may prevent some women from achieving a position where the cervix can be visualised and a sample can be taken. Each case must be considered individually and any decision to defer screening or be ceased from recall must be made with the full informed consent of the woman.

5.18 Mental capacity

Issues of mental capacity are subject to the Mental Capacity Act 2005²⁷. Both physical and mental health conditions can affect people's mental capacity, but the severity of this can vary over time. Each case must be considered separately.

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

²⁷ <http://www.legislation.gov.uk/ukpga/2005/9/section/1>

5.19 Learning disabilities

Learning disabilities alone are not a reason for ceasing women from the programme. It may be very much in a woman's interest to have cervical screening and assumptions should not be made about appropriateness and ability to participate. Materials are available to assist women with learning disabilities to make an informed choice about whether or not to participate in the programme.

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

5.20 Accessibility

The programme provides call and recall letters and information to support informed choice in English. This must be available in an accessible format.

Those responsible for IT systems must ensure they meet the requirements of the Accessible Information Standard²⁸ where this is relevant.

It is assumed that people who cannot read English will have access to some form of local support. Information to support patient choice is provided in other languages via downloads from the GOV.UK website (www.gov.uk), and other accessible information formats are available on request.

6 Call and recall process

6.1 Summary

The call and recall process is based on the routine transfer of demographic information from GP registration IT systems to the call and recall service. When women reach the required age, their details are automatically made available to the call and recall

²⁸ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

service so they can be invited for screening, and an initial next test due date (NTDD) is calculated.

Before any invitation is issued, GP practices are notified of women on their list due for screening through a prior notification list (PNL). This allows the practice to manage any women who do not want or need to be screened. For example, women who need their screening deferred due to pregnancy.

Once the PNL list is closed, invitation letters are sent. Unless a woman requests to be ceased, moves outside of the country or dies, she will be recalled by the programme according to current protocols until she reaches the upper age limit and is ceased from screening.

Women who choose to be screened must have a sample taken. This is usually by making an appointment at their GP practice. In some areas, Community and Sexual Health (CaSH) clinics will also offer a sample taking service. The sample is then sent to a cervical screening laboratory for analysis and reporting.

The result of the laboratory analysis is returned to the call and recall service for them to notify the woman of the outcome of the test by letter. The results letter should be sent within 14 days of the sample being taken. This is known as the 14 day turnaround time (14 day TAT).

Colposcopy services will arrange an appointment for women with an abnormal result. A summary of the timetable for a standard screening round is in Appendix E.

6.2 Routine recall intervals

Routine recall intervals are assigned by PHE. Current policy is:

- age 24½ to 49: recall every 3 years
- age 50 to 64: recall every 5 years

Where women are undergoing further investigation or treatment they must remain in the programme until their treatment is complete.

6.3 Self-referral into the programme

Women who are not registered with an NHS GP practice will not receive an invitation for cervical screening automatically. They can choose to self-refer for screening at routine intervals provided that they satisfy the age and residency requirements. Self-referral will usually be through a Community and Sexual Health (CaSH) clinic. Sample takers must ensure that accurate contact information is recorded and that age, residency and any other requirements are validated.

Women who have made an informed choice to be ceased from the programme remain eligible for screening. They may self-refer at any time after their last test would have become due. If they do choose to self-refer, they will be sent invitations and reminders in line with current protocols.

Call and recall services are responsible for recording contact information provided for women not registered with a GP practice and for sending results and appropriate recall invitations when due. In a situation where there is no address, it is the sample takers responsibility to make appropriate arrangements for the woman to receive her test results and follow-up.

6.4 Opportunistic sampling

Opportunistic sampling is defined as any sample taken from a woman after she has reached non responder status following a screening invitation. All opportunistic screening is for women whose attendance is overdue. Opportunistic screening is not appropriate for women who present with symptoms and the appropriate gynaecological referral pathways should be followed.

6.5 Specifying non routine recall intervals

Cervical screening laboratories and or colposcopy services may define non routine recall intervals where necessary. How these are determined is covered in the relevant laboratory and colposcopy guidance. Recall intervals specified by cytology laboratories

must conform to the coding structure defined on NHS Digital cervical screening pages²⁹. Recall intervals specified by colposcopy should be detailed in the colposcopy discharge report (Appendix F) that provides the formal notification of discharge to the call and recall service.

6.6 Colposcopy referral and discharge

The process for referring women into colposcopy and discharging them back to the call and recall service is covered in detail NHSCSP Publication 20: 'Colposcopy and programme management guidelines'³⁰. Colposcopy departments should use the form in Appendix F to notify the call and recall service of women discharged and to specify the NTDD.

6.7 Calculating NTDD from screening history

Where NTDD is determined by reference to screening history, only valid screening history events should be used. Invalid screening history events include:

- replaced/superseded results
- normal results taken outside the UK
- normal results taken in private practice
- screening events that took place more than ten years before the point at which the calculation is made

Where they are known, abnormal results taken outside the UK or in private practice must be treated in the same way as all other abnormal results.

7 Prior notification lists

7.1 Overview

GP practices have a responsibility to provide assurance that women are being screened appropriately. This is managed through the prior notification list (PNL)

²⁹ <http://systems.digital.nhs.uk/ssd/downloads/cervical/contents/1-2codes>

³⁰ <https://www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management>

process. The PNL is a list of women from the GP practice who are due to be called or recalled for screening. This provides an opportunity for practice staff to consider deferral or ceasing if appropriate.

7.2 Deferring screening

Through the PNL process, GPs may defer a woman's screening invitation for a limited number of reasons. Deferral must include a specified reason. This will recalculate the NTDD based on the length of the deferral.

The legitimate reasons for deferral are:

- a recent test (such as a known test in a community or private setting)
- current pregnancy
- a patient request to defer
- being under treatment relevant to screening (May include in vitro fertilisation (IVF) therapy)
- administrative reasons
- being under the care of colposcopy

The GP practice must specify how long the deferral is for in multiples of 6 months, up to a maximum time of 18 months. So a woman may be postponed for 6, 12 or 18 months at any one time.

When a deferral ends, the woman must be returned to the PNL. It is acceptable for subsequent deferrals to be created, but any such multiple deferrals must be identified and reported to SQAS to be audited.

Deferral because the GP practice is undertaking the invitation process is no longer a legitimate reason. All primary invitations and reminders must be sent by the call and recall service.

8 Invitations and reminders

8.1 Invitation letters

All eligible women must receive a written invitation to attend for screening together with the standard explanatory leaflet (currently 'NHS cervical screening: helping you decide'³¹) to enable them to make an informed choice about attendance.

Where call and recall services have not received a test result from the relevant cytology lab within 126 days (18 weeks) of the invitation letter being created, the woman is considered to be 'overdue' and a reminder letter must be created and sent.

All invitation and reminder letters must use the national templates provided by PHE Screening.

8.2 Local content in letters

National invitation letter templates allow up to 5 lines of additional text to be added to provide locally relevant information, such as how to book a screening appointment. Additional text must be clear, factual and of direct relevance to the screening programme. It is vital that key information is included in additional text if this does not feature in the body of the letter.

Standard letters can include an additional paragraph of free text specific to a GP practice. This should be encouraged as a way of individual practices advising of the availability a female GP / practice nurse or of details of surgery times. The inclusion of such text may assist in improving uptake rates.

8.3 Undelivered mail

Where letters are returned undelivered, call and recall services must notify the GP registration authority and raise a request to check the validity of the postal address. This process must not stop further mail being sent. Following investigation by the GP registration authority, either a change of address will be notified, or the original address will be confirmed as still valid.

³¹ See <https://www.gov.uk/government/publications/cervical-screening-description-in-brief>

Where a change of address is notified, the last mail item must be re-created and sent to the new address. Where the original address is validated, the last mail item must be re-created and sent to this address again.

9 Test ordering

9.1 HMR101

All screening samples must be submitted to the laboratory accompanied by a suitable test request form which is completed legibly and in full. The HMR101 is the national standard form which includes all data fields necessary to support patient identification and reporting. Sample takers may use locally-printed versions provided that these include all standard HMR101 data fields as a minimum.

The HMR101 (2009 version) available from the Open Exeter system will be pre-printed with each woman's demographic details and screening history. This system should always be used in preference to hand-completed forms to ensure that laboratories are provided with all relevant information already recorded on the master index. It is essential that all pre-printed information is checked with the woman herself in case there have been any errors or recent updates. A sample HMR101 form is shown in Appendix C.

Where GP practices have electronic ordering communications or 'order-comms' systems available³², it is acceptable for these to be used to transmit data to laboratories to support the sample instead of an HMR101. Reliable technology must be in place to link the sample to the order-comms data, such as bar coding conforming to the relevant NHS Information Standard³³.

³² For example SunQuest ICE and EMIS Indigo4

³³ <http://content.digital.nhs.uk/isce>

10 Sample processing and reporting

10.1 Cervical screening laboratories

Cervical screening laboratories are responsible for analysing samples and for assigning standard results codes that determine follow-up actions. This includes both cytology results and HPV status where this is tested for.

Laboratories have a responsibility to process samples promptly and send results back to the call and recall service to support the 14 day turnaround time. The programme advocates the use of electronic messaging systems to do this.

The standard coding system specified by NHS Digital³⁴ must be used for all results. Appendix D contains a table of valid result code combinations. All results files must be formatted correctly and quality checked before dispatch.

10.2 Receipt by call and recall services

On receipt of the results file, the call and recall service must validate the file and issue a confirmation of receipt back to the sending cervical screening laboratory. This must include:

- number of records received
- details of any results failing validation

The sending laboratory must correct any files failing validation as a matter of urgency and then re-submit them.

³⁴ <http://systems.digital.nhs.uk/ssd/downloads/cervical/contents/1-2codes>

11 Notification of test results

11.1 Notification timetable and standards

All women must be notified in writing of the results of their primary screening test. Test result letters must be sent within 14 days of the sample being taken.

11.2 14 day turnaround time

The 14 day turnaround time (14 day TAT) was introduced in December 2010 following a policy commitment in the 2007 'Cancer Reform Strategy'³⁵. Call and recall services must work in collaboration with the other elements of the programme to ensure the 14 day TAT standard is met. For more information see 'Cytology improvement guide – achieving a 14 day turnaround time in cytology'³⁶.

11.3 Test result letters

PHE Screening determines the wording and content of results. As a minimum, results letters contain the details of the result and will provide information on what follow up actions are recommended.

Women may define a correspondence address for results to be sent to rather than their home address. This must be discussed and agreed with the sample taker. The alternative correspondence address will only be used for one screening episode and will not be recorded as a permanent detail on the IT system.

11.4 Notification to GP practices

Cervical screening laboratories will notify GP practices of the results of all screening tests for women on their practice list participating in the programme³⁷. Electronic messaging to GP systems is the recommended route where possible. This includes

³⁵ <http://www.nhs.uk/NHSEngland/NSF/Documents/Cancer%20Reform%20Strategy.pdf>

³⁶ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437141/cytology-14day-tat.pdf

³⁷ See Section 7a Specification 25; Section 1.12 Page 8.

both the results of primary screening and the results of any further tests, right through to diagnosis of invasive cancer.

11.5 Amendments to results

Occasionally, amendments may need to be made after results have been sent to a woman. Under these circumstances bespoke letters may be required to clarify the reason for a change to a previously notified result.

11.6 Addresses for results letters

Results letters must be sent to the patient's usual home address (determined to be the address at which they are registered with their GP) unless clear instructions are provided by the sample taker to use an alternative correspondence address.

Where an alternative correspondence address is provided, this must only be used for a single screening episode. It must not be used for future call and recall letters or for results messaging for a future screening episode unless a further instruction is received from the relevant sample taker.

Where a woman chooses not to register with a GP, the address details provided by the sample taker must be used for all communications including future call and recall.

However, all efforts must be made to ensure the woman's details are identified in the NHS Spine Personal Demographics Service (PDS). Where a PDS record is identified, the address provided by the sample taker must be treated as a correspondence address and future call and recall letters must be sent using the address from PDS.

Where call and recall services cannot identify an up to date address for the women (for example if mail is returned, or the woman has de-registered from her last GP), then the sample-taking organisation must be informed and provided with the results.

When the service is notified that women have relocated to another home nation, her results information must be forwarded on to the responsible authorities.

12 The Home Nations: migration in and out of England

12.1 Migration from England to other Home Nations

12.1.1 General principles

Where a woman moves from England to become a resident in Scotland, Wales, Northern Ireland or the Isle of Man, she will no longer be eligible for recall in England. Her screening history must be copied to the relevant NHS body for the Home Nation to inform their call and recall services. For practical purposes this process should be triggered by a change of usual address registered with the woman's GP practice. The records of women who relocate outside England must be retained in IT systems on the assumption that they may return to England and re-join the screening programme.

12.1.2 Age ranges

The sending of records to other home nations applies to all women that have a valid NTDD regardless of age. So the process also applies to women who are under 25 (such as those that may have migrated from another home nation that starts screening from a lower age) and those women who are retained in the programme over the age of 65.

12.1.3 Ceased women

This process also applies to the records of women who have been ceased from recall whilst they remain within the screening age range. This is to ensure the wishes of women who have chosen to be ceased from recall are respected regardless of their relocation to another home nation.

12.2 Migration into England from another Home Nation

12.2.1 General principles

Where a woman relocates from Scotland, Wales, Northern Ireland or the Isle of Man to become a resident in England, the programme expects the relevant NHS body to make the woman's screening history available. This includes the details of women who have been ceased to ensure their wishes are respected.

Where age criteria differ in other home nations, the screening regime under which the woman started the programme should be maintained as far as possible. For example, if a woman was screened at 20 before she moved to England, any available NTDD should be respected. If no existing NTDD is available, then a new NTDD should be set based on English rules (so, first contact at age 24½).

A change of address to an English postcode should trigger the process of 'reintroduction' into the English cervical programme if a woman has any existing screening history in England.

12.2.2 Acknowledgements

Where the responsible authorities in other home countries provide a woman's screening history to the call and recall services in England, an acknowledgement of receipt must be provided by the call and recall service. The screening history provided by the other home nation must be entered into her English screening record and used to calculate the NTDD.

If the screening history has not been received from the sending home nation 10 days from the point of reintroduction, a reminder should be sent.

12.2.3 Failsafe process

If the woman's screening history has not been received within 21 days of reintroduction into the English programme, a 'failsafe' NTDD should be set. This should be 91 days (13 weeks) from the point of reintroduction. If the woman's screening history is received after this failsafe NTDD is set and before recall letters are created, her correct NTDD should be calculated and set in the system, and her GP practice notified.

If the woman's screening history is received after the failsafe NTDD is set and after the recall letter is created, then the screening cycle must be allowed to proceed. The NTDD calculated from her full screening history must be recorded in her screening history record.

Women screened under this failsafe process must be recorded in the system to allow the Screening Quality Assurance Service (SQAS) to monitor the incidence of these events and recommend process improvements.

12.2.4 Unique patient identifiers

Where the unique patient identifier used by another home nation is made available as part of a woman's screening history this must be recorded (for example, the Scottish Community Health Index CHI Number). This is to support the call and recall of women who may relocate between home nations a number of times whilst within the screening cohort.

13 Managing serious incidents

All providers contributing to a screening pathway have a joint accountability to ensure safe and coherent screening for the population screened in accordance with national service specifications.

Each provider is accountable for the safe and coherent delivery of their part of the screening pathway and has joint accountability at the interface with another provider. Both the NHS England 'Serious Incident Framework'³⁸ and PHE's guidance on managing safety incidents in screening programmes³⁹ apply to the cervical screening programme. Providers of services have a responsibility to operate within this guidance. Provider incident policies should reference both sets of guidance.

When a screening safety incident is suspected or declared, the provider will:

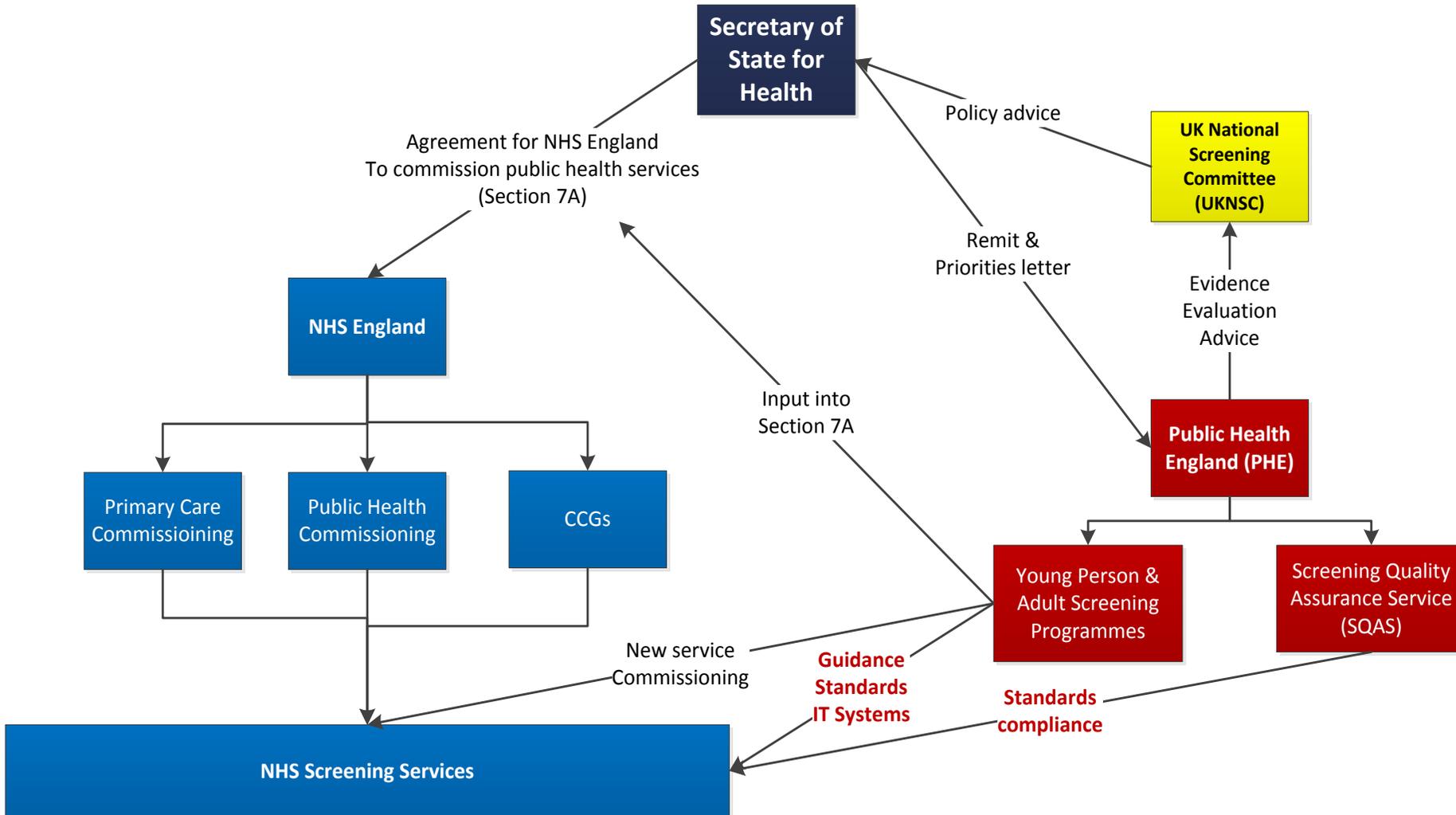
³⁸ <https://www.england.nhs.uk/patientsafety/serious-incident/>

³⁹ <https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes>

- notify the local SQAS and the PHE Screening and Immunisation Team (SIT) embedded in/associated with the commissioner of the service
- fact find
- manage and investigate the safety issue taking account of SQAS advice and reporting to the screening and immunisation team
- coordinate work effectively with other providers
- where agreed, assume a 'lead provider' role

In addition to the above, the provider must provide reports to the commissioner of the screening service and to the commissioner that leads on contracting with the provider (if this is different). Commissioners should work with providers to ensure this happens.

Appendix A: high level programme governance



Appendix B: record retention schedule

Data	Description	Retention period	Reason held
Prior notification lists	Any paper lists from GP practice re invitations to be sent	3 months	to resolve any potential queries. Unless notification to cease, then indefinitely
	Details of any cases rejected back to practice (exception list)	3 months	to resolve any potential queries
Invitations	Details of invitation letters being sent	3 months	to resolve any potential queries
Lab Links	List of results received	3 months	to resolve any potential queries
	Data regarding records that required manual input	12 months	To resolve any potential queries
	Details of exceptions returned to laboratory	12 months	To enable audit to ensure all records updated
Letter print audit	Confirmations from print provider (CDIS) of receipt, production and despatch of screening notifications	12 months	To ensure all data sent in line with national timescales
Colposcopy discharge notifications	Notification of discharge from colposcopy.	6 years	Authorisation for amendment of test due date
Documents requiring manual input	Any screening data received that required manual intervention to the database e.g. non responder data, HMR101 reports	12 months	to resolve any potential queries
Cervical Screening Disclaimer Letters	Disclaimer letter to cease patients from system/from recall for cervical screening	Indefinitely	possible use of information in future legal proceedings;
Cervical Screening Deferral notifications	Deferral notification to screening delaying recall	6 years	To provide evidence to support delaying recall
Invasive Cancer audit data (CRUK)	Report to assist in audit of cervical cancer	6 months	to resolve any potential queries
Any correspondence which results in a woman being removed from the screening programme	Ceasing requests and supporting documentation	Indefinitely	possible use of information in future legal proceedings

Appendix C: HMR101 standard template

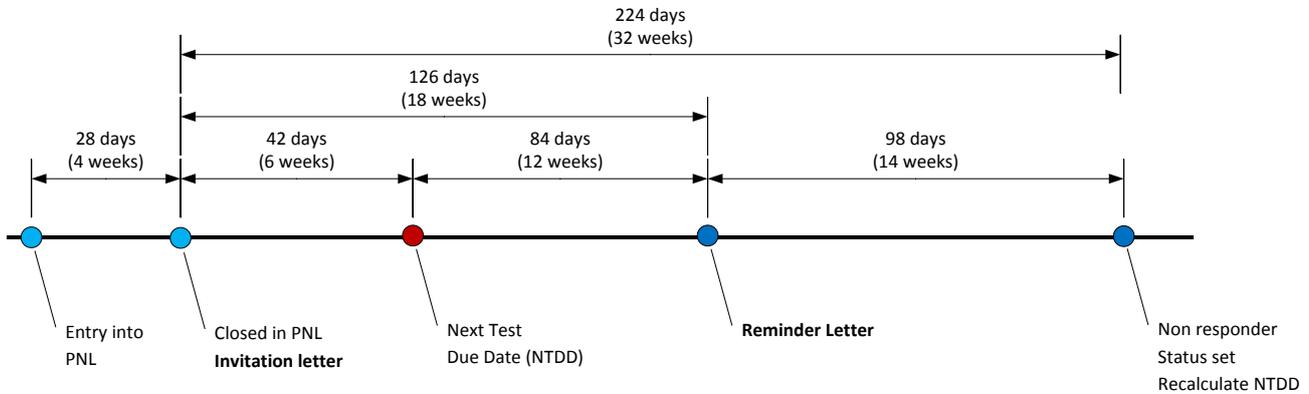
The HMR101 template can be accessed from Open Exeter and will be available from within the Capita call and recall system when this is available.

https://nww.openexeter.nhs.uk/nhsia/servlet/HMR101Generator?form_type=blank&type=A5_2009

Appendix D: normal and abnormal results combinations

HPV test result → Cytology result ↓	none (no HPV test)	0 (negative)	9 (positive)	U (no result)
0	normal	n/a	n/a	n/a
G	n/a	normal	abnormal	normal
1	normal	n/a	n/a	n/a
2	normal	n/a	n/a	n/a
N	n/a	normal	abnormal	normal
3	abnormal	n/a	n/a	n/a
M	n/a	normal	abnormal	normal
4	abnormal	abnormal	abnormal	abnormal
5	abnormal	abnormal	abnormal	abnormal
6	abnormal	abnormal	abnormal	abnormal
7	abnormal	abnormal	abnormal	abnormal
8	abnormal	n/a	n/a	n/a
B	n/a	normal	abnormal	normal
9	abnormal	n/a	n/a	n/a
E	n/a	normal	abnormal	normal

Appendix E: call and recall timetable



Entry into the cohort

Women must be included in the screening cohort in good time to be entered into their first prior notification list (PNL) 210 days (30 weeks) before their twenty fifth birthday. This allows the first invitation to be sent out when the woman reaches 24½ or 182 days (26 weeks) before her twenty fifth birthday. The initial Next Test Due Date (NTDD) is set 140 days (20 weeks) before the twenty fifth birthday.

Prior notification list timing

Details of women due to be screened must be added to a GP practices' PNL 70 days (10 weeks) before their NTDD.

GP practices have 28 days (4 weeks) to review the woman's PNL entry. At the end of this period (42 days before the woman's NTDD) the PNL entry must be closed. At this point, call/recall letters will be created and dispatched.

GP practices must be notified by the call and recall service of these timings and reminded where necessary.

Letter timings

Invitation letters must be created 42 days (6 weeks) before a woman's NTDD, and dispatched as soon as possible thereafter.

Where call and recall services have not received a test result from the relevant cytology lab within 126 days (18 weeks) of the invitation letter being created, the woman is considered to be 'overdue' and a reminder letter must be created and sent.

Setting non responder status

Where the call and recall services have not received a test result from the relevant cytology lab within 224 days (32 weeks) of the call or recall letter being sent, the woman is considered to be a 'non-responder'. At this point her GP practice must be notified so they can take any follow up activity they deem appropriate.

At this point, the woman's NTDD must be reset based on her age and any known screening history.

